

The Brook House Inquiry Report

Volume I

A public inquiry into the mistreatment of
individuals detained at Brook House
immigration removal centre

Kate Eves, Chair of the Brook House Inquiry

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Presented to Parliament pursuant to section 26 of the
Inquiries Act 2005

Ordered by the House of Commons to be printed
19 September 2023



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ISBN 978-1-5286-4421-1

E02788100 09/23

Printed on paper containing 40% recycled fibre content minimum

Printed in the UK by HH Associates Ltd. on behalf of the Controller of His Majesty's Stationery Office

Foreword

It is just over six years since the BBC first aired the *Panorama* programme 'Undercover: Britain's Immigration Secrets' on 4 September 2017. Filmed covertly at Brook House immigration removal centre between March and July 2017, it was shocking in the violence and distress it exposed.

This Inquiry was announced in November 2019, just over two years after that broadcast. I am conscious that the drawn-out process of a public inquiry can expose raw emotions, and that recalling difficult experiences may be retraumatising for those involved. I therefore wish to begin by expressing my gratitude to all those who provided witness statements to the Inquiry, and who gave evidence in person at the hearings. This will not have been an easy process for many, and for some this Report will not be easy to read. I particularly want to thank the crisis support charity Hestia, for the support that it provided to witnesses throughout the course of this Inquiry.

This is an important report, reflecting as it does on the events at Brook House in 2017, what has changed and, most importantly of all, what further change is still needed to ensure that such events are not repeated. I have reflected carefully on the evidence, submissions and advice I have received. I have tried at all times to weigh carefully the evidence before me and conduct this Inquiry in a fair and open manner.

When I was commissioned to conduct this Inquiry, the use of immigration detention was falling and a number of immigration removal centres had been closed. The government has made clear its intention to expand the use of immigration detention. This Inquiry has not considered – and I do not comment on – government policy or related legislative changes, but any expansion or other change should be considered in the context of learning lessons from past failures. My Report comes as the latest in a long line of reports and investigations into immigration detention – many, with depressing regularity, making broadly similar findings and recommendations. It has long since been time to act on recommendations, rather than simply keep repeating them.

This is a lengthy report – and it is accompanied by important footage that should be viewed alongside it – but that should not detract from the need for those to whom my recommendations are addressed to read it carefully. Moreover, it should be read with an openness to engage with the recommendations and a 'can do' attitude. To give this Report less consideration than this would be a disservice to the Core Participants who have fought for this Inquiry, the witnesses who contributed to it and the wider public interest in the issues raised. It should therefore be seen not as the end product of an

Inquiry but rather the start of a new and more humane approach to the treatment of those in detention.

Chairs are the figureheads of public inquiries but behind them is a team enabling and supporting them and without whom this would have been a lengthier and more difficult task. I therefore wish to end by expressing my thanks to the Inquiry team, who have provided me with support and advice throughout. In particular, I wish to thank: Brian Altman KC, Counsel to the Inquiry; Ellis Pinnell and Alex Momcilovic, Solicitors to the Inquiry; and the wider legal team for their hard work and advice. I also wish to thank the Inquiry secretariat, led by Secretary to the Inquiry Sam Ashby, for their contribution behind the scenes. They are a small group, but they have been diligent in their work throughout this Inquiry and in enabling me to deliver this Report.

A handwritten signature in blue ink, appearing to read 'Kate Eves', with a stylized, cursive script.

Kate Eves

Chair of the Brook House Inquiry

September 2023

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Executive summary

- 1.** Out of sight, out of mind: places of detention are the hidden spaces in our society. Most people will have no experience of being incarcerated and few will have worked in such environments. They are places where communication is restricted, rights and freedoms are curtailed, where isolation from loved ones is a fact of life, and where the toll of detention can have an impact on people's mental and physical wellbeing. For anyone who has been detained by the State, it is a profoundly life-altering experience.
- 2.** There is no higher role for the State than as a guardian of all those in its care. This is particularly important for non-citizens, whose rights in the UK are more limited. Their precarious status makes them inherently more vulnerable, particularly when factors such as language barriers, poor health or other characteristics intersect with this fundamental vulnerability. Moreover, the potentially lasting impact of detention on individuals means that the State has a moral duty to ensure that those it detains are treated fairly, humanely, and with dignity and respect.
- 3.** As this Report will show, the story of Brook House during the relevant period (1 April 2017 to 31 August 2017) has been one of stress and distress. Although this Report is focused on the events that took place at Brook House in the relevant period, the issues raised within it are likely to be of wider application. Immigration detention is a challenging environment to work in, and those challenges should not be underestimated. However, stress and distress should not be accepted as 'inevitable' for those who are detained, nor indeed for those who work with detained people. Rather, they are warning signs to which the Home Office, its contractors and monitoring bodies should be continually alert. I have made 33 separate recommendations based on my findings. The vast majority are directed either to the Home Office or to the government more generally. It is clear that more needs to be done at the highest levels of government to ensure that detained people are accorded the dignity and compassion they deserve.

The background to this Inquiry

- 4.** On 4 September 2017, the BBC broadcast a *Panorama* programme called 'Undercover: Britain's Immigration Secrets' (referred to in this Report as 'the *Panorama* programme'). This had been filmed covertly over five months at Brook House, an immigration removal centre (IRC) near Gatwick Airport in Sussex. Containing disturbing footage, the documentary portrayed Brook House as violent, dysfunctional and unsafe. It showed the use of abusive, racist and derogatory language by some staff towards those in their care, the

effects of illicit drugs, and the use of force by staff on mentally and physically unwell detained people.

5. Following the broadcast of the *Panorama* programme, a series of investigations were conducted, including a special investigation by the Prisons and Probation Ombudsman (PPO) in 2019, which I led. On 5 November 2019, the Home Secretary announced that the PPO’s special investigation would be converted to a statutory inquiry under section 15 of the Inquiries Act 2005, and that I was to be appointed as the Chair of the Inquiry.

6. In her written ministerial statement establishing the Inquiry, the Home Secretary drew attention to the shocking nature of the *Panorama* footage and to the Government’s commitment to learn from what took place at Brook House:

“The Government takes any allegation of mistreatment, and the welfare of immigration detainees, very seriously, and I want to establish the facts of what took place at Brook House and ensure that lessons are learnt to prevent these shocking events happening again.”

(Immigration Statement, Priti Patel MP (Home Secretary), 5 November 2019)

7. The Terms of Reference of the Inquiry and its methodology are set out in Appendix 1 in Volume III of this Report. As I made clear when I determined the scope of this Inquiry, I would be led where the evidence took me. This has remained my approach throughout.

8. It is not possible to appreciate the true nature of the events that took place without viewing the footage received by the Inquiry – albeit that it is often very distressing to watch. Therefore, this Report must be read alongside this key evidence (particularly in relation to the incidents in Part C, which are also listed in Appendix 6 in Volume III), in order for my findings to be fully understood and to be put into their proper context.

9. I am mindful that the Home Office has now transferred the management of Brook House from G4S Care and Justice Services (UK) Ltd (G4S) to Serco Group PLC (Serco), and that the relevant period was around six years ago. Consequently, I also considered current practice where it was necessary for me to make recommendations for the future. While this Inquiry has not been an investigation into wider current practice within Brook House or into immigration detention more generally, it is concerning that the Inquiry has identified evidence that suggests that many of the issues present during the relevant period persist under Serco’s management of Brook House.

10. Where matters have arisen of wider application to the treatment of those detained for immigration purposes, I have considered them. However, this has not been, nor should it be considered to be, an investigation into wider current practice within Brook House or into immigration detention more generally.

11. The Home Office has reiterated its desire to learn lessons from this Inquiry. I consider this to be a particularly important function of this Inquiry, not least because one of the key themes to emerge is how often lessons have not been learnt in the past. This failure runs as a dark thread throughout this Report.

This Report

Parts A and B: Context

12. Parts A and B of the Report set out much of the background to this Inquiry. This includes:

- the events at Brook House in 2017 that led to the Inquiry;
- the role and methodology of the Inquiry;
- other relevant investigations and reviews; and
- the broader context to immigration detention and key aspects of the management of Brook House.

Part C: Incidents of mistreatment

13. As set out in greater detail in Part C, in order to fulfil the Inquiry's Terms of Reference I must reach conclusions about the mistreatment of detained people where there is credible evidence. Having analysed the evidence, and by application of the two-stage test I explain in Part C.1, I found 19 incidents in which there was credible evidence of acts or omissions that were capable of amounting to mistreatment "*contrary to Article 3*" of the European Convention on Human Rights, which states: "*No one shall be subjected to torture or to inhuman or degrading treatment or punishment.*" The relevant period of this Inquiry is relatively short (five months). It is therefore of significant concern that, within a limited time frame, I identified 19 such incidents.

14. One of the most shocking incidents I considered, which was central to the *Panorama* programme, was the moment Detention Custody Officer (DCO) Ioannis (Yan) Paschali placed his hands firmly around the neck of one detained person (referred to by the Inquiry as D1527), leaned forward over him and said in a quiet voice:

"You fucking piece of shit, because I'm going to put you to fucking sleep."

(Footage: Day 2 AM 24 November 2021 00:53:00-01:23:53
(KENCOV1007 - V2017042500021))

The experience for D1527 of being restrained by staff and having pressure applied to his neck must have been terrifying and could have resulted in serious injury.

15. I also received concerning evidence about other incidents during the relevant period.

- 15.1** Force was used inappropriately against D1234, D2416, D1527, D687, D1914, D149, D390, D1851, D1538 and D2054. D687 was attempting self-harm at the time.
 - 15.2** D1234, D2416 and D2054 were all forcibly removed from their cells and presented to escort staff while naked or near-naked.
 - 15.3** Pain was unnecessarily inflicted upon D1234, D687, D149 and D1538 during use of force on them.
 - 15.4** An inherently dangerous restraint technique was used on D1234, D1914, D149 and D2054.
 - 15.5** D1527, D2953 and D313 were subjected to physical violence.
 - 15.6** Staff made inappropriate and humiliating comments towards D1527 and D687 as they were attempting to take their own lives.
 - 15.7** D1527, D1914 and D1538 were all inappropriately segregated in a separate part of Brook House.
 - 15.8** In a one-month period, staff used inappropriate force towards D1538 causing him pain, likely made a homophobic comment towards him, and failed to provide him with adequate support after he witnessed his cell mate self-harm.
 - 15.9** When D865 was found unconscious having attempted to self-harm by hanging himself from a ligature, staff initially stood and looked at him without trying to help him.
 - 15.10** Staff made derogatory and humiliating remarks towards D1275 while he was receiving emergency medical treatment due to the effects of a drug overdose.
 - 15.11** Staff repeatedly used aggressive and threatening language to D728 while he was under constant supervision and had therefore been identified as being extremely vulnerable to self-harm and suicide. They also denied D728 access to a shower and therefore prevented him from performing cleansing rituals fundamental to his religion.
- 16.** While I do not make recommendations specifically in relation to the incidents described in Part C, many of the themes that emerge – for example, the inappropriate use of force, the lack of compassion and desensitisation of staff, and the inappropriate use of isolation – are explored more widely in Part D in Volume II. These incidents have been at the forefront of my mind

when determining the lessons that should be learned and the measures required to ensure that other detained people do not experience similar treatment in the future.

Part D: Issues at Brook House

17. In Part D in Volume II, I focus in detail on the core issues affecting Brook House. One key theme that runs throughout Part D is that rules and processes already existed to address the risks associated with immigration detention, and many of the issues that I identify relate to failures to follow those rules.

The contract to run Brook House (Chapter D.2)

18. G4S operated Brook House from 2009 to 2020 on behalf of the Home Office. In this part of the Report, I look at contract monitoring, the assessment of value and quality in the bid proposals, and the original procurement process.

19. In accordance with the Home Office's process at the time, when assessing various bids for the contract it gave equal weighting to the operational 'quality' of each bid and to the cost element. Potential shortcomings, particularly in respect of staffing levels and the freedom of movement and welfare of detained people, were identified at an early stage. However, concerns raised about the quality of certain bids were not acted upon. I have concluded that these bids, which fell so far short of meeting an acceptable standard, should have been rejected or wholly revised, and that, in reality, cost-effectiveness was prioritised over the care and welfare of detained people.

20. The penalty structure of the contract emphasised security over care. There were no specific financial penalties for unsanctioned use of force, or for the abuse of detained people. The financial penalty for an escape was penalised at three times that of a death in detention from self-harm involving a failure in procedures. I consider this indicative of a lack of concern towards the wellbeing of detained people.

21. The contract largely relied on G4S to self-report any failures. The Home Office has accepted that it did not sufficiently resource its staff to enable more effective monitoring of the contract. Mr Philip Riley, Director of Detention and Escorting Services (DES) within the Home Office, told the Inquiry:

"if we had adequately resourced our management of the contract, then I don't think that the abuse would have happened".

(Mr Philip Riley, Director of Detention and Escorting Services within the Home Office, [Philip Riley 4 April 2022 94/11-13](#))

I explored in particular the reporting of incidents of self-harm, which were significant, as a particular example of the inadequacy of the monitoring

process. The evidence suggests that G4S and Home Office staff tasked with monitoring G4S's arrangements for the prevention of self-harm did not take appropriate steps to check for failings, despite significant known levels of self-harm. Further, as a result of inadequate monitoring by the Home Office, G4S did not face financial sanctions in circumstances where robust monitoring would likely have revealed failures and, critically, opportunities to improve safety were also missed.

The physical design and environment (Chapter D.3)

22. The Home Office DES Area Manager for Gatwick IRCs, Mr Ian Castle, characterised Brook House as a place where:

“if you spend more than 24 hours ... you're going to develop mental health issues. It's not a nice place to be.”

(Mr Ian Castle, Home Office DES Area Manager, Ian Castle 15 March 2022 38/16-18)

23. Brook House was described by many witnesses as unfit for purpose as an immigration removal centre. It had been built to the specification of a Category B prison, but without the appropriate facilities for holding detained people for more than a few days. In practice, most were held for much longer periods.

24. Poor, sometimes dirty, facilities and a lack of activities further contributed to the harshness of the environment. Detained people stayed in small, poorly ventilated cells, containing toilets that were sometimes unscreened and unclean. This led to humiliating experiences for many detained people. Constant noise – from the nearby airport and the loud internal environment – added to the already challenging living conditions. A humane and supportive regime was difficult to maintain, and the detrimental effects were particularly acute for those with mental ill health or other vulnerabilities.

25. Overcrowding was an issue. Following a request from the Home Office, the Extra Beds Programme was introduced. Brook House's capacity was increased by 60 beds in 2017, which meant that some cells were converted from two-person to three-person capacity. Concerns about this change were raised by monitoring bodies and staff in advance. However, these warnings went unheeded.

26. Activities were limited by a lack of physical space and understaffing, and also as a result of being insufficiently valued by the Home Office and G4S. I am particularly concerned by the evidence the Inquiry received about the difficulties detained people experienced accessing the internet. Unnecessary restrictions were imposed on websites and, too often, computers were broken. This appears to have had the effect of impeding some detained people's access to justice.

Detained people's safety and experience (Chapter D.4)

27. Although people should only have been detained at Brook House if there was a realistic prospect of removal from the UK within a reasonable period of time, there was no fixed or maximum period for which someone could be detained at Brook House or any other IRC – and that is still the case. The Inquiry heard that indefinite detention caused uncertainty, frustration and anxiety for detained people, and had a negative impact on their health and wellbeing, a point that has been made by numerous observers repeatedly over many years.

28. Illicit drug use by detained people at Brook House was a significant problem during the relevant period, particularly with the new psychoactive substance known as 'spice'. G4S and the Home Office were aware of the availability of drugs at Brook House. The Inquiry heard evidence alleging that staff members may have been bringing drugs into Brook House. G4S's response to specific allegations against individual staff members was slow and inadequate. There was a sense of defeat from staff in how to address the spice problem and this was compounded by a lack of training on how to deal with those who were suffering the effects of spice.

29. Language barriers reduced the ability of detained people to interact with staff, access healthcare, make complaints and communicate with visitors. Insufficient steps were taken by G4S during the relevant period to reduce these barriers, including an over-reliance on informal translation. There were also deficiencies in the reception and induction given to detained people upon arrival at Brook House, and an inadequate process for assessing risk when allocating detained people to cells. The use of a policy of 'no-notice removals' during the relevant period appeared to have a detrimental impact on detained people, increasing levels of uncertainty, fear and use of force.

30. I am also concerned about the length of time detained people were locked in their cells overnight. This is an issue that has been raised previously on a number of occasions. Lengthy lock-ins have a detrimental impact on wellbeing and need to be kept to a minimum. I have concluded that one of the drivers for the restrictive regime was financial – higher staffing levels may be required to maintain safety when detained people are out of their cells. Regardless of the reason, detained people were and continue to be locked in their cells overnight for an excessive period of time.

Safeguards for vulnerable individuals (Chapter D.5)

31. I also looked in detail at failures in safeguards at Brook House for those individuals who may be vulnerable to suffering harm in detention. Those safeguards are intended to ensure that people are only detained when it is appropriate to do so and that they are not at serious risk of harm by continued detention. Failures to follow safeguarding rules and procedures clearly

contribute to an environment in which harm may more easily occur. It was clear from the evidence the Inquiry saw that staff within Brook House, including medical professionals, were failing to apply the safeguards consistently.

32. I found serious failings in the application of Rule 34 and Rule 35 of the Detention Centre Rules 2001. These Rules require a physical and mental examination of a detained person by a medical practitioner within 24 hours of admission, and a medical report to be produced if a person's health is likely to be affected by detention, they are suspected of being suicidal or they may have been a victim of torture. Many of these concerns have been raised previously by various oversight bodies and non-governmental organisations. Where Rule 35 reports were completed, the quality was generally poor. Dr James Hard, the Inquiry's medical expert, considered that around 75 per cent of the Rule 35(3) reports he examined were inadequately completed. In particular, he noted that there was either no conclusion regarding the possibility of previous ill treatment being torture, or no conclusion on the impact of ongoing detention.

33. I have been particularly critical of the practice of using incorrect forms to notify the Home Office of vulnerable detained people. This was wholly inappropriate as it would not prompt a review of an individual's suitability for ongoing detention, and I found no evidence of this practice acting as an effective safeguard.

34. I considered the Home Office's Adults at Risk policy, which gives guidance on the care and management of detained people deemed to be particularly vulnerable or at risk in detention, and the Assessment Care in Detention and Teamwork process, which promotes a holistic approach to self-harm and suicide prevention. I found evidence of a disconnect between these policies and the Rule 35 process. There was no recognition that a holistic view needed to be taken in relation to self-harm and suicide risk, and that the various processes should be complementary. This undoubtedly exposed vulnerable people to a risk of harm and, in some cases, caused actual harm to be suffered.

35. I remain gravely concerned about the dysfunction in the operation of these layers of safeguards. Based on the evidence I have seen throughout this Inquiry, vulnerable people in detention are not being afforded the appropriate protections that these safeguards are designed to provide.

Restrictions on detained people (Chapter D.6)

36. Rule 40 (removal from association) and Rule 42 (temporary confinement) of the Detention Centre Rules 2001 contain powers that restrict the rights of detained people, segregating them to some degree from each other. These are important and necessary powers that should be used exceptionally for the shortest possible time and be subject to strict governance.

37. Safeguarding considerations are vital when it comes to segregation. A decision to segregate a person in a detention setting should not be taken lightly. Segregation has been associated with worsening symptoms of mental ill health, and in the case of already vulnerable individuals can exacerbate pre-existing conditions such as post-traumatic stress disorder (PTSD). Suicidal thoughts and the risks of acting on them can also increase.

38. I saw evidence that suggests that Rules 40 and 42 were routinely misunderstood, misinterpreted and misapplied by both G4S and the Home Office. Those working at Brook House, including senior members of staff, did not have a clear understanding of the circumstances in which the Rules could be used and who could authorise their use. Indeed, I heard evidence that this confusion and potential misunderstanding persists under Serco. By failing to adhere to the strict rules around these powers, far too many individuals may have been segregated without the proper level of authority or scrutiny. Evidence suggesting that 'urgent' provisions were being used to enable immediate segregation when there was time to seek the proper authorisation is of serious concern.

39. In addition to concerns about the authorisation of Rules 40 and 42, I found evidence of Rule 40 being used inappropriately as a punishment and for administrative convenience prior to a planned removal or transfer; and evidence of Rules 40 and 42 being used inappropriately to manage detained people with mental ill health. The Inquiry also received evidence that accommodating those subject to Rule 40 on E Wing, which was also used to house the most vulnerable detained people, had a harmful impact on those vulnerable individuals. In its 2021 report, the Independent Monitoring Board at Brook House (Brook House IMB) identified that there were continuing problems with the use of Rule 40 under Serco's management of Brook House.

40. Overall, I have found the entire safeguarding system in a number of areas to be dysfunctional. This is not because the safeguards themselves are poor, but rather the adherence to and implementation of these safeguards is disregarded. This has resulted in a failure to protect those detained, as the safeguards intend them to be, and has left vulnerable people at risk of harm. A more consistent and robust application of existing safeguards is essential.

Use of force (Chapter D.7)

41. Force must only be used on detained people as a last resort, and should not be used unnecessarily, inappropriately or excessively. I found too often that this was not the case. When force is used unnecessarily, inappropriately or excessively, it has the potential to cause harm, and therefore it has been a critical focus of this Inquiry.

42. Several concerning themes arose from the evidence I reviewed, including force being used in order to provoke and punish detained people, use of force when it was not a last resort, a failure to employ de-escalation

techniques and inappropriate use of Personal Protective Equipment (PPE). I was particularly troubled by the use of unauthorised techniques, including the continued practice of handcuffing detained people with their hands behind their backs when seated – which is no longer authorised following the death of a detained person in 2010 after being restrained by G4S officers.

43. The Inquiry also heard alarming evidence from those against whom force was used. The practice of using force on detained people who were mentally or physically unwell was common and sometimes used as a way to manage symptoms of illness. Force was also used inappropriately against naked or near-naked detained people, which resulted in the degrading treatment of individuals.

44. Monitoring and oversight of the use of force by senior managers was inadequate, which led to dangerous situations for detained people and staff. The reports officers submitted about incidents of use of force were sometimes inaccurate or lacked detail, and on some occasions were never completed at all. There were failures to wear or activate body worn cameras, despite such footage being crucially important in enabling the identification of serious issues arising from use of force incidents and in providing an opportunity to learn from them. Debriefs following incidents were generally of poor quality. Ineffective, cursory and/or delayed reviews of incidents meant opportunities to identify and address poor practice were missed.

45. There is no specific detention services order for the use of force inside IRCs. Instead, use of force within immigration detention is governed by a prison service order. This does not therefore take account of the specific needs, circumstances and vulnerabilities of detained people in immigration detention. A new detention services order that sets out comprehensive and mandatory guidance about the appropriate use of force in IRCs is urgently required.

Healthcare (Chapter D.8)

46. Immigration detention is a highly challenging environment in which to deliver healthcare services. There are high levels of mental ill health among the detained population. A significant proportion are likely to be acutely vulnerable, having been victims of torture or having experienced trauma, and there are heightened risks of suicide and self-harm. All of these factors can make it difficult to assess and treat the medical needs of patients in detention.

47. The Inquiry received evidence from formerly detained people that doctors and nurses were dismissive and exhibited a lack of care or empathy. A view sometimes prevailed that a patient was exaggerating their symptoms, conditions or past history for the purposes of furthering their immigration case. The failure to recognise challenging behaviours as a manifestation of mental ill health rather than wilful disobedience is a theme that runs throughout this Report.

48. For example, the Inquiry received records in relation to approximately 60 detained people refusing food and fluid during the relevant period for varying lengths of time. There may be many different reasons why a detained person refuses food and fluid, such as distress or psychological causes. I found food and fluid refusal was not afforded the attention it merited; there was inadequate consideration of the detained person's mental capacity, and food and fluid refusal was generally felt to be a form of protest about detained people's immigration cases, rather than a sign of mental ill health. Crucially, it did not necessarily prompt consideration of a Rule 35 report by a GP, or monitoring under Adults at Risk procedures. Moreover, the Home Office was not informed and so did not have the opportunity to review the individual's detention and consider their release.

49. I found instances of inappropriate mocking or derogatory remarks made by healthcare staff about, and in the presence of, detained people. The Inquiry also received evidence that healthcare staff failed to challenge inappropriate behaviour from custodial staff.

50. I am particularly concerned that healthcare staff did not understand their obligations towards detained individuals and failed to appreciate their key safeguarding role. This was particularly evident in the context of use of force. They must be focused on the welfare of the detained person and not inappropriately defer to detention staff, matters of convenience, or security considerations.

Staffing and culture (Chapter D.9)

51. I considered the staffing issues at Brook House, the culture among those working at Brook House, and the extent to which circumstances have changed under the current contract with Serco.

52. During the relevant period, the environment at Brook House was not sufficiently caring, secure or decent for detained people or staff. It is clear that inadequate staffing levels were a significant issue and affected the experience of detained people. Indeed, witnesses told the Inquiry that Brook House was dangerous because of understaffing. Senior G4S managers and the Home Office were aware of staffing issues, but I found little evidence of attempts to combat them and in turn meet the needs of the increasing numbers of detained people.

53. I found evidence that the Senior Management Team (SMT) within G4S was dysfunctional. Senior managers were not sufficiently visible to junior staff, who were left largely to manage on their own, and SMT inattention was compounded by unprofessional behaviour such as in-fighting. The gulf between senior managers and those 'on the ground' reduced the likelihood of custodial staff seeking SMT advice or sharing concerns. It also reduced the ability of SMT members to act upon troubling behavioural and cultural issues, of which they should have been aware.

54. When working in a very challenging environment, staff are likely to feel the need to rely on colleagues. For example, Detention Custody Manager (DCM) Stephen Loughton (now Assistant Director of Brook House) in his evidence to the Inquiry talked of staff feeling “*let down*” by DCO Callum Tulley. However, while this reliance on colleagues can create strong bonds, it can also operate as a powerful disincentive to reporting poor staff behaviour, and those in leadership roles must constantly be alert to this risk.

55. Evidence obtained by the Inquiry revealed the use of abusive, racist and derogatory language towards detained people by G4S staff. Disturbingly, this was explained by some as a way to ‘fit in’. It was common for staff to talk about detained people in an abusive manner. There were also multiple occasions where staff talked about past violence, verbal abuse and threats to detained people, or described future intentions to use violence. I was shocked at how desensitised many staff appeared to be towards the vulnerabilities of detained people. For example, the Inquiry saw footage of occasions where staff, talking about a detained person, used the phrase “*if he dies, he dies*” – evidence of a dehumanising response to detained people’s welfare by some staff.

56. There was little recognition among staff witnesses of the power imbalance that exists between detained people and those responsible for their care. Too often, inappropriate behaviour was dismissed as ‘banter’ and it was evident that some staff felt emboldened to behave without fear of consequence. I am particularly concerned by the lack of reflection by some of those who remain working at Brook House, a number of whom are now in more senior roles. It inevitably casts doubt on how far the cultural changes described by Serco can be said to have been embedded. There is more to do.

Complaints and whistleblowing (Chapter D.10)

57. Many detained people felt unable to complain about their treatment or raise concerns. This applied to many of the incidents shown in the *Panorama* programme. Language and communication issues, a lack of understanding of their rights, a lack of confidence in the complaints system, and a belief that nothing would change or no one would listen, created barriers to detained people making complaints. Some feared repercussions from staff and/or for their immigration case. When detained people did make complaints, they were often poorly investigated.

58. Complaints about minor misconduct and about service delivery were dealt with by G4S. This included complaints about facilities, staff behaviour, bullying and access to property. Most were found to be unsubstantiated. Some complaints were investigated by DCMs who themselves had been subject to multiple complaints and I am concerned that there may have been a tendency to believe an accused staff member over a detained person. There was a financial incentive for G4S to find complaints against their own staff to be

unsubstantiated – penalty points were incurred under the contract for substantiated complaints.

59. Complaints about serious misconduct were required to be allocated to the Home Office Professional Standards Unit (PSU) for investigation. However, there were some occasions where cases were wrongly allocated or there was a delay in taking meaningful action. Further, I identified a number of concerning themes arising from the PSU's investigations, including the process under which some of the investigations were carried out, the decision-making of investigators when determining whether allegations were substantiated or not, and the communication of outcomes.

60. Staff at Brook House lacked trust in the whistleblowing process – when 'Speak Out' posters were defaced with graffiti saying "*snitches*" and "*don't be a rat*", they remained up for months. I found no common practice of reporting colleagues for inappropriate behaviour towards detained people. A culture of not 'snitching' was allowed to prevail, and several members of staff told the Inquiry that they did not report incidents for fear of being labelled a "*grass*" or being bullied. Although the extent of whistleblowing was not entirely clear, a large number of staff at Brook House witnessed inappropriate behaviour during the relevant period but did not use Speak Out or any other process to raise concerns about that behaviour. Senior management showed a lack of understanding about the willingness of staff to use the processes in place and the reasons why they might not do so. The whistleblowing policy and processes themselves were inadequate, ineffective and were not adequately tailored to Brook House or IRCs more generally. Disappointingly, when staff did raise concerns or grievances, there was often an inadequate response.

Inspection and monitoring (Chapter D.11)

61. Primary responsibility for the welfare of detained people at Brook House and compliance with rules and procedures lay with the Home Office and its contractors (during the relevant period G4S, and currently Serco). It was therefore alarming to discover, in the course of this Inquiry, the extent to which both the Home Office and G4S relied upon the monitoring provided by volunteers on the Brook House IMB, and on infrequent inspections conducted by HM Inspectorate of Prisons (HMIP). While both organisations have important and complementary roles in monitoring welfare standards, neither organisation can provide a level of scrutiny that can act as a substitute for critical internal monitoring, and it is crucial that the Home Office and its contractors recognise this.

62. It is not surprising that neither organisation identified the abuses shown on the *Panorama* programme. These are behaviours that would be kept hidden from monitors. Indicators of abuse can be insidious and I have found that both HMIP and the Brook House IMB need to do more to ensure that they are alert

to the signs of mistreatment, that they carry out their roles with robust independence and that their methodologies are effective.

63. Every IRC has an IMB operating within it, to provide regular and independent oversight with a focus on the welfare of detained people, and IMB members visit at least once a week. The Inquiry saw evidence from Brook House IMB members raising concerns on behalf of detained people on many occasions. However, the Brook House IMB was insufficiently challenging of G4S and the Home Office, and the Inquiry saw examples of an inappropriately sympathetic approach to these bodies. More recent evidence has demonstrated a more robust and rights-based approach by the Brook House IMB, which must continue.

64. HMIP's purpose is to report on the treatment of detained people and conditions in detention centres. Although HMIP received some information between inspections, this was sporadic and largely reliant upon an individual or organisation deciding to raise a matter.

65. The 2016 HMIP inspection report about Brook House was overly positive in places, including in the introduction and comments on the governance of use of force. Where it was critical it sometimes did not go far enough, while in some instances the inspection report did not adequately reflect some of the adverse evidence HMIP had obtained about Brook House. HMIP deserves credit for its swift and proactive response to the *Panorama* programme, and the enhanced methodology introduced in the aftermath is an improvement on the previous approach. As HMIP cannot enforce adherence to its recommendations, the onus is on the Home Office and its contractors to respond properly to recommendations, and to accept them wherever feasible.

66. It is vital that, in closed institutions, those responsible for management and oversight embrace challenge and feedback. A culture of robust scrutiny must prevail, but primary responsibility for ensuring the proper treatment of detained people lies with the Home Office and its contractors.

Part E: Recommendations to prevent recurrence of mistreatment

67. Given the passage of time and contractual changes that have since occurred, I have considered carefully whether lessons have been learned and what action could be taken to prevent incidents like those shown in the *Panorama* programme from recurring.

68. There are a number of overarching themes that I have come across repeatedly. I have seen the damaging effect that indefinite detention has on detained people. People should not be detained indefinitely in a Category B specification environment for immigration purposes. In light of what I have found, I recommend that the Government introduce a time limit, whereby

those detained at IRCs, including Brook House, should only be kept there for a maximum of 28 days.

69. The Home Office has ultimate safeguarding responsibility for the welfare of detained people. The process of subcontracting cannot remove that responsibility and it is unacceptable for the Home Office to attempt to delegate its fundamental role of caring for and protecting some of society's most vulnerable people to its contractors. Similarly, it is inappropriate for the Home Office to rely on the monitoring of the IMB and/or HMIP as a substitute for conducting rigorous oversight of its own.

70. I have rejected the narrative portrayed by both the Home Office and G4S in their evidence, that events at Brook House were primarily the result of the behaviour of a small minority of staff. The evidence produced in the course of the Inquiry does not support this, and attempts to characterise the events in this way both minimise what occurred and seek to distance the Home Office and G4S from their responsibility for the prevailing culture. Many of the issues I have identified relate to a failure to follow the rules and safeguards that already exist in recognition of the risks associated with immigration detention. The troubling tendency to pay only superficial attention to the rules contributed to the toxic environment that existed at Brook House.

71. I have found that, too often, my findings closely mirror those from previous investigations and reviews into the treatment of detained people. Lessons must be learned, a culture of change must prevail and recommendations must be acted upon. The events that occurred at Brook House cannot be repeated.

72. A full list of my recommendations is contained in Part E in Volume II of the Report. I return to the former Home Secretary's wish to learn lessons. On this occasion, lessons must be learned and more than mere lip service paid to my recommendations. The Home Office and others must publish details of the steps they will take in response to each recommendation, including the timetable involved, within six months of the publication of this Report.

73. Finally, the experiences of detained people lie at the heart of this Inquiry. No review of process or examination of policy should lose sight of the individual person who, whatever the reason for their detention, will inevitably find their life profoundly affected by the experience. It is for this reason that this Report begins with some of their accounts.

Pen portraits

Introduction

1. The Inquiry heard and received evidence from formerly detained people about their experiences at Brook House. A selection of their accounts is set out in this chapter – collated from oral evidence, witness statements and other documentary evidence – in order to illustrate a range of experiences of detained people at Brook House during the relevant period (from 1 April 2017 to 31 August 2017). These pen portraits are the accounts of individuals, and they are included to provide an insight into personal experiences of detention at Brook House, and its impact on detained people. They are not findings of fact, and any findings in respect of those featured here will be set out later in this Report.

D643

2. D643 was born in St Vincent and the Grenadines.¹ He confirmed to the Inquiry that he joined the British Army in 2001 and served as a Commonwealth soldier for eleven and a half years, undertaking three tours of service.² He was discharged in August 2012³ and his leave to remain expired in September 2012.⁴ As a result of a number of traumatic combat-related incidents, he began to develop post-traumatic stress disorder (PTSD) in 2007, when he returned from a tour of service, and turned to alcohol as a coping mechanism.⁵ D643 was convicted of a criminal offence and went to prison.⁶

3. After serving his sentence, he was detained under immigration powers from October 2016 to May 2018 and spent the majority of this time in detention at Brook House.⁷

4. D643 felt that being detained at Brook House exacerbated his PTSD.⁸ The things he saw and heard, such as fighting and loud, unexpected noises, left him feeling like he was being “*mentally tortured*”.⁹ In January 2017 and

¹ [DL0000228_0001](#) para 1

² [D643 22 February 2022 2/3-10](#)

³ [DL0000228_0001](#) para 5

⁴ [DL0000228_0002](#) para 10

⁵ [D643 22 February 2022 2/20-23](#); [DL0000228_0002](#) paras 7 and 10

⁶ [DL0000228_0002](#) para 10

⁷ [DL0000228_0003](#) paras 14-15

⁸ [D643 22 February 2022 3/10](#)

⁹ [D643 22 February 2022 3/11-14 and 18/11](#)

March 2018, he was assessed by Brook House doctors, who agreed and informed the Home Office that continuing detention would worsen his symptoms,¹⁰ but he was not released.¹¹ He said:

“Each time I heard a door banging I thought it was an explosion in a war zone and I would throw myself to the floor and I would become breathless and panicked.”¹²

5. During his detention, he experienced chest pains and was taken to hospital.¹³ At the hospital, he was handcuffed. When he needed to go to the toilet, he was attached by a long chain at the wrist to a custody officer. He said:

“I cried the entire journey back to Brook House because I felt so humiliated and degraded by this experience.”¹⁴

6. In May 2018, D643 was released from detention.¹⁵ After his time at Brook House, he initially found it difficult to engage with health professionals.¹⁶ Reflecting on his experience, D643 said: *“I endured psychological torture at Brook House, the effects of which I am still suffering.”¹⁷* He told the Inquiry that, following his release, he brought a claim for unlawful detention, which the Home Office agreed to settle in 2019.¹⁸

D1527

7. D1527 is an Egyptian national who was detained at Brook House from April to June 2017.¹⁹ He came to the UK in January 2014 to claim asylum²⁰ and said that he had experienced *“horrible abuse and torture in Egypt”*.²¹ His asylum claim was dismissed in October 2015.²² Prior to his detention, he spent time in prison in the UK.²³ While he was in prison he experienced mental health issues and attempted suicide.²⁴

¹⁰ [DL0000220_0001](#); [DL0000220_0003-004](#); [HOM032403](#)

¹¹ [DL0000228_0037](#) para 135; [DL0000228_0063](#) para 213

¹² [DL0000228_0020](#) para 80

¹³ [DL0000228_0031](#) para 116

¹⁴ [DL0000228_0031](#) para 117

¹⁵ [DL0000228_0077](#) para 248

¹⁶ [DL0000228_0079](#) para 260

¹⁷ [DL0000228_0079](#) para 259

¹⁸ [DL0000228_0077](#) para 248

¹⁹ [DL0000144_0001](#) para 1; [DL0000144_0002](#) para 8

²⁰ [DL0000144_0045](#) para 106

²¹ [DL0000144_0058](#) para 141

²² [DL0000150_0003](#) para 8

²³ [DL0000144_0003](#) para 9

²⁴ [DL0000144_0002](#) para 7

8. D1527 told the Inquiry that, while at Brook House, his mental health deteriorated.²⁵ If he did anything to hurt himself, the staff would put him on E Wing,²⁶ a wing within Brook House which, among other purposes, was used to hold vulnerable detained people. There, he featured in covert recordings that were broadcast on the *Panorama* programme.

9. When D1527 was moved to E Wing, he self-harmed. On 25 April 2017, he tied a T-shirt around his neck, put a battery in his mouth, and tried to strangle himself with his own hands.²⁷ D1527 said:

“I know that after this one of the detention centre staff sat on my head and strangled me ... I thought that I was going to die, that the man doing this to me was going to kill me.”²⁸

After this happened, he recalled being left on the floor.

10. He did not complain about the abuse he experienced at Brook House because he thought that these experiences were normal in detention. He said:

“I was told the man who attacked me was just doing his job. Who could I complain to? ... There was so much happening I just thought it was a part of being in detention ... I didn’t know what was normal in this country.”²⁹

11. In June 2017, D1527 was released from Brook House following a successful challenge to his detention³⁰ and, in November 2021, when he provided a witness statement to the Inquiry, was awaiting his discretionary leave application to be granted.³¹ While he was at Brook House, D1527 suffered from PTSD, including flashbacks, and was diagnosed with Major Depressive Disorder.³² He said:

“People who have mental health problems like me should not be in there. It is not safe and you only get worse.”³³

²⁵ [DL0000144_0061](#) para 148

²⁶ [DL0000144_0015-0016](#) para 48

²⁷ [DL0000144_0018-0019](#) para 49 (referring to paras 39, 40 and 42)

²⁸ [DL0000144_0019](#) paras 42-43

²⁹ [DL0000144_0020](#) para 49

³⁰ [DL0000144_0002-0003](#) para 8

³¹ [DL0000144_0056](#) para 135

³² [DL0000144_0030](#) para 47

³³ [DL0000144_0061](#) para 148

D1851

12. D1851 is a Nigerian national who came to the UK in June 2015.³⁴ He told the Inquiry that he is married to an EU citizen and that he was unlawfully detained at Brook House from April to July 2017.³⁵

13. When D1851 first arrived at Brook House, he thought the environment was like a prison.³⁶ He found it oppressive, the conditions *“disgusting”* and felt that his experience was *“completely dehumanising”*.³⁷ He saw staff using *“bad and abusive language”*.³⁸ In terms of the manner in which staff spoke to detained people, he said: *“You’re reminded and being told, ‘You should know your place’.”*³⁹ He felt he could not complain:

*“no-one will listen to you, because, in reality, no-one cares about what is happening to you”.*⁴⁰

He was *“reminded every day that you could be picked up and thrown back to where you came from at any time”*, which made him feel stressed and depressed.⁴¹

14. D1851 described the effect that Brook House had on his mental health as *“crushing”*.⁴² Since his detention, he has been diagnosed with PTSD, anxiety and depression,⁴³ and he has experienced negative intrusive thoughts on a regular basis, flashbacks and nightmares.⁴⁴ Speaking about his time at Brook House, D1851 said:

*“I don’t pray anyone experiences it, and part of the reason why I came into this inquiry is to please do something about it.”*⁴⁵

D687

15. D687 was born in the Republic of Somaliland.⁴⁶ He came to the UK in 1994 as a 10 year old with his family, who were granted refugee status in

³⁴ [D1851 3 December 2022 58/22-23](#)

³⁵ [D1851 3 December 2022 59/4-15](#)

³⁶ [D1851 3 December 2022 63/20-64/6](#)

³⁷ [DL0000143_0001](#) para 4

³⁸ [DL0000143_0007](#) para 28

³⁹ [D1851 3 December 2022 66/21-22](#)

⁴⁰ [D1851 3 December 2022 98/19-20](#)

⁴¹ [D1851 3 December 2022 73/3-5](#)

⁴² [D1851 3 December 2022 60/6](#)

⁴³ [DL0000143_0001](#) para 3

⁴⁴ [D1851 3 December 2022 111/2-12](#)

⁴⁵ [D1851 3 December 2022 104/6-9](#)

⁴⁶ [DPG000021_0001](#) para 2

1997, and he has lived in the UK continuously ever since.⁴⁷ After his arrival in the UK, he spent time in care.⁴⁸ He struggled with his mental health and spent time in prison.⁴⁹ At the end of a prison sentence in 2015, he was detained under immigration powers and placed in detention.⁵⁰ He said:

“Even though I wasn’t born here, I feel as British as anyone who was ... My British identity is really important to me. It hurts when people try to tell me I’m not British. It’s like they are denying who I am, my identity.”⁵¹

16. D687 spent 987 days in immigration detention from March 2015 to November 2017, 563 of which were spent at Brook House.⁵² He said: *“I remember being confused and scared when I first arrived at Brook House. The physical environment made that worse.”⁵³* He told the Inquiry that officers were verbally and racially abusive towards him;⁵⁴ he also submitted a complaint about excessive force being used.⁵⁵ He said:

“The abuse that I experienced at Brook House was so frequent and so woven into the culture of the centre, it became completely normal.”⁵⁶

17. While D687 was detained, his brother died and he was unable to attend the funeral.⁵⁷ D687 said that this, along with past trauma, the length of time spent in detention, and how he had been treated, contributed to his worsening mental health and ultimately led him to try to take his own life in May 2017.⁵⁸ This incident was shown on the *Panorama* programme. He said:

“As my mental health deteriorated, I then started to give up on life to the extent I wanted to die.”⁵⁹

⁴⁷ [DPG000021_0001](#) para 2; [DPG000021_0003](#) para 10

⁴⁸ [DPG000021_0003](#) para 11

⁴⁹ [DPG000021_0006](#) para 19

⁵⁰ [DPG000021_0008](#) paras 25-26

⁵¹ [DPG000021_0003-0004](#) para 12

⁵² [DPG000021_0002](#) para 5

⁵³ [DPG000021_0011-012](#) para 36

⁵⁴ [DPG000021_0023](#) para 69

⁵⁵ [HOM002725_0001](#)

⁵⁶ [DPG000021_0020](#) para 65a

⁵⁷ [DPG000021_0051](#) para 141

⁵⁸ [DPG000021_0070](#) para 197

⁵⁹ [DPG000021_0070](#) para 197

18. Speaking about his experience at Brook House, he said:

*"I was treated like an animal. Something less than human. It's left an impact on me and on my mental health which I don't think I'll ever get over. When I entered Brook House, I felt relatively normal. When I left it, I felt broken, hopeless and mad."*⁶⁰

19. Since leaving Brook House, D687 has been diagnosed with recurrent depressive disorder and PTSD.⁶¹ He said:

*"My hope is that lessons can be learned – they must be – to prevent anything like this happening to anyone else."*⁶²

D180

20. D180 is a Jamaican national.⁶³ He had been living in the UK for 22 years prior to being detained under immigration powers. He was detained at Brook House from May 2015 to May 2017.⁶⁴

21. From the time when D180 arrived at Brook House until August 2016, he was visually impaired,⁶⁵ which made moving around the building *"really challenging"*.⁶⁶ When he arrived, he told staff that he was visually impaired but, in his induction, he was *"shown"* where things were and he was allocated a cell upstairs.⁶⁷ He was later moved to a cell downstairs but, as the canteen and shower cells were located on the upper floor, he had to rely on other detained people to assist him.⁶⁸ He said:

*"I wasn't given any help by detention staff to cope with my disability. Nobody asked me about my visual impairment and my needs."*⁶⁹

22. Speaking about his experiences at Brook House, D180 said:

*"It was very difficult and often frightening for me at Brook House being almost blind. I didn't know anyone there and I couldn't see other detainees properly. I didn't know my way around and couldn't see how to get around. The place was extremely noisy, with loud banging of doors and shouting. I felt scared, intimidated and very vulnerable."*⁷⁰

⁶⁰ [DPG000021_0077](#) para 218

⁶¹ [DPG000021_0001](#) para 3

⁶² [DPG000021_0079](#) para 226

⁶³ [DPG000040_0001](#) para 2

⁶⁴ [DPG000040_0001](#) paras 2-3

⁶⁵ [DPG000040_0001](#) para 4

⁶⁶ [DPG000040_0004](#) para 14

⁶⁷ [DPG000040_0003](#) paras 11 and 13

⁶⁸ [DPG000040_0003](#) para 13; [DPG000040_0004](#) para 16; [DPG000040_0005](#) para 20

⁶⁹ [DPG000040_0005](#) para 21

⁷⁰ [DPG000040_0003](#) para 12

23. In May 2017, after two years in detention, D180 voluntarily returned to Jamaica.⁷¹

D1618

24. D1618 was born in Afghanistan.⁷² He told the Inquiry that, while living there, he was the victim of an attempted kidnapping.⁷³ After this, he left Afghanistan and arrived in the UK in 2014 to join his father, a British citizen, and to claim asylum. He was detained at Brook House from May 2017 to November 2017.⁷⁴

25. When D1618 arrived at Brook House, he found that the cell he was allocated was dirty.⁷⁵ He struggled with the lack of privacy, the smells and hygiene, and he felt unsafe, witnessing violence, fighting and drug use.⁷⁶ He said:

“Brook House was not a good place, it was very dirty and unsafe ... it was a violent place where I frequently felt that I was in danger.”⁷⁷

26. D1618 told the Inquiry that he had never been to prison and was frightened to be detained with people who had spent time in custody:

“Everyone was mixed together and we didn’t even know who the dangerous criminals were. This made me very scared as I did not know who to be wary of.”⁷⁸

27. In respect of how he was treated by staff at Brook House, he said: *“They were not helping me ... if I need anything, they were ignoring me.”⁷⁹* He lodged over 20 complaints about the facilities, access to cleaning products, and staff, but says he did not receive any response.⁸⁰

28. During a removal attempt, he was put in restraints that cut into his hands and caused bleeding, and he felt scared and in pain.⁸¹ He was taken to hospital as a result of his injuries.⁸²

⁷¹ [DPG000040_0001](#) para 3

⁷² [INQ000055_0001](#) para 2

⁷³ [D1618 3 December 2021 9/16-19](#)

⁷⁴ [D1618 3 December 2021 2/4-25](#)

⁷⁵ [D1618 3 December 2021 11/14](#)

⁷⁶ [D1618 3 December 2021 11/20-12/23](#)

⁷⁷ [INQ000055_002](#) para 8

⁷⁸ [INQ000055_005](#) para 25

⁷⁹ [D1618 3 December 2021 17/21-22](#)

⁸⁰ [D1618 3 December 2021 17/3-6](#)

⁸¹ [INQ000055_0008](#) para 44

⁸² [INQ000055_0008](#) para 47

29. D1618 was released from detention on bail in November 2017 and granted refugee status in 2020.⁸³ Since leaving Brook House, he has been diagnosed with PTSD:⁸⁴

“Whilst my immigration status has been resolved, my poor mental health has continued. I believe that my experiences in Brook House IRC [immigration removal centre] are a significant factor in my poor mental health.”⁸⁵

D1914

30. D1914 is a Romanian national.⁸⁶ He arrived in the UK as an EU citizen in 2009.⁸⁷ In 2016, he was diagnosed with a heart condition, which has caused him several serious health issues.⁸⁸ D1914 was detained at Brook House from March to August 2017.⁸⁹ A deportation order was made in April 2017, as a result of D1914’s foreign convictions.⁹⁰ Some of D1914’s experiences at Brook House were filmed and shown on the *Panorama* programme.

31. During D1914’s detention at Brook House, he was admitted to hospital three times for his physical health and on one occasion for his mental health. Doctors deemed him fit for detention in May 2017.⁹¹ D1914 said:

“My time at Brook House affected me mentally and physically – it caused me distress, stress and anxiety which I believe in turn worsened my heart condition.”⁹²

32. Prior to an attempted removal, force was used on D1914 to move him to E Wing. He recalled:

“I was shouting and howling in pain – I was struggling to breathe, I thought I might be dying. The pain in my chest was very severe. That moment, I felt I was looking at death.”⁹³

33. D1914 said that, in July 2017, he attempted suicide after hearing that a judge had refused his bail application and found that he was fit for detention.

⁸³ [INQ000055_0001](#) para 2

⁸⁴ [INQ000055_0013](#) para 85

⁸⁵ [INQ000055_013](#) para 86

⁸⁶ [DL0000229_001](#) para 2

⁸⁷ [DL0000229_001](#) para 4

⁸⁸ [DL0000229_001](#) para 5; [DL0000229_007](#) paras 18-19

⁸⁹ [DL0000229_002](#) para 5; [DL0000229_003](#) para 8

⁹⁰ [DL0000229_003](#) para 6

⁹¹ [DL0000229_004](#) para 9; [DL0000229_053-060](#) paras 187-205; [CJS001160](#)

⁹² [DL0000229_006](#) para 14

⁹³ [DL0000229_042](#) para 151

He had never tried to harm himself before being detained at Brook House but felt that his *“experiences there are what drove me to try to take my own life”*.⁹⁴

34. D1914 was released from Brook House in August 2017 due to his health condition.⁹⁵ After his release, his relationship with his long-term partner broke down, due to the stress his detention had placed on the relationship. He lost contact with his children, became homeless and has continued to suffer with ill health.⁹⁶

*“My time in detention in Brook House IRC broke my life. I cannot believe the state I have been reduced to.”*⁹⁷

In June 2018, D1914 was told that his appeal against his deportation order had been successful.⁹⁸

D1275

35. D1275 is an Iranian national who entered the UK in November 2012.⁹⁹ His initial asylum claim was unsuccessful and subsequent appeals were refused.¹⁰⁰ From August to December 2015, he served a prison sentence.¹⁰¹ While in prison, his mental health deteriorated.¹⁰² From December 2015 to July 2016 and from October 2016 to June 2018, D1275 was detained in immigration detention.¹⁰³ He was detained at Brook House for 422 days and also spent significant periods in other immigration removal centres.¹⁰⁴

36. While in detention, he presented with *“serious and untreated mental health issues”*,¹⁰⁵ including exhibiting bizarre behaviour, hearing voices, and experiencing feelings of paranoia and hallucinations.¹⁰⁶ In March 2018, a doctor compiled a report suggesting that D1275’s detention was perpetuating his mental health disorder, as he could not receive the support he needed.¹⁰⁷ Following meetings with two psychiatrists, who said that D1275 *“presents as vulnerable”* and recommended that a *“full capacity’ assessment be*

⁹⁴ [DL0000229_054](#) paras 190-191

⁹⁵ [DL0000229_068](#) para 226

⁹⁶ [DL0000229_073](#) paras 246-249

⁹⁷ [DL0000229_073](#) para 245

⁹⁸ [DL0000229_0003](#) para 6

⁹⁹ [BHM000042_0003](#) para 9

¹⁰⁰ [BHM000042_0003](#) para 9

¹⁰¹ [BHM000042_0003](#) para 10

¹⁰² [BHM000042_0003](#) para 10

¹⁰³ [BHM000042_0003](#) paras 10-11; [BHM000042_0005](#) para 16

¹⁰⁴ [BHM000042_007](#) para iv

¹⁰⁵ [BHM000042_0050](#) para 162a

¹⁰⁶ [BHM000042_0003](#) para 10; [BHM000042_0012](#) para 41

¹⁰⁷ [BHM000042_0017-18](#) paras 58-59

undertaken", tests were carried out that indicated that D1275 had a learning disability.¹⁰⁸ An Advocacy Coordinator with Gatwick Detainees Welfare Group met D1275 and recorded that he was *"unaware he was detained. Unaware he was in England"*.¹⁰⁹

37. His solicitor told the Inquiry that, while at Brook House, D1275 was bullied.¹¹⁰ He was used by other detained people as a guinea pig to test drugs that were brought in.¹¹¹ A medical emergency following D1275's use of a new psychoactive substance known as 'spice' in June 2017 was captured on film and broadcast on the *Panorama* programme.¹¹² A Security Information Report (regarding information relevant to the safety and security of the immigration detention estate) noted the use of D1275 by others as a guinea pig *"to try out the drugs that are trafficked in"*, and assessed that *"it appears other officers have witnessed him being mistreated but have not reported it"*.¹¹³

38. D1275's solicitor told the Inquiry that, after the *Panorama* programme was broadcast, D1275 spent a further 295 days in Brook House.¹¹⁴ He was released from immigration detention to asylum support accommodation in June 2018 without any support arrangements being in place.¹¹⁵ In August 2018, he was sectioned for treatment under section 3 of the Mental Health Act 1983, until December 2018.¹¹⁶ In 2019, D1275 was granted discretionary leave to remain in the UK.¹¹⁷

¹⁰⁸ [BHM000042_0022](#) para 69; [BHM000042_0024](#) para 75

¹⁰⁹ [BHM000040_0004](#) para 12

¹¹⁰ [BHM000042_0016](#) para 56

¹¹¹ [BHM000042_0009](#) para 29

¹¹² [BHM000042_0007](#) para 23

¹¹³ [CJS005347_0005](#); [BHM000042_0034](#) paras 117-118

¹¹⁴ [BHM000042_0050](#) para 161

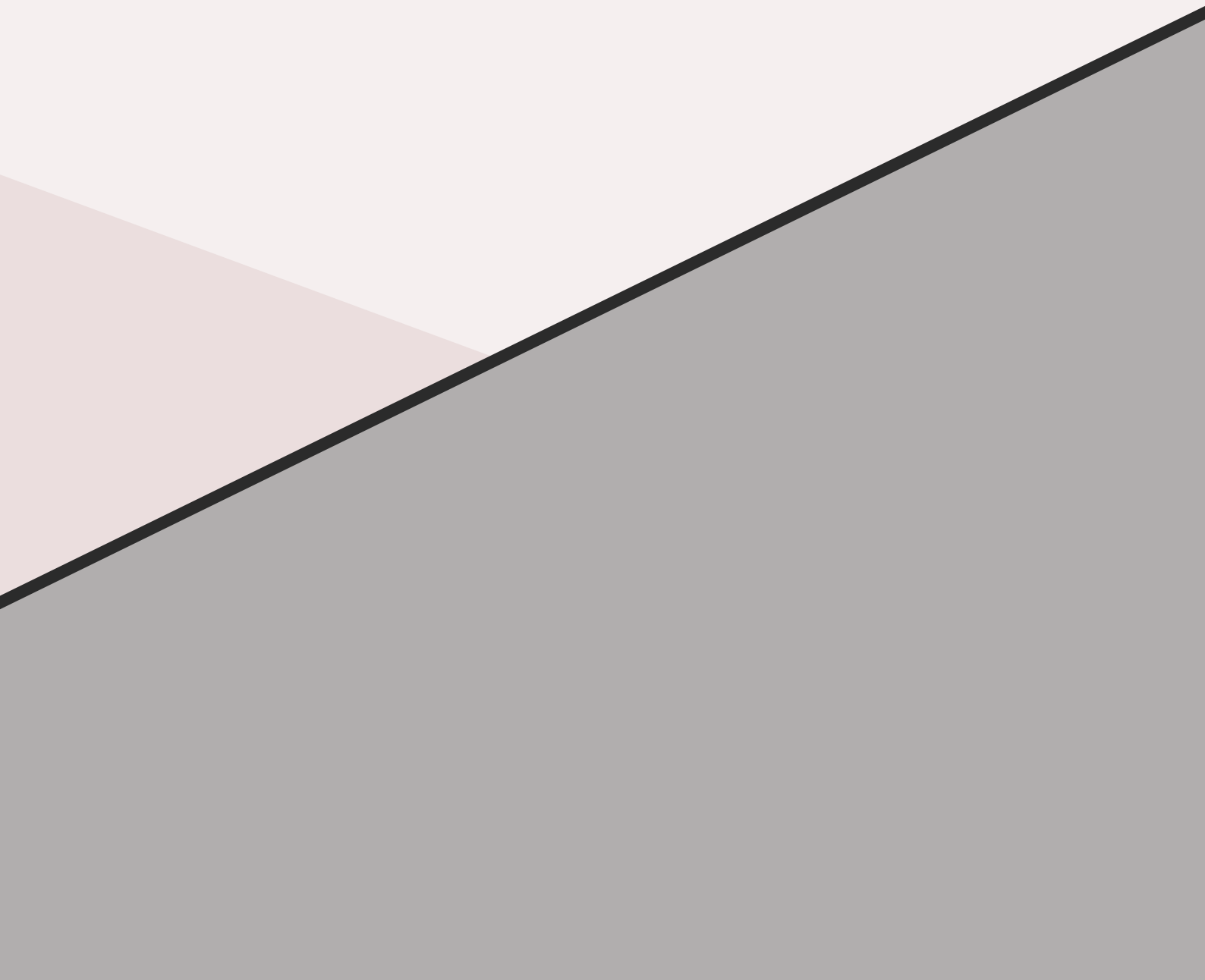
¹¹⁵ [BHM000042_0026](#) paras 84-86

¹¹⁶ [BHM000042_0028](#) para 96

¹¹⁷ [BHM000042_0031](#) para 108

Part A

Brook House and this Inquiry



Brook House and this Inquiry

The events at Brook House

- 1.** Around 20,000 people are held in the UK under immigration powers every year.¹ People are detained in detention centres known as immigration removal centres (IRCs), as well as in short-term holding facilities, pre-departure accommodation and prisons. A person is detained in an IRC typically in order to effect their removal from the country, to establish their identity or the basis of their claim to live in the UK, or because there is reason to believe that they will fail to comply with the conditions attached to a grant of immigration bail.²
- 2.** IRCs in the UK are currently managed on behalf of the Home Office by private firms, as permitted under the Immigration and Asylum Act 1999. The Home Office retains ultimate responsibility for the welfare of detained people. IRCs must be operated in accordance with a range of legislation, rules and guidance, as well as in compliance with the terms of a contract with the Home Office. These deal with issues such as the safety, care, activities, discipline and control of detained people.³ Further details regarding the legal framework are set out in Part B, and Appendix 2 in Volume III.
- 3.** One of seven IRCs in the UK, Brook House immigration removal centre (referred to throughout this Report as 'Brook House') is located near Gatwick Airport, West Sussex.⁴ From its opening until May 2020 (including during the relevant period, 1 April 2017 to 31 August 2017), G4S Care and Justice Services (UK) Ltd (G4S) was contracted to operate, manage and maintain Brook House.

¹ In 2017, covering the key period considered by the Inquiry (1 April 2017 to 31 August 2017), 27,348 people were detained. In 2022, the most recent year for which data are available, 20,446 were detained. (See *Home Office Immigration detention statistics*, year ending December 2022, Detention – Summary Tables, Det_01, Det_02_a.)

² *Enforcement Instructions and Guidance*, Home Office, Chapter 55, para 55.1.1

³ Section 149 of the *Immigration and Asylum Act 1999* contains a power for the Secretary of State to contract out the management of IRCs. Where that has been done, it specifies that the contracted-out IRC must be operated in accordance with the rules made by the Secretary of State under section 153 of the Act, namely the *Detention Centre Rules 2001*

⁴ The seven IRCs are Brook House (Gatwick), Colnbrook (Middlesex), Derwentside (County Durham), Dungavel House (South Lanarkshire), Harmondsworth (Middlesex), Tinsley House (Gatwick) and Yarl's Wood (Bedfordshire). Colnbrook and Harmondsworth are covered by one contract

Figure 1: Aerial view of Brook House, Gatwick Airport and the surrounding area



Source: Google Earth

4. Mr Callum Tulley worked as a Detention Custody Officer (DCO) at Brook House from 6 January 2015 to 7 July 2017.⁵ He became increasingly concerned about the treatment of detained people by staff at Brook House. He also experienced an incident involving what he called a “*completely unnecessary*” use of force.⁶ Mr Tulley said that he found the general culture and use of language by staff at Brook House to be “*deeply disturbing*”.⁷ After watching a BBC *Panorama* programme involving secret filming of abuse at Medway Secure Training Centre, Mr Tulley contacted *Panorama* on 12 January 2016.⁸ The BBC subsequently employed Mr Tulley as a specialist researcher from 6 March 2017 to 19 September 2017, assisting with a *Panorama* investigation into Brook House.⁹ During that period, Mr Tulley was trained in and undertook undercover reporting, including covert filming at Brook House.

5. Some of the product of this work was included in a BBC *Panorama* programme, ‘Undercover: Britain’s Immigration Secrets’ (referred to in this Report as ‘the *Panorama* programme’), which was first broadcast on 4 September 2017.¹⁰ It showed a number of people detained at Brook House being subjected to wholly unacceptable physical and verbal abuse by staff members. Staff, including healthcare staff, were involved in misconduct, treating detained people in a dehumanising and depersonalising manner, as well as subjecting them to physical assaults and verbal and racial abuse.

⁵ [INQ000052_001](#) para 2

⁶ [INQ000052_015](#) para 66

⁷ [INQ000052_016](#) para 69

⁸ [INQ000052_019](#) paras 80-81

⁹ [INQ000052_001](#) para 3

¹⁰ [INQ000052_001](#) para 3; ‘Undercover: Britain’s Immigration Secrets’, BBC *Panorama*, 4 September 2017

The covertly recorded footage was later described by the then Immigration Minister, Caroline Noakes MP, as “*appalling*”.¹¹

6. The treatment revealed in the *Panorama* programme was shocking and has no place in a decent and humane immigration detention system. This has been acknowledged by the Home Office, which apologised for “*the failures in the contract, in the level of Home Office supervision*”.¹² G4S also apologised, commenting:

*“Both the mistreatment of the detainees and the failure, by other staff who were present, to intervene to stop it or, to report it was wholly inappropriate, and abhorrent.”*¹³

7. However, the Inquiry’s work has revealed that abuse within Brook House was even more widespread than was shown in the *Panorama* programme. There was physical abuse, including through the inappropriate and unjustified use of force, as well as the use of abusive and racist language towards and about detained people. This is most clearly demonstrated by the footage the Inquiry received and reviewed. It is not possible to appreciate the true nature of the incidents without viewing the footage (see the Inquiry’s [YouTube channel](#), as well as Appendix 6 in Volume III and throughout this Report), which this Report must be read alongside – albeit that it is often very distressing to watch – in order for my findings to be fully understood and to be put into their proper context.

Other investigations and reports

8. A number of investigations took place at Brook House following the *Panorama* programme. More broadly, a range of investigations into immigration detention have been conducted over 20 years, in response either to incidents that have occurred at particular IRCs or to specific policy concerns. Brook House has also been subject to regular monitoring and inspection throughout its operation.

9. This Inquiry builds upon the findings of these reviews, inspections and investigations, and has sought not to duplicate the work of others.¹⁴ I considered a number of reports of particular relevance to this Inquiry, which were produced by:

¹¹ [Inquiry to be held into Brook House detainees ‘abuse’](#), BBC News, 11 October 2018

¹² [Philip Riley 4 April 2022 1/17-25](#); see also [HOM0332005_002](#) para 5; [HOM0332165_001-002](#) paras 3-5

¹³ [CJS0074153_002](#) paras 3-4

¹⁴ [Notice of Determination Inquiry Scope](#), Brook House Inquiry, para 31

- HM Inspectorate of Prisons (HMIP), which carries out independent inspections and produces reports on the conditions for, and treatment of, prisoners and other detained people, including those held in IRCs;¹⁵
- the Independent Monitoring Board at Brook House (Brook House IMB), which is made up of unpaid volunteers who monitor day-to-day life at Brook House, in order to ensure that proper standards of care and decency are maintained;¹⁶ and
- Mr Stephen Shaw, a former Prisons and Probation Ombudsman (PPO), who undertook a number of investigations in relation to immigration detention in that capacity and subsequently.¹⁷

10. In his reports, Mr Shaw identified a number of concerns regarding immigration detention, some touching on Brook House. These concerns included:

- the design and use of detention centre buildings;¹⁸
- staffing levels and training;¹⁹
- senior management;²⁰
- staff whistleblowing;²¹
- healthcare for detained people;²²
- use of psychoactive substances or ‘legal highs’ by detained people;²³
- immigration case work;²⁴

¹⁵ [What we do](#), HM Inspectorate of Prisons, updated 18 July 2022

¹⁶ [Members for Independent Monitoring Boards throughout England, Scotland, Northern Ireland, and Wales](#), Gov.uk role details (March 2023)

¹⁷ The Prisons and Probation Ombudsman (PPO) is appointed by the Secretary of State for Justice and acts as an independent adjudicator for prisoner complaints. The remit of the Prisons Ombudsman was extended in 2001 to include complaints from those under probation supervision

¹⁸ [INQ000240_167-169](#); [INQ000060_045-047](#) paras 3.3-3.19; *Assessment of Government Progress in Implementing the Report on the Welfare in Detention of Vulnerable Persons*, Stephen Shaw, Cm 9661, July 2018, paras 2.75, 2.77, recommendations 7, 8

¹⁹ [INQ000240_285-288](#); *Report of the Independent Advisory Panel on Non-Compliance Management*, March 2014, para 4.66; *Assessment of Government Progress in Implementing the Report on the Welfare in Detention of Vulnerable Persons*, Stephen Shaw, Cm 9661, July 2018, paras 6.23-6.24

²⁰ [INQ000240_295-297](#); *Inquiry into Allegations of Racism and Mistreatment of Detainees at Oakington Immigration Reception Centre and While Under Escort*, Prisons and Probation Ombudsman, July 2005, foreword, p4

²¹ *Assessment of Government Progress in Implementing the Report on the Welfare in Detention of Vulnerable Persons*, Stephen Shaw, Cm 9661, July 2018, para 6.30

²² [INQ000060_13](#); [INQ000060_158-182](#); *Assessment of Government Progress in Implementing the Report on the Welfare in Detention of Vulnerable Persons*, Stephen Shaw, Cm 9661, July 2018, para 3.36

²³ [INQ000060_030](#) para 1.109; [INQ000060_047](#) para 3.17

²⁴ [INQ000060_183-190](#) paras 10.1-10.36

- procedural safeguards for detained people;²⁵
- Home Office guidance;²⁶ and
- contract monitoring and oversight by the Home Office.²⁷

11. The last of Mr Shaw’s reports was commissioned in September 2017, before the broadcast of the *Panorama* programme. However, he was subsequently asked by the Home Office to consider in that report the events at Brook House shown in the programme, including issues of staff culture, recruitment and training, the sufficiency of complaints mechanisms and the effectiveness of whistleblowing procedures.²⁸

12. Following the broadcast of the *Panorama* programme, a number of further investigations took place.

12.1 Verita: In November 2017, G4S commissioned Verita, an external investigations company, to investigate and report on the issues at Brook House raised by the *Panorama* programme. The investigation was conducted by Ms (now Baroness) Kate Lampard CBE and Mr Ed Marsden, and a report was published in November 2018 (the 2018 Verita report). It identified a number of concerns, including:

- failings in senior management and weak line management arrangements;²⁹
- undervalued empathy and care towards detained people;³⁰
- a lack of activities to occupy detained people;³¹
- understaffing and inexperienced staff, with an Initial Training Course that did not adequately prepare new staff, as well as uncompetitive remuneration, shift patterns, and terms and conditions of employment that compounded recruitment problems;³²

²⁵ [INQ000060_102-109](#) recommendation 21; *Assessment of Government Progress in Implementing the Report on the Welfare in Detention of Vulnerable Persons*, Stephen Shaw, Cm 9661, July 2018, recommendations 14-15, pp35-41

²⁶ [INQ000060_090](#) para 4.36

²⁷ *Report of the Independent Advisory Panel on Non-Compliance Management*, March 2014, paras 5.5-5.6; [INQ000060_100-101](#) recommendation 20; *Assessment of Government Progress in Implementing the Report on the Welfare in Detention of Vulnerable Persons*, Stephen Shaw, Cm 9661, July 2018, para 6.75, recommendations 41, 42, 112-114; [INQ000240_315](#)

²⁸ *Assessment of Government Progress in Implementing the Report on the Welfare in Detention of Vulnerable Persons*, Stephen Shaw, Cm 9661, July 2018, pp127-128

²⁹ [CJS0073709_010](#) para 1.24; [CJS0073709_078](#) para 7.48

³⁰ [CJS0073709_254](#) para 15.11

³¹ [CJS0073709_254](#) para 15.11; [CJS0073709_131](#) para 9.13

³² [CJS0073709_109](#) paras 8.48 and 8.91; [CJS0073709_098-099](#) para 8.6

- a lack of confidence among staff in confidential reporting and whistleblowing processes;³³
- bullying between staff;³⁴ and
- an IMB that identified too closely with the aims of the Home Office and G4S, and was not robust enough in its monitoring.³⁵

12.2 Home Office Professional Standards Unit: In November 2017, the Home Office referred 10 cases of alleged serious misconduct for investigation by its Professional Standards Unit. Of these, seven were accepted for investigation, and reports were completed in 2018.³⁶

12.3 Home Affairs Committee: The Home Affairs Committee undertook its own inquiry into immigration detention. Its report, published in March 2019, noted serious failings in “*almost every element*” of immigration detention and made a number of recommendations, including the need for more judicial oversight and “*an end to indefinite immigration detention*”.³⁷ It described the Home Office as having a “*shockingly cavalier attitude*”, and suggested that it needed to be much more “*robust*” with its contractors managing IRCs.³⁸

12.4 National Audit Office: Concerned by some of the evidence of financial and contractual issues at Brook House, the Home Affairs Committee asked the National Audit Office to look at the contract with G4S in March 2019.³⁹ The National Audit Office observed:

- The level of risk carried by G4S on the contract was not high, with an inability to impose significant financial consequences for the abuse of detained people and difficulties in contractually enforcing action.⁴⁰
- Home Office contract monitoring was carried out at a junior level and relied primarily on G4S self-reporting.⁴¹

12.5 Sussex Police: Sussex Police conducted a criminal investigation into 14 of the incidents broadcast in the *Panorama* programme. In respect of 13

³³ [CJS0073709_227](#) para 13.53

³⁴ [CJS0073709_221](#) para 13.32

³⁵ [CJS0073709_236](#) para 14.18

³⁶ [HOM0331707](#)

³⁷ *Immigration Detention – Fourteenth Report of Session 2017-19*, House of Commons Home Affairs Committee, 21 March 2019, pp4-5

³⁸ *Immigration Detention – Fourteenth Report of Session 2017-19*, House of Commons Home Affairs Committee, 21 March 2019, p26, para 65

³⁹ *Immigration Detention – Fourteenth Report of Session 2017-19*, House of Commons Home Affairs Committee, 21 March 2019, p80, para 247

⁴⁰ [DL0000175_07](#) para 13; [DL0000175_010](#) para 27; [DL0000175_026](#) para 2.21

⁴¹ [DL0000175_027](#) para 3.2

of the 14 incidents, no further action was taken.⁴² One key incident on 25 April 2017 was investigated further but the Crown Prosecution Service confirmed in November 2018 that no criminal charges would be brought.⁴³

12.6 Prisons and Probation Ombudsman: On 21 September 2018, a PPO special investigation was announced to investigate the decisions, actions and circumstances surrounding the mistreatment of detained people at Brook House broadcast in the *Panorama* programme. The PPO’s investigation was subsequently converted to this statutory Inquiry.

12.7 Independent Chief Inspector of Borders and Immigration: Between July 2020 and March 2021, the Independent Chief Inspector of Borders and Immigration (ICIBI) conducted an inspection of ‘Adults at Risk’ in immigration detention. The ICIBI found a widespread tendency within the Home Office to view claims of vulnerability and the use of safeguarding mechanisms as spurious and a misuse of process, and slow progress in addressing recommendations made by previous investigations.⁴⁴ It made a number of recommendations for strengthening procedural safeguards for detained people.⁴⁵ Following a third annual inspection between June and September 2022, which focused on the effectiveness and efficiency of Rule 35 of the Detention Centre Rules 2001, the ICIBI noted:

“Rule 35 provides an important safeguard, bringing to the Home Office’s attention ... individuals who are particularly vulnerable. This inspection found that this important safeguard was not working consistently or effectively.”⁴⁶

13. It is important to understand the nature of these reports and relevant recommendations and, as will be considered later in the Report, the extent to which the Home Office and its contractors have acted on them. The key inspection and investigation reports are set out in Table 1, and a table listing key relevant previous recommendations is included in Appendix 4 in Volume III of this Report. The Home Office also produced for the Inquiry a table of these third-party recommendations, indicating whether they were accepted or rejected, and giving details of the action taken where accepted and the reasons for any partial or complete rejection.⁴⁷

⁴² [SXP000053](#)

⁴³ This incident is examined in detail in Chapter C.4; see also [DL0000150](#) para 28c

⁴⁴ [INQ000156_012](#) paras 3.3-3.4

⁴⁵ [INQ000156_018](#) para 4.10

⁴⁶ [Third Annual Inspection of ‘Adults at Risk in Immigration Detention’](#), Independent Chief Inspector of Borders and Immigration, January 2023

⁴⁷ [HOM0332050](#)

Table 1: List of key inspection and investigation reports

Body / Author	Report and publication date	Referred to in this Report as
Mr Stephen Shaw, Prisons and Probation Ombudsman	<u><i>Report of the Inquiry into the Disturbance and Fire at Yarl's Wood Removal Centre</i></u> , November 2004	n/a
	<u><i>Inquiry into Allegations of Racism and Mistreatment of Detainees at Oakington Immigration Reception Centre and While Under Escort</i></u> , July 2005	The 2005 Shaw report
	<u><i>Review into the Welfare in Detention of Vulnerable Persons</i></u> , January 2016	The 2016 Shaw report
	<u><i>Assessment of Government Progress in Implementing the Report on the Welfare in Detention of Vulnerable Persons</i></u> , July 2018	The 2018 Shaw follow-up report
HM Inspectorate of Prisons	<u><i>Report on an Unannounced Full Follow-up Inspection of Brook House Immigration Removal Centre 12–23 September 2011</i></u> , January 2012	The 2011 HMIP inspection report
	<u><i>Report on an Unannounced Inspection of Brook House Immigration Removal Centre 28 May–7 June 2013</i></u> , October 2013	The 2013 HMIP inspection report
	<u><i>Report on an Unannounced Inspection of Brook House Immigration Removal Centre 31 October–11 November 2016</i></u> , March 2017	The 2016 HMIP inspection report
	<u><i>Report on an Unannounced Inspection of Brook House Immigration Removal Centre 20 May–7 June 2019</i></u> , September 2019	The 2019 HMIP inspection report
	<u><i>Report on an Unannounced Inspection of Brook House Immigration Removal Centre 30 May–16 June 2022 (see HMIP000702)</i></u> , September 2022	The 2022 HMIP inspection report

Body / Author	Report and publication date	Referred to in this Report as
Independent Monitoring Board, Brook House	<u><i>Annual Report of the Independent Monitoring Board for Brook House Immigration Removal Centre 1 January 2016 to 31 December 2016</i></u> , April 2017	The 2016 IMB report
	<u><i>Annual Report of the Independent Monitoring Board at Brook House IRC for Reporting Year 2017</i></u> (see VER000138), May 2018	The 2017 IMB report
	<u><i>Annual Report of the Independent Monitoring Board at Brook House IRC for Reporting Year 2018</i></u> , June 2019	The 2018 IMB report
	<u><i>Annual Report of the Independent Monitoring Board at Brook House IRC for Reporting Year 2019</i></u> , June 2020	The 2019 IMB report
	<u><i>Annual Report of the Independent Monitoring Board at Brook House IRC: For Reporting Year 1 January – 31 December 2020</i></u> , May 2021	The 2020 IMB report
	<u><i>Annual Report of the Independent Monitoring Board at Gatwick IRC: For Reporting Year 1 January – 31 December 2021</i></u> , June 2022	The 2021 IMB report
	Verita: Ms Lampard and Mr Marsden	<u><i>Independent Investigation into Concerns about Yarl’s Wood Immigration Removal Centre</i></u> , January 2016
<u><i>Independent Investigation into Concerns about Brook House Immigration Removal Centre</i></u> (see CJS0073709), October 2018		The 2018 Verita report
House of Commons Home Affairs Committee	<u><i>Immigration Detention – Fourteenth Report of Session 2017–19</i></u> , 21 March 2019	The Home Affairs Committee 2019 report

14. Also in the aftermath of the *Panorama* programme, D1527 and D687 (both formerly detained people at Brook House who were shown on the *Panorama* programme) brought a judicial review claim against the Home Secretary. D1527 and D687 were known as MA and BB respectively for the purposes of the judicial review proceedings. They argued that a statutory inquiry was necessary to meet the requirements of an investigation compliant with the State's obligations under Article 3 of the European Convention on Human Rights (Article 3). In a judgment dated 14 June 2019, the court found in favour of MA and BB. It concluded that an effective investigation in compliance with Article 3 required there to be powers to compel witness attendance, to hold hearings in public and to ensure that MA and BB had properly funded legal representation.⁴⁸

The role of this Inquiry

15. On 5 November 2019, the Home Secretary announced that a special investigation (discussed below) by the PPO would be converted to a statutory inquiry under section 15 of the Inquiries Act 2005, and that I was to be appointed as the Chair of the Inquiry.⁴⁹

The scope of the Inquiry

16. The Terms of Reference required the Inquiry to investigate into and report "*on the decisions, actions and circumstances surrounding the mistreatment*" of detained people at Brook House, and to make recommendations as appropriate.⁵⁰ The Inquiry was also required to investigate a range of other key issues, including the wider treatment of detained people, whether any clinical care issues caused or contributed to any mistreatment identified, and the adequacy of the complaints and monitoring mechanisms. In addition, the Inquiry was specifically required to "*include investigation in to the mistreatment of ... MA [D1527] and BB [D687]*".⁵¹ The key period to be considered by the Inquiry was 1 April 2017 to 31 August 2017 (the relevant period).

17. I am required by the Terms of Reference to reach specific conclusions about the treatment of detained people, particularly where I find that there has been credible evidence of acts or omissions that are capable of amounting to "*mistreatment*" with reference to Article 3, which states: "*No one shall be subjected to torture or to inhuman or degrading treatment or punishment.*"⁵²

⁴⁸ *MA & BB v Secretary of State for the Home Department* [2019] EWHC 1523 (Admin)

⁴⁹ *Immigration Statement*, Priti Patel MP (Home Secretary), 5 November 2019

⁵⁰ Purpose, *Terms of Reference*, Brook House Inquiry. See Appendix 1 in Volume III for further information

⁵¹ Scope, *Terms of Reference*, Brook House Inquiry

⁵² Purpose, *Terms of Reference*, Brook House Inquiry; *European Convention on Human Rights*, Article 3

I have identified the facts underlying that mistreatment and who is responsible for it.⁵³ In addition, there are a number of key issues to be addressed in order to fulfil the Terms of Reference:

- the extent to which policies, practices, staffing and management arrangements at Brook House caused or contributed to any identified mistreatment (that required a consideration of a number of issues, including staffing levels, staff and management culture, the use of control and restraint techniques, the use of segregation, and the management of self-harm and food refusal);
- the adequacy of the safeguards designed to protect detained people from mistreatment; and
- changes made in response to the *Panorama* programme, and the adequacy of those changes.⁵⁴

18. On 6 January 2021, I set out the Inquiry’s scope in more detail.⁵⁵ I decided that the starting point would be to examine the evidence to establish what happened to detained people at Brook House during the relevant period. I kept that scope under review throughout the Inquiry’s investigation and I have followed where the evidence has led me.

19. Although the focus of this Report is on the relevant period, it was also necessary for me to consider evidence about previous years. I have addressed the construction and purpose of Brook House, early warning signs, staffing levels and capacity, as well as allegations of misconduct. The reasons for this are:

- This evidence provides context for what happened during the relevant period.
- Some staff members started working at Brook House between 2010 and 2016, and remained employed during the relevant period.
- Many of the physical and contractual structures that were in place during the relevant period were set up and developed over the preceding years.
- This evidence is relevant to the question of whether the relevant period was uniquely problematic, or whether any other five-month period might have revealed similar issues.

In fact, the evidence suggests that the level of mistreatment during the relevant period was far from uncommon. The covert filming by Mr Tulley documented and recorded it in a way that is indisputable.

20. I am also required by the Terms of Reference to consider whether “any changes to these methods, policies, practices and management arrangements

⁵³ Purpose, Terms of Reference, Brook House Inquiry

⁵⁴ Chair’s Opening Statement, Brook House Inquiry, 21 April 2020

⁵⁵ Notice of Determination Inquiry Scope, Brook House Inquiry, 6 January 2021

would help to prevent a recurrence of any identified mistreatment” and whether “any changes to clinical care would help to prevent a recurrence of any identified mistreatment”.⁵⁶ The Inquiry therefore heard evidence about changes since the relevant period, in order to examine current practice both at Brook House and in the immigration detention estate more generally.

Methodology of the Inquiry

21. A detailed summary of the Inquiry’s methodology is set out in detail in Appendix 1 in Volume III.

Call for evidence

22. When this Inquiry was opened, there was a call for evidence from staff, formerly detained people and anyone else involved in or affected by Brook House to share their experiences of Brook House during the relevant period. To facilitate this, the Inquiry established a freephone number and freepost address, and set out key information on its website, which was translated into 17 languages.

23. On 23 November 2020, the Inquiry sought from the Home Secretary a limited undertaking to the effect that any evidence given to the Inquiry by a former detained person would not be used by the Secretary of State to support certain adverse immigration decisions. The undertaking, which was formally accepted on 4 August 2021, was intended to give those who were detained at Brook House some comfort, and to encourage them to come forward and give evidence to the Inquiry without fear of repercussions.⁵⁷

24. Significant efforts were made by the Inquiry to contact formerly detained people, current and former staff members at Brook House, as well as other G4S staff and other relevant witnesses. The Inquiry attempted to contact potential witnesses by either post, telephone or email (or a combination of these where appropriate). While correspondence was generally sent in English, translation and interpretation services were made available to all formerly detained people. The Inquiry also engaged a specialist external witness-tracing service to conduct open-source searches to try to identify up-to-date contact details where necessary. The external witness-tracing service was also used to attempt to identify the email and postal addresses of key witnesses who were believed to be outside the UK. In addition, the Inquiry authorised funding under section 40 of the Inquiries Act 2005 for Gatwick Detainees Welfare Group (which provides a range of emotional and practical support to detained people at Gatwick IRCs – see below, under Language) and Detention Action (an organisation that works with people in immigration detention) to contact

⁵⁶ Purpose, [Terms of Reference](#), Brook House Inquiry

⁵⁷ [Letter from Chair of Brook House Inquiry to Home Office Parliamentary Under Secretary of State Chris Phelp MP, 4 August 2021](#)

their clients who may have had experiences relevant to the Inquiry's Terms of Reference. This resulted in a number of additional formerly detained people being identified, and attempts were made by the Inquiry to contact these individuals, some of whom provided statements to the Inquiry.

Evidence considered

25. The Inquiry received and reviewed over 90 hours of undercover recordings made for the BBC by Mr Tulley at Brook House, along with 36 video diaries in which he summarised events that took place on particular shifts he had worked. More than four hours of the key footage was disclosed to Core Participants in video format and other relevant material was provided in transcripts. The Inquiry also obtained closed-circuit television (CCTV), body worn and handheld camera footage relating to specific incidents within the relevant period. This footage was reviewed and where relevant disclosed to Core Participants. In addition, the Inquiry disclosed more than 100,000 pages of documentary material to Core Participants.

26. While the Inquiry heard and received evidence from a relatively small proportion of those who were detained at Brook House, this is in many ways unsurprising. Many of those detained at Brook House during the relevant period have since been deported or left the UK. In addition, those who remained in the UK may have been hesitant to engage with the Inquiry due to their uncertain immigration status or because they did not feel able to talk publicly about their experiences at Brook House. Those formerly detained people who were willing and able to give oral evidence were called to do so. It is important to acknowledge that there are many formerly detained people from whom the Inquiry did not hear or receive evidence, some of whom are also likely to have had negative experiences similar to those described by witnesses. As such, the evidence provided to the Inquiry is unlikely to be representative of the experiences of every detained person at Brook House.

27. I do not doubt that, during the relevant period, there were members of staff working at Brook House who genuinely cared for detained people and treated them well. Indeed, I heard evidence of compassion and kindness shown by some members of staff to detained people at Brook House.⁵⁸ However, that does not mean that the poor treatment of detained people, about which the Inquiry heard evidence, were isolated incidents, nor does some positive conduct excuse abuse. Mr Tulley only filmed during his allotted shift times over 36 days, and yet he was able to film many incidents within a short period of time. It is inherently unlikely that the only incidents of this kind that occurred during the relevant period happened, by coincidence, to take place during the particular shifts when Mr Tulley was working, and at the particular times and locations where he was filming.

⁵⁸ [Owen Syred 7 December 2021 30/25-31/3, 112/11-24](#)

28. For different reasons, the oral evidence heard by the Inquiry from members of staff working at Brook House during the relevant period is also unlikely to be representative of the experiences of every member of staff. This is because a large number of the staff working at Brook House during the relevant period provided some form of written evidence to the Inquiry (whether by completing a questionnaire or providing a witness statement), and those who gave oral evidence were chosen to do so because they provided particularly relevant evidence about cultural problems at Brook House, or because they were potentially involved in alleged mistreatment. Those members of staff who raised no issue with the culture or practices at Brook House during the relevant period, and who were not known to be potentially involved in alleged mistreatment, were not called to give oral evidence. When making findings, reaching conclusions and making recommendations within this Report, I have taken this into account and I have considered both the written evidence that was received by the Inquiry (including staff questionnaires) and the oral evidence that was heard by the Inquiry.

29. The Inquiry heard evidence that Mr Tulley himself had, occasionally, made inappropriate comments while working at Brook House. For example, DCO Daniel Small alleged that Mr Tulley had used inappropriate language, such as shouting “*wet dick*” and making “*sex noises*”.⁵⁹ Mr Tulley denied some of the comments attributed to him, and told the Inquiry that he had to maintain his cover, that he did not make such comments in front of detained people, and that he never used any racially charged language in the time that he worked at Brook House.⁶⁰ Having read and heard Mr Tulley’s extensive evidence, it is right to observe that he was in a unique position as a working DCO and undercover reporter. As part of his role as an undercover reporter, he was required to act in accordance with an agreed protocol for undercover operatives.⁶¹ I am satisfied that Mr Tulley acted in the way that he did in order to avoid arousing any suspicion that he was acting undercover.⁶² Also, I do not consider that Mr Tulley encouraged incidents to occur when they might not otherwise have done, nor that he entrapped officers in any way. In addition, I do not accept any of the allegations made by some former Brook House staff that the footage recorded by Mr Tulley was edited in a misleading way, dubbed or otherwise doctored by the BBC or by anyone else.⁶³

30. While the Inquiry will not have heard evidence of the full extent of the incidents that took place at Brook House during the relevant period, I reach my conclusions and make recommendations on the basis of the evidence before the Inquiry.

⁵⁹ [Daniel Small 28 February 2022 130/1-3](#)

⁶⁰ [Callum Tulley 30 November 2021 58/25-59/20](#); [Callum Tulley 9 March 2022 157/19-161/1](#)

⁶¹ [CPS000025](#)

⁶² [Callum Tulley 30 November 2021 58/25-59/20](#)

⁶³ [Ioannis Paschali 24 February 2022 117/23-119/7](#); [Derek Murphy 2 March 2022 79/25-80/15](#); [INQ000120_013](#)

31. The Inquiry also appointed three experts: Professor Mary Bosworth (cultural expert), Dr James Hard (medical expert) and Mr Jonathan Collier (use of force expert), who produced detailed reports and gave oral evidence at the Inquiry’s hearings. The evidence and opinions of each of these expert witnesses were of great assistance in evaluating the evidence collected and heard throughout this Inquiry, particularly those concerning technical matters, such as techniques used by officers during use of force incidents. However, I am not bound to accept their opinions, nor have I done so on every point. The conclusions reached and the comments made throughout this Report are my own.

Core Participants

32. In April 2020, I formally invited applications from individuals and organisations who wished to be considered for Core Participant status in accordance with Rule 5 of the Inquiry Rules 2006. Core Participants have rights in the Inquiry process, including receiving disclosure of documentation, being legally represented, making submissions and suggesting lines of enquiry. They – as well as witnesses – were also able to apply to the Inquiry for funding to cover legal and other costs.

33. The Inquiry granted Core Participant status to:

- 12 formerly detained people;
- four former members of Brook House staff;
- the BBC;
- G4S Care and Justice Services (UK) Ltd, which managed Brook House during the relevant period;
- G4S Health Services (UK) Ltd, which provided healthcare services at Brook House during the relevant period;
- Gatwick Detainees Welfare Group, a charity that offered emotional and practical support to detained people on a daily basis at Brook House;
- the Home Office, which has been responsible for the management of Brook House since its opening, including during the relevant period;
- HM Chief Inspector of Prisons, the head of HM Inspectorate of Prisons, an independent body which inspects and reports on conditions for, and treatment of, those in IRCs, as well as in other institutions such as prisons and young offender institutions;
- the National Chair and Management Board of Independent Monitoring Boards on behalf of the members of the Brook House IMB, which monitored the welfare of those detained at the centre;

- Medical Justice, a non-governmental organisation that provides medico-legal reports and advice to detained people;
- Practice Plus Group, which has provided healthcare services at Brook House since September 2021; and
- Serco Group PLC, which has managed Brook House since May 2020.

Hearings

34. The Inquiry’s public hearings took place over 46 days (divided into two phases, between 23 November 2021 and 6 April 2022), with oral evidence from 78 witnesses including four formerly detained people.⁶⁴ In addition, 23 written witness statements from people formerly detained at Brook House were summarised by agreement between the Inquiry and the witnesses’ legal representatives and then read into evidence. In total, the Inquiry heard evidence (read and live) from 25 formerly detained people.⁶⁵

This Report

35. This Report comprises several Parts:

- Part A provides an introduction to Brook House and this Inquiry.
- Part B sets out relevant background concerning immigration detention and arrangements at Brook House.
- Part C considers specific incidents where there is credible evidence of mistreatment contrary to Article 3.
- Part D in Volume II focuses in detail on the core issues affecting Brook House.
- Part E in Volume II summarises the Inquiry’s findings and recommendations.

Other relevant material is appended to the Report, in Volume III.

Language

36. During the course of its work, the Inquiry received evidence of the use of highly abusive and derogatory language, including racist abuse. In writing this Report, I have at times quoted this language, where it was appropriate to accurately convey the reality faced by detained people at Brook House. Some readers may find this content upsetting.

⁶⁴ [Chair’s Closing Statement](#), Brook House Inquiry, 7 April 2022

⁶⁵ In addition, while D1275 did not feel able to provide evidence to the Inquiry (either by way of a witness statement or orally), witness statements from Mr Hamish Arnott (D1275’s solicitor) and Ms Naomi Blackwell (former Advocacy Coordinator at Gatwick Detainees Welfare Group) were read into evidence so that D1275’s experiences at Brook House could also be considered by the Inquiry

37. A glossary of terms and abbreviations used in this Report are set out in Appendix 5 in Volume III, although some key terms are highlighted below to assist the reader.

37.1 Detained people: In this Report I refer to those who were detained at Brook House as detained people or derivations of that term, which was largely used by the legal representatives of the detained people who are Core Participants. I consider that this terminology confers greater dignity than other possible terms, such as ‘detainee’. There will, however, be occasions where the word ‘detainee’ will be found in this Report, typically when it has been sourced or quoted from elsewhere. I have not used the term ‘residents’ to refer to detained people, notwithstanding that this was the term used by some Home Office and staff at Brook House in their evidence to the Inquiry, because I do not consider that this term accurately conveys the status and experience of detained people at Brook House. When referring to a particular detained person, the Report uses the cipher assigned to them by the Inquiry.

37.2 Relevant period: As set out in the Inquiry’s Terms of Reference, the Inquiry considered decisions, actions and circumstances surrounding the mistreatment of detained people at Brook House during the period 1 April 2017 to 31 August 2017.

37.3 Immigration detention estate: This term is used to refer to all immigration removal detention facilities, including IRCs.

37.4 Personal Protective Equipment (PPE): This is described in Prison Service Order 1600: Use of Force as:

“● Short shield / mini shield (may be carried by the number 1)

● Helmets

● Shin / knee guards

● Forearm guards

● Gloves

● Flame retardant overalls (if required)”.⁶⁶

37.5 Cells: Throughout this Report, I refer to the spaces in which detained people were accommodated as ‘cells’ rather than ‘rooms’. I consider that this term more accurately reflects the reality of the space in which detained people were accommodated.⁶⁷

⁶⁶ [Prison Service Order 1600: Use of Force \(INQ000185\)](#), HM Prison Service, August 2005, p39

⁶⁷ [D1851_3 December 2021 69/22-70/1](#). This language was used occasionally by G4S (see [CJS0074041_035](#) para 176) and is the language used by HMIP (see [HMIP000613_027](#) and [HMIP000674_005](#))

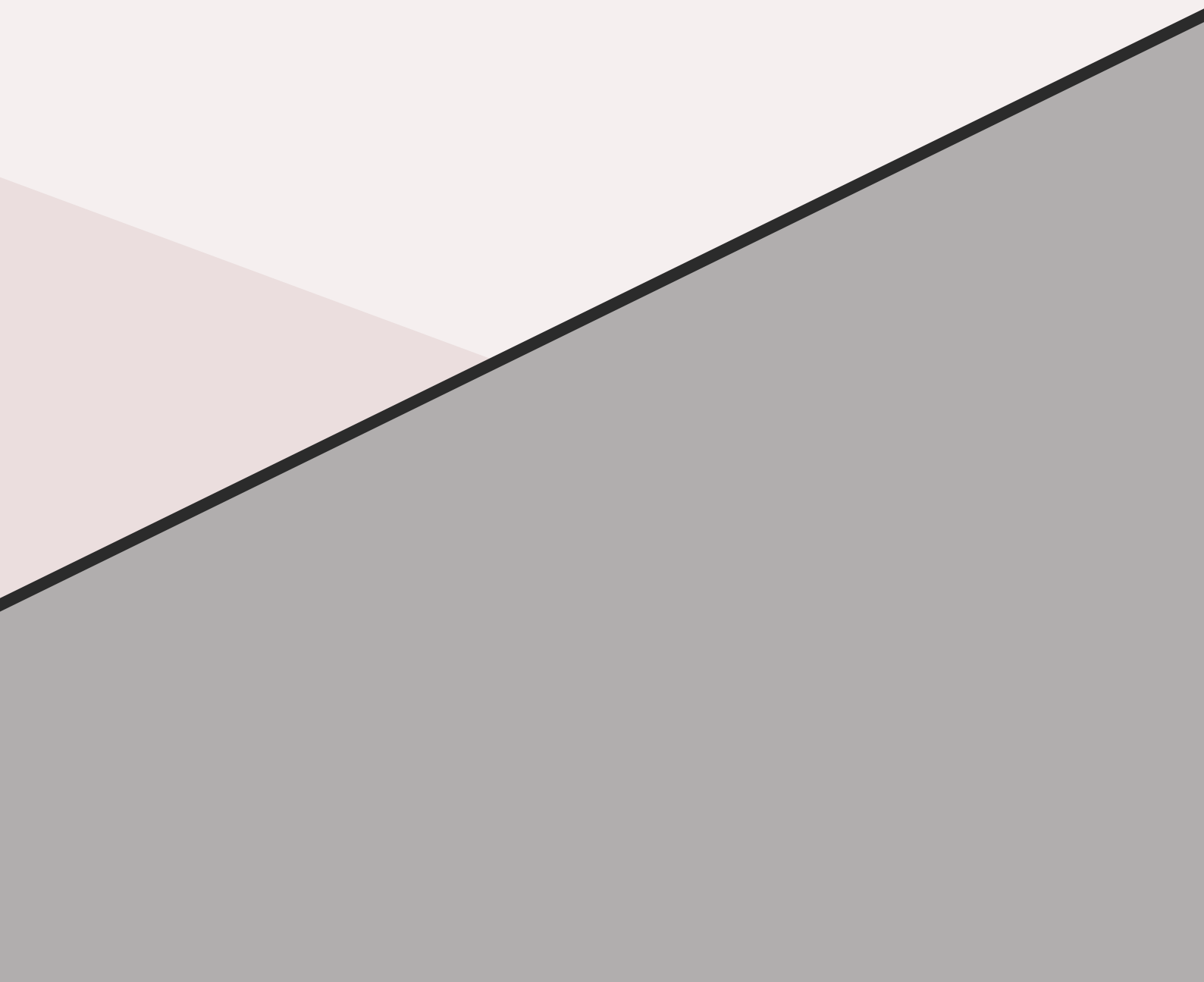
- 37.6 G4S:** G4S Care and Justice Services (UK) Ltd managed Brook House between 2008 and 2020, including during the relevant period. All references to 'G4S' in this Report are to G4S Care and Justice Services (UK) Ltd, unless otherwise indicated. Its 2008 contract with the Home Office (which was originally awarded to another service provider) was in force during the relevant period and subsequently extended in 2018, and is referred to as 'the G4S contract'.
- 37.7 Serco:** Serco Group PLC (referred to as 'Serco' in this Report) took over the management of Brook House in May 2020 under a contract dated February 2020 (referred to as 'the Serco contract').
- 37.8 Healthcare:** Healthcare services at Brook House were contracted separately by G4S Health Services (UK) Ltd (referred to in this Report as 'G4S Health Services') from September 2014 until 31 August 2021 and then by Practice Plus Group from September 2021. GP services were subcontracted to Doctor PA Ltd during the relevant period and as at January 2023. These services are referred to collectively in this Report as 'Healthcare'.
- 37.9 Gatwick IRCs:** Brook House and Tinsley House (another IRC nearby, opened in 1996) are referred to collectively as Gatwick IRCs.
- 37.10 'Mistreatment':** I have made findings relating to 'mistreatment' in relation to specific incidents in Part C. Here, I have applied the definition as provided for in the Terms of Reference, that is, "*contrary to Article 3 ECHR, namely torture, inhuman or degrading treatment, or punishment*".⁶⁸
- 38.** In general, individuals are referred to in this Report by the title that they had during the time period being discussed. However, to aid the reader, individuals who were DCOs or Detention Custody Managers (DCMs) at Brook House during the relevant period are referred to initially by that title, even if they no longer hold that position.
- 39.** Unless otherwise stated, images contained in this Report were taken from video footage submitted as evidence to the Inquiry. They include images taken from handheld video cameras used by staff during use of force incidents, and from the covert filming undertaken by Mr Tulley. Some images have been blurred to prevent identification or as otherwise appropriate.

⁶⁸ Purpose, Terms of Reference, Brook House Inquiry; European Convention on Human Rights, Article 3

40. In the footnotes of this Report, references such as ‘HMIP000613’ and ‘CJS001506’ are to documents that have been published on the Inquiry website. A reference such as ‘Mohammed Khan 24 March 2022 5/6-10’ is to evidence heard during the Inquiry, specifically to the witness, the date they gave evidence, and the page and line references within the relevant transcript (which is also available on the Inquiry website) – in this example, Mr Mohammed Khan on 24 March 2022, page 5, lines 6 to 10.

Part B

The context



The context

Immigration detention

1. UK immigration legislation provides powers to detain foreign nationals in certain circumstances.¹ As set out in Home Office guidance:

“Detention is most usually appropriate:

- *to effect removal*
- *initially to establish a person’s identity or basis of claim*
- *where there is reason to believe that the person will fail to comply with any conditions attached to a grant of immigration bail.”²*

Detention must also be in accordance with Home Office policy.

2. At the end of December 2017, there were 2,545 people in immigration detention.³ At the end of March 2023, the figure was 1,591 people.⁴

The legal framework

3. Immigration removal centres (IRCs), such as Brook House, are required to operate in accordance with a range of legislation, rules and guidance.

3.1 Section 153 of the Immigration and Asylum Act 1999 (the 1999 Act) provides that the Secretary of State must make rules for the regulation and management of removal centres and that these rules may, among other things, make provision with respect to the safety, care, activities, discipline and control of detained people.⁵ In addition, section 149 of the 1999 Act contains a power for the Secretary of State to contract out the management of removal centres. Where that has been done, it specifies that the contracted-out removal centre must be operated in accordance with the rules made by the Secretary of State under section 153.⁶

¹ [Immigration Act 1971](#), Schedule 2 para 16 and Schedule 3 para 2

² [Detention: General instructions](#), Home Office, January 2022

³ See [Home Office Immigration Statistics, year ending December 2022, Detention – Summary Tables](#), Det_D03c: People in detention, by length of detention

⁴ See [Summary of latest statistics](#), Home Office, May 2023, para 6.1; also [Immigration System Statistics year ending March 2023 \(Detention – Summary Tables\)](#), DET_D02. Updated statistics were due to be published at the time this Report was going to press

⁵ [Immigration and Asylum Act 1999](#), section 153

⁶ [Immigration and Asylum Act 1999](#), section 149

- 3.2** The Detention Centre Rules 2001 (the Rules) are secondary (ie delegated) legislation made under the 1999 Act. They govern the operation and management of IRCs.⁷ The Rules cover a range of issues, including the purpose of detention centres, the welfare, privileges and religious needs of detained people, as well as restrictions that can be imposed on them, such as removal from association and temporary confinement, and the use of force.
- 3.3** Detention service orders are instructions outlining procedures to be followed by the Home Office and its contractors' staff in the management of detention centres.⁸ They cover a range of issues, including accommodation standards, internet access, management of adults at risk, mental vulnerability, paid activities, induction and welfare services.
- 3.4** The Detention Services Operating Standards Manual provides the standards set by the Home Office for contractors that manage IRCs.⁹ It sets out standards in relation to matters such as accommodation, education, use of force, access to activities and the library, catering, clothing, communications, complaints, healthcare, hygiene, incentives schemes, interpreters/translators, race relations and religion. The standards are said by the Home Office to be "*designed to build on the Detention Centre Rules and to underpin the arrangements we have for the management of removal centres*", and are "*a means of achieving a level of consistency across the removal estate*".¹⁰

Further details regarding the legal framework are set out in Appendix 2 in Volume III of this Report.

Recent developments

- 4.** The legal landscape of immigration detention remains fundamentally similar to that in place during the relevant period considered by this Inquiry (1 April 2017 to 31 August 2017).
- 4.1** There remains no overall maximum time limit on detention.
- 4.2** A provision introduced in January 2018 required the Secretary of State to "*arrange consideration of bail*" for individuals who have been detained for four months who are not foreign national offenders, and make a reference to an immigration tribunal for that purpose.¹¹

⁷ [Detention Centre Rules 2001](#)

⁸ [Detention services orders](#), Gov.uk

⁹ [Detention Services Operating Standards Manual for Immigration Service Removal Centres](#), January 2005

¹⁰ [Detention Services Operating Standards Manual for Immigration Service Removal Centres](#), January 2005, p1

¹¹ [Immigration Act 2016](#), Schedule 10 para 11

4.3 New proposed legislation – the Illegal Migration Bill – will, if enacted, expand the Secretary of State’s role in detention decision-making and will make provision for the detention of additional categories of individuals.

5. The current legal framework is discussed below. In recent years, there have also been major changes in immigration detention practice, as a result of a number of factors.

The impact of the Covid-19 pandemic

6. Although it is not within the scope of the Inquiry to consider detention policy during the Covid-19 pandemic, the Inquiry heard evidence of its practical effects on Brook House.

7. The size of the detained population nationwide reduced significantly during the Covid-19 pandemic. Brook House closed entirely for a short period at the beginning of 2021.

8. The pandemic also affected induction, activities and staff training, including in the use of force.¹² For example, the Inquiry heard evidence of the use of force by detention staff who had not undergone 12-monthly refresher training.¹³ Due to the difficulty in running practical training sessions during the Covid-19 pandemic, the Home Office granted a temporary national dispensation to all IRCs, suspending the need for refresher training.¹⁴ Serco data from November 2020 showed an increased use of force during that month, with force used to prevent self-harm.¹⁵ Mr Steven Hewer, the current Director of Brook House and Tinsley House (Gatwick IRCs), said that this was “discussed at every meeting” with the Home Office.¹⁶ While I appreciate the difficulties facing an IRC required to remain open during a pandemic, I have some concern about permitting the use of force by officers not up to date with training, and an unrealistic assertion on behalf of Serco that this gave rise to “no risk”.¹⁷ Much more fundamental is the fact that detained people were placed and remained in Brook House in these circumstances.

¹² [SER000451_012-013](#) para 50; [Gatwick immigration detention centre closed due to staff Covid cases, The Guardian](#), 8 January 2021; [SER000451_012](#) para 47; [SER000451_013-014](#) para 57; [SER000451_016](#) para 68

¹³ [SER000451_016-017](#) paras 68-71; [LIB000015](#); [INQ000115](#)

¹⁴ [Steven Hewer 1 April 2022 125/25-127/3](#)

¹⁵ [LIB000176_002-003](#)

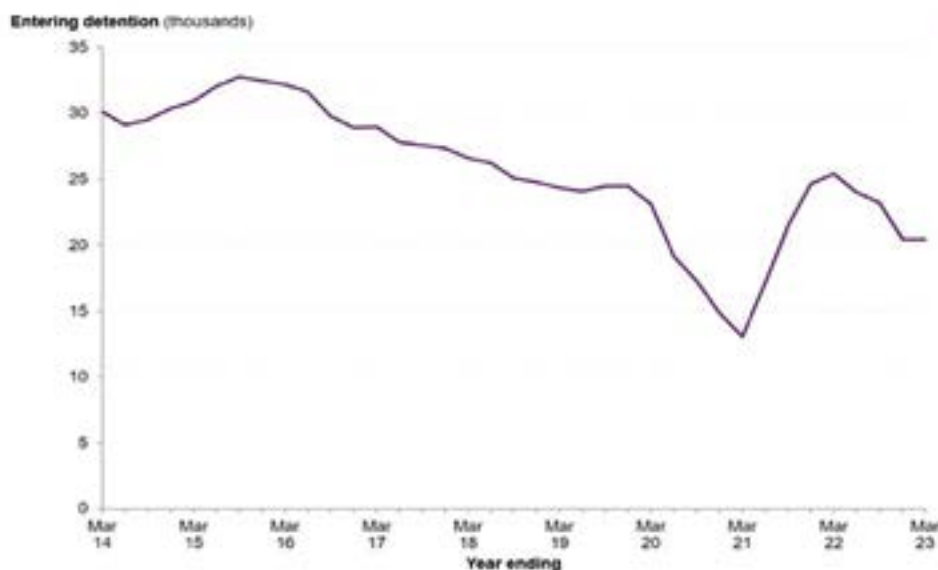
¹⁶ [Steven Hewer 1 April 2022 125/3-22](#)

¹⁷ [Steven Hewer 1 April 2022 127/18-23](#)

The current approach to immigration detention

9. The Home Office told the Inquiry in November 2021 that detention was being “used sparingly, and as a last resort”.¹⁸ Levels of detention were broadly comparable to pre-pandemic numbers by June 2022, as shown in Figure 2.¹⁹

Figure 2: People entering immigration detention in the UK, year ending March 2014 to year ending March 2023



Source: *National statistics How many people are detained or returned?*, Home Office, published 25 May 2023; see also *Home Office Immigration detention statistics, Det_D01*. Updated statistics were due to be published at the time of going to press.

10. The Home Office also told the Inquiry: “practices in the field of immigration detention have evolved significantly since 2017”.²⁰ It also considered that the events at Brook House did not represent the broader treatment of those detained in IRCs but nevertheless “acted as a spur for the ambitious programme of reform”, which focused on:

*“minimising the use of detention; strengthening decision-making, and safeguards for the vulnerable; improving transparency, and ensuring that everyone is treated with dignity in an estate fit for purpose”.*²¹

11. The Inquiry’s assessment of the safeguarding of vulnerable people in detention is dealt with elsewhere in this Report (particularly Part D in Volume II), but immigration detention and policy remain subject to fast-moving political developments.

¹⁸ [HOM0332005_010](#) para 27

¹⁹ [INQ000232](#)

²⁰ [HOM0332005_002](#) para 5. This was endorsed by Mr Stephen Kershaw, Senior Director of the Immigration Enforcement Board at the Home Office: [HOM0332166](#) para 16

²¹ [HOM0332005_002](#) para 5

12. In the second half of 2020, following Britain’s withdrawal from the European Union (EU), Brook House was used as accommodation for men who had arrived in the UK, having crossed the English Channel in small boats, and who were to be removed to EU Member States before the end of the transition period on 31 December 2020.²² This charter flight removal programme was pursuant to an EU scheme for determination of asylum claims, which the UK was no longer to participate in following the end of the Brexit transitional period. It resulted in a steep increase in the number of vulnerable people detained at Brook House, evidenced by an increase in the use of the Assessment Care in Detention and Teamwork (ACDT) process and the number of detained people on food and fluid refusal.²³ The Independent Monitoring Board at Brook House (Brook House IMB) recorded that the response to the risk of self-harm and suicide among the population was frequently constant supervision by officers to prevent further harm.²⁴

Table 2: Numbers of detained people placed on constant supervision in the months of the charter flight removal programme (2020)

Month (2020)	Average daily population	Number of detained people on constant supervision during the month
August	93	32
September	115	33
October	107	31
November	122	34
December	80	23

Source: [IMB000202_11](#)

13. In its 2020 Annual Report (the 2020 IMB report), the Brook House IMB stated:

“Concern about a detainee’s state of mind must be very high indeed to justify assigning staff to watch them at all times. Moreover, these are only the most extreme cases; more detainees were, at the same time, on hourly, overnight or less frequent watch.”²⁵

²² [Regulation \(EU\) No 604/2013 of the European Parliament and of the Council of 26 June 2013 \(the Dublin Regulation\)](#), 26 June 2013; see [DL0000140_113-116](#), [IMB000206](#). This was the programme using charter flights to remove detained people to EU countries party to the Dublin Convention prior to 31 December 2020. Brook House was used as the sole base for this programme ([IMB000202_005](#))

²³ [DL0000140_113-116](#). These matters are discussed further in Chapters D.5 and D.8

²⁴ [IMB000202_11](#)

²⁵ [IMB000202_011](#)

It found that *“circumstances in the centre amounted to inhumane treatment of the whole detainee population”*, emphasising that the circumstances rather than the staff at Brook House were responsible for this treatment.²⁶

14. Mr Hewer told the Inquiry that he accepted the Brook House IMB’s description of the events and its summary of concerns regarding this *“difficult period”*, and accepted that Brook House *“wasn’t safe”*, with high levels of self-harm.²⁷ He said that the Home Office was aware of the *“spike in self-harm”* and the population’s vulnerability, which was discussed at regular meetings. He believed his concerns were made clear and acknowledged.²⁸ He noted that it was the Home Office’s decision to continue to send people to Brook House, stating that he *“had no control on what were allocated to us when”*.²⁹

15. Mr Ian Castle, former Home Office Detention and Escorting Services Area Manager for Gatwick IRCs, told the Inquiry of the huge stress for staff and detained people at this time, leading to senior managers being signed off sick.³⁰ He told the Inquiry that *“the political drive to remove people [who had arrived] across the Channel in the small boats was difficult to keep up with”*.³¹ Mr Hewer agreed.³²

16. As discussed in Chapter D.11 in Volume II, on 2 October 2020, Brook House IMB members wrote to Mr Chris Philp MP (then Minister for Immigration Compliance and Courts) informing him of the IMB’s concerns about the harmful impact of the charter flight removal programme, which it said amounted to *“inhumane treatment”*.³³ The government’s response, when it came, failed to address the concerns adequately. It referred to existing policies (which the IMB had shown were not keeping people safe) and repeated references to effecting removals of people *“with the appropriate safeguards in place”*, despite the fact the safeguards were seemingly insufficient.³⁴ The response betrayed a lack of concern for these men, and also ignored the position in which the Home Office had placed Serco and other staff at Brook House.

17. The Home Office has a wider responsibility for those detained at its behest and who are held under its care. The situation at Brook House in late 2020, described above, is a concerning example of the Home Office placing individuals into an environment where they were at risk of harm and distress,

²⁶ [IMB000202_008-009](#)

²⁷ [Steven Hewer 1 April 2022 103/18, 104/6-13](#)

²⁸ [Steven Hewer 1 April 2022 110/1-111/15](#)

²⁹ [Steven Hewer 1 April 2022 111/19-22](#)

³⁰ [Ian Castle 15 March 2022 56/16-25](#)

³¹ [Ian Castle 15 March 2022 56/1-3, 57/3-4](#)

³² [Steven Hewer 1 April 2022 106/17](#)

³³ [DL0000140_113](#)

³⁴ [IMB000206](#)

and failing to intervene when these effects became known. This undermines the Home Office's assertion to the Inquiry that lessons have been learned, that the unacceptable treatment was due to a "*small minority of staff*", and that issues with the G4S contract or insufficient Home Office resources were the primary cause of the failures at Brook House.³⁵ It calls into question the Home Office's assurance that, since the *Panorama* programme, sufficient steps have been taken to make IRCs "*a safe environment*".³⁶

18. The impact of, and reaction to, this concentrated programme of detaining particularly vulnerable people provides some insight into the reality of life at Brook House since the relevant period.

19. In April 2022, the Government announced that it was "*expanding*" immigration detention facilities.³⁷

20. Recent changes to the law and policies concerned with seeking asylum include changes affecting those who passed through a "*safe third country*" and plans to speed up processing the claims of such applicants by introducing new "*asylum reception centres*" to replace hotel accommodation.³⁸ The Home Office has subsequently indicated that it intends to procure a contract "*for the provision of design, build or renovation and operation of national Accommodation Centres*".³⁹

21. On 14 April 2022, a migration and economic development partnership was announced, which provides that certain people seeking asylum in the UK who have claims deemed "*inadmissible ... and have made a dangerous and illegal journey to the UK may be relocated to Rwanda for processing under their asylum system*".⁴⁰ It was widely reported that Brook House would be used to detain individuals prior to removal to Rwanda.⁴¹ The Home Secretary confirmed that the first tranche of people notified were all detained pending

³⁵ Philip Riley 4 April 2022 94/11-15; HOM0332005_003 para 6; HOM0332005_006-007 para 17; see also Part C of this Report

³⁶ Philip Riley 4 April 2022 75/3-4

³⁷ PM speech on action to tackle illegal migration: 14 April 2022, Prime Minister's Office and the Rt Hon Boris Johnson MP, 14 April 2022. The Home Office has also indicated that it intends, in 2023, to procure contracts for the provision of operational, management, maintenance and related works and services at Campsfield House immigration removal centre and Haslar immigration removal centre (see [Home Office procurement pipeline](#), 20 December 2019, references C23340, C23929)

³⁸ [Immigration Rules](#) (as amended on 31 December 2020, updated 30 January 2005), Part 11: asylum; [Borders Act to overhaul asylum system becomes law](#), Home Office and UK Visas and Immigration, 28 April 2022. See also [Factsheet: Linton-on-Ouse Asylum Accommodation](#), Home Office news team, 14 April 2022; [Asylum Reception Centre: Linton-on-Ouse](#), Hansard HC Deb, 24 May 2022, vol 715 col 271

³⁹ [Home Office procurement pipeline](#), 20 December 2019, reference C21671 (see also [Home Office procurement pipeline](#))

⁴⁰ [Migration and Economic Development Partnership with Rwanda: equality impact assessment](#), Home Office, updated 4 July 2022

⁴¹ [Home Office threatens hunger strikers with faster deportation to Rwanda](#), *The Guardian*, 2 June 2022

removal.⁴² In fact, the planned flight was cancelled shortly before departure due to legal challenges.

22. The Nationality and Borders Act 2022 was passed in April 2022. The Home Office said that it was designed to deter illegal entry to the UK and to more easily remove those with no right to be in the UK.⁴³ I was concerned and disappointed to hear that, while the Bill was passing through Parliament, the Government “*paused*” plans to reform the Detention Centre Rules and Adults at Risk policy.⁴⁴ As this Report sets out in detail, particularly in Part D in Volume II, the Inquiry has received troubling evidence that clearly demonstrates that this review is urgently needed.

23. As discussed above, Parliament is currently considering proposed new legislation, the Illegal Migration Bill. The Home Office states that it would change the law:

“so that people who come to the UK illegally will not be able to stay. Instead, they will be detained and then promptly removed, either to their home country or a safe third country like Rwanda.”⁴⁵

24. If enacted as currently worded, the Home Secretary would be required to remove individuals to whom the Bill applied as soon as “*reasonably practicable*”.⁴⁶ The Bill also provides that those individuals may be detained “*in any place*” that the Home Secretary considers appropriate.⁴⁷

25. The Bill provides that individuals may be detained for such a period as is “*reasonably necessary*” to effect removal. It would be for the Secretary of State, and not the courts, to decide what is a “*reasonable*” period of time. The Bill, in its current form, provides that if it became apparent that deportation would not happen within a reasonable period, the person could remain in detention “*for such further period as, in the opinion of the Secretary of State, is reasonably necessary to enable such arrangements to be made for the person’s release as the Secretary of State considers to be appropriate*”.⁴⁸ The Bill also includes proposed restrictions on the ability to challenge detention by way of seeking immigration bail.

26. It is not for this Inquiry to assess the policy or proposed legislative changes. However, as detailed throughout this Report, many of the safeguards

⁴² [Home Office detains all asylum seekers it plans to send to Rwanda, *The Guardian*, 22 May 2022; Migration and Economic Development Partnership with Rwanda: equality impact assessment, updated 4 July 2022](#)

⁴³ [Implementing the Nationality and Borders Act 2022: Amendments to tribunal fees, 23 November 2022](#)

⁴⁴ [HOM0332051_008 para 34](#)

⁴⁵ [Home Office, Policy paper, Illegal Migration Bill: overarching factsheet, updated July 2023](#)

⁴⁶ [Illegal Migration Bill](#), clause 5

⁴⁷ [Illegal Migration Bill](#), clause 10(2)

⁴⁸ [Illegal Migration Bill](#), clause 11(1)

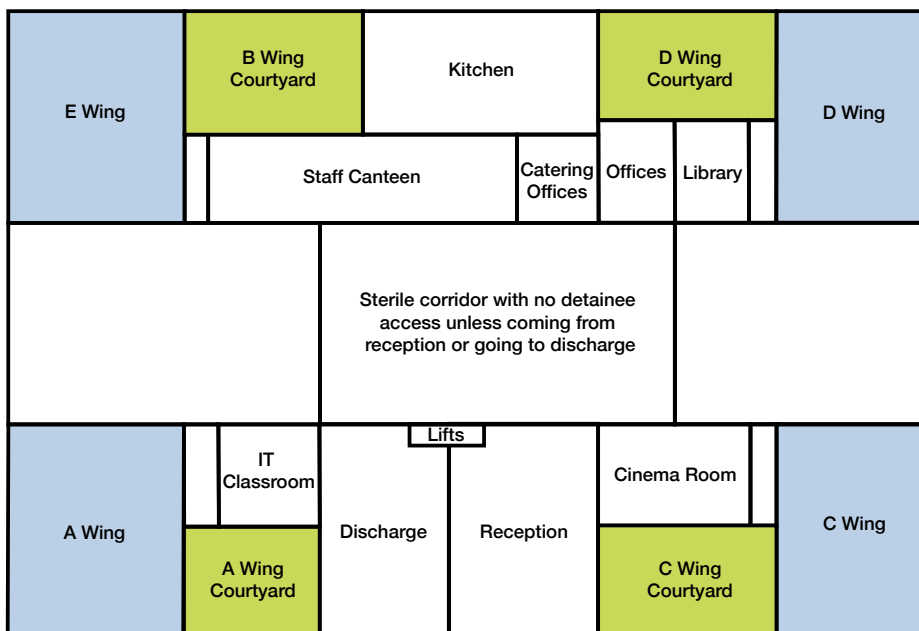
designed to protect vulnerable detained people failed during the relevant period. I remain very concerned about the function of those safeguards and have made a number of recommendations, which should be considered on an urgent basis. Whatever the future of immigration detention policy, it must be underpinned by sufficient and effective rights and protections, representing a minimum standard of care.

Brook House immigration removal centre

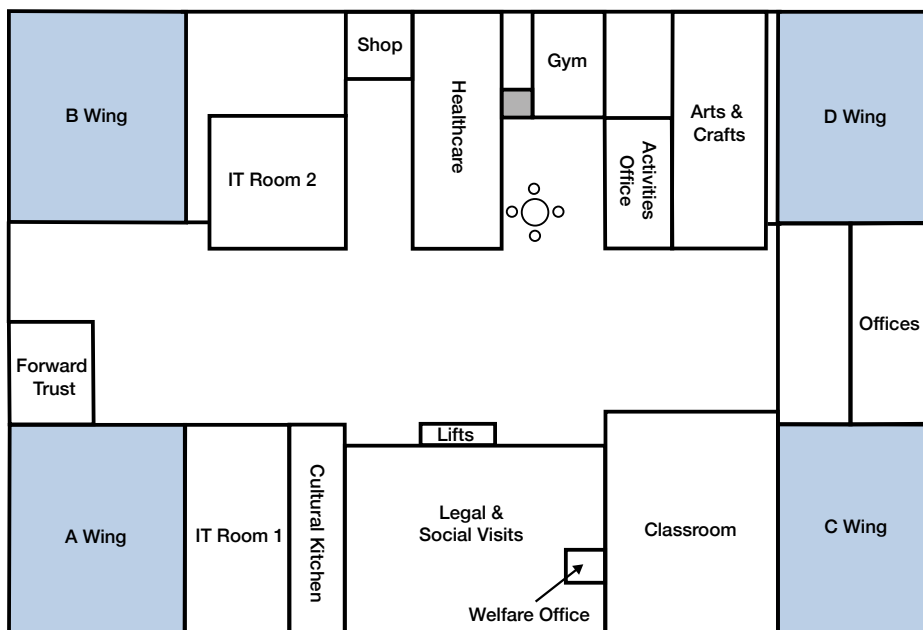
27. The design of Brook House and related issues are considered in detail in Chapter D.3 in Volume II. It opened in March 2009 as a 448-bed, male-only, purpose-built centre.

Figure 3: Generic floor plans of Brook House

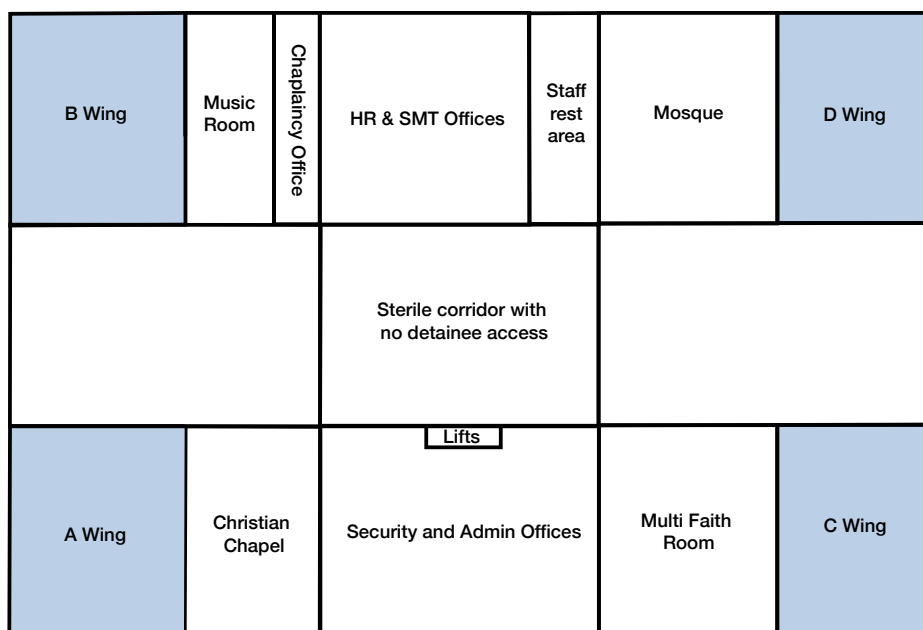
Ground floor



First floor



Second floor



Source: CJS004587

28. The reasons for detention at Brook House broadly fell into three categories:

- foreign nationals who had served a sentence in a UK prison, having been convicted of a criminal offence, and were due to be deported as a result (known as time served foreign national offenders or TSFNOs);⁴⁹
- individuals whose applications for asylum had been rejected and others thought to have entered or remained in the UK illegally; and
- those whose applications for asylum were still being considered.

The management of Brook House under G4S

29. G4S was contracted to run Brook House from its opening in 2009 until May 2020.

30. Mr Ben Saunders was the Centre Director for Gatwick IRCs during the relevant period. He reported to the Managing Director of G4S Custodial & Detention Services, Mr Jeremy Petherick, who in turn reported to G4S Regional President UK & Ireland, Mr Peter Neden.⁵⁰

31. During the relevant period, the Senior Management Team (SMT) also included Mr Stephen Skitt, Ms Sarah Newland, Ms Michelle Brown and Mr Julian Williams.⁵¹ Each of these “*functional heads*” (at D grade) was responsible for their own department(s) and teams.⁵² Monthly SMT meetings covered “*departmental updates, audits and compliance matters, and operational updates/matters*”, along with considering functional heads’ reports and directors’ feedback, and reviewing use of force incidents.⁵³ Individual SMT members might attend daily morning meetings, and each held their own monthly meetings with their staff.⁵⁴

⁴⁹ The average proportion of detained people at Brook House who were TSFNOs during the relevant period was 33–35 per cent (see [CJS000905](#); [CJS000908](#); [CJS000914](#); [CJS000910](#); [CJS000619](#); [IMB000021](#); [IMB000050](#); [IMB000011](#); [IMB000047](#); [IMB000019](#)). See also [CJS0073709_060](#) para 6.1

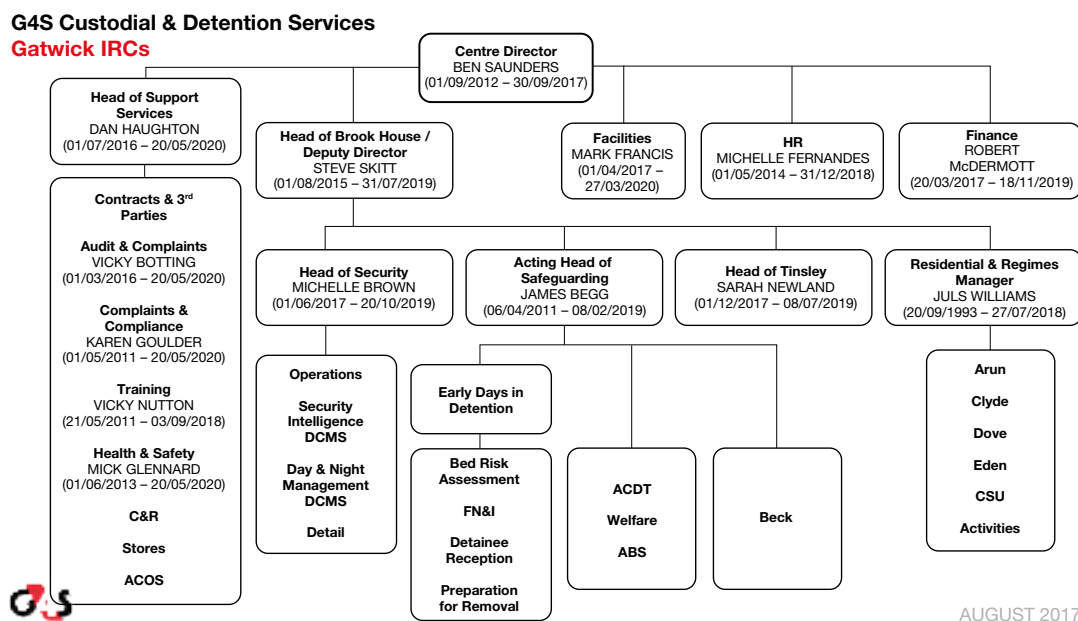
⁵⁰ [KEN000001](#) para 24; [CJS0072810_001](#)

⁵¹ [KEN000001](#) para 24

⁵² [SER000455](#) para 153

⁵³ [SER000455](#) paras 154-155

⁵⁴ [SER000455](#) para 153

Figure 4: The G4S management structure at Brook House in August 2017

Source: [CJS0072810](#)

32. Below the SMT were intermediate managers (at E1 grade).⁵⁵ Those who were part of the SMT or E1 grade would perform the role of Duty Director on a rotating basis. On each shift, there would always be a named Duty Director, either on site or on call.⁵⁶ The Duty Director role involved “operational oversight” of Brook House, including being responsible for reviewing those detained people subject to Rule 40 or 42 of the Rules (removal from association and temporary confinement) or those on ACDT plans, attending to staffing issues, and being made aware of any incidents within Brook House.⁵⁷

33. On a more day-to-day level, Detention Custody Managers (DCMs) were line managers of the Detention Custody Officers (DCOs) in their team, and were typically recruited from existing staff.⁵⁸ Mr Saunders believed that there was “quite a large gap” between DCM and E1 grade roles.⁵⁹

34. DCOs were the primary staff points of contact with detained people. They were generally designated to a particular area of Brook House but could be relocated as required. Some worked on residential wings, generally remaining on the same wing for all shifts, while others (such as DCO Callum

⁵⁵ [SER000453](#) para 5

⁵⁶ [Daniel Haughton 16 March 2022 127/21-128/4](#). Mr Haughton explained that he acted as Duty Director about once a week and every six to eight weekends; [SER000453](#) para 6

⁵⁷ [SER000453](#) para 6; [Daniel Haughton 16 March 2022 77/6-14](#). [Detention Services Order 01/2022: Assessment Care in Detention and Teamwork \(ACDT\) \(INQ000214\)](#) (Home Office, October 2022) provides mandatory operational guidance regarding “a holistic approach to self harm and suicide prevention within the broader context of decency and safety”

⁵⁸ [INQ000064](#) para 4.26

⁵⁹ [KEN000001](#) para 30

Tulley) were Activities staff, working across various areas such as the gym, library and ‘cultural kitchen’.

35. Assistant Custody Officers (ACOs) worked in areas such as the gatehouse and visitors centre, undertaking “*very mundane tasks*” such as escorting vans or opening security doors.⁶⁰ ACOs had no direct contact with detained people.⁶¹

36. The Inquiry did not consider in detail non-custodial G4S employees, such as human resources and administrative staff, as they had limited or no contact with detained people. Alongside G4S staff were those employed by subcontractors, such as cleaning and catering staff, and Healthcare staff employed by G4S Health Services. There were also Home Office employees working within Brook House (discussed further in Chapter D.2 in Volume II).

Other key organisations at Brook House

37. As one of the few non-governmental organisations with a presence on the ground at Brook House, and the only one concerned with general welfare, Gatwick Detainees Welfare Group (GDWG) was particularly important to the experience of detained people at Brook House.

38. GDWG provides a range of emotional and practical support to detained people at Gatwick IRCs, which includes offering friendship and support, advocating for fair treatment, and calling for positive change in conditions.⁶² It includes a team of advocacy coordinators who match volunteers with detained people, refer detained people to external agencies and help them to navigate the detention system (including how to use complaints processes and raise concerns with Brook House management); and a team of volunteer visitors, who provide emotional and practical support for detained people with whom they are matched, and visit them regularly.⁶³

39. Several detained people described GDWG in positive terms and emphasised the importance of its role at Brook House.⁶⁴ There were, however, a number of occasions prior to and during the relevant period in which the Home Office and G4S took a defensive and heavy-handed approach towards GDWG.

39.1 There was a negative reaction to a GDWG Advocacy Coordinator, Ms Naomi Blackwell, providing a witness statement in support of a

⁶⁰ [INQ000052](#) paras 13-15

⁶¹ [INQ000064](#) para 4.4

⁶² [DPG000002_002-004](#) paras 7-13

⁶³ [DPG000002_003-004](#) paras 10-11; [DPG000002_008-009](#) para 20; [INQ000027_001-002](#) paras 1-5

⁶⁴ [D668 22 February 2022 68/14](#); [DPG000023_010](#) para 37; [DPG000040_010](#) para 43; [Anton Bole 8 December 2021 160/1-10](#); [SER000455_022](#) para 60; [SER000453_057](#) para 253

detained person's judicial review in October 2015.⁶⁵ Although this was, in my view, a reasonable thing for GDWG to do, it was regularly brought up by G4S and the Home Office as a criticism.⁶⁶ Mr James Wilson, Director of GDWG during the relevant period, was told by G4S that GDWG should not be providing witness statements in support of detained people's legal cases.⁶⁷

39.2 'Drop in' meetings took place in legal visit rooms once an appointment was made, meaning that detained people had to go through a security search and be given access through a barred gate.⁶⁸ A proposal by GDWG in February 2017 for it to have a desk in Brook House alongside Welfare Officers was rejected, although Ms Anna Pincus, current Director of GDWG, noted that Serco was considering the possibility of GDWG having drop-in sessions in the library going forward.⁶⁹ In 2016 and 2017, GDWG staff were restricted by G4S and the Home Office to only having one drop-in session with each detained person, unless there were exceptional circumstances.⁷⁰ Although there was some dispute about whether a February 2016 draft Memorandum of Understanding, setting out this position, had been agreed, by the time of the relevant period both parties appeared to be proceeding on the basis of the February 2016 version, but were in discussion about a revised version being agreed.⁷¹

39.3 I cannot see any good reason why repeat drop-in visits were not allowed during the relevant period and think that this was most likely an example of G4S and the Home Office seeking to restrict the role of GDWG.⁷² Although GDWG could make requests for repeat visits where it was considered particularly important, there was one occasion in which this was refused by Mr Daniel Haughton, G4S Support Services Manager during the relevant period, due to "*scrutiny from outside*" and concerns

⁶⁵ [James Wilson 10 December 2021 31/11-32/3](#); [GDW000001_006](#) para 18; [GDW000001_008](#) para 25

⁶⁶ [DPG000002_059-061](#) paras 167-169; [James Wilson 10 December 2021 9/6-10/20](#); [GDW000001_006](#) para 18; [GDW000001_009-010](#) para 29

⁶⁷ [GDW000001_008](#) para 25

⁶⁸ [DPG000002_013](#) para 30

⁶⁹ [James Wilson 10 December 2021 5/20-8/23](#); [GDW000001_009](#) para 27; [Anna Pincus 9 December 2021 14/5-17, 94/8-24](#); [DPG000017_002-003](#) paras 6-11; [DPG000018](#)

⁷⁰ As described at the start of the paragraph, these were a meeting between a detained person and a member of staff from GDWG in a private room. These differed from visits, which took place in a communal room and were with a GDWG volunteer visitor. See [Anna Pincus 9 December 2021 19/22-20/10](#); [GDW000003_001](#)

⁷¹ [James Wilson 10 December 2021 15/14-20, 20/10-14](#); [DPG000044](#); [HOM0332156](#); [DPG000042_002](#) para 4; [GDW000003_010-012](#); [GDW000003_13](#); [GDW000003_018-020](#); [GDW000003_027](#); [GDW000003_029](#); [GDW000003_034](#); [James Wilson 10 December 2021 16/24-17/7](#); [HOM0332150](#)

⁷² At the time of the Inquiry's hearings, GDWG was able to make repeat visits without seeking permission from Serco (which now manages Brook House): [Anna Pincus 9 December 2021 36/14-17](#). [DPG000002_016-017](#) paras 37-39; [VER000290](#)

that it had developed into a welfare surgery.⁷³ He said: “*From the Home Office’s point of view this [is] not the purpose of your drop-in.*”⁷⁴ On another occasion, Mr Haughton refused the request because “*drop-in clinics are not the place to maintain regular contacts with detainees*”, which was said to be due to a “*shared understanding*” that regular contact should instead take place in the context of social visits.⁷⁵ At a meeting in June 2017, Mr Skitt (Deputy Director of Brook House during the relevant period) complained that GDWG was requesting repeated drop-ins.⁷⁶ The consequence of this, according to Ms Pincus, was that GDWG felt deterred from making requests during the relevant period, despite describing repeat visits as “*crucial*” for building up trust and rapport.⁷⁷

39.4 In August 2017, Ms Pincus asked Mr Haughton whether G4S would consider moving a detained person from Brook House to Tinsley House to help him cope better with post-traumatic stress disorder (PTSD).⁷⁸ Mr Skitt complained that this was an example of a concern being raised to the right person in the wrong way,⁷⁹ which Ms Pincus described as an illustration of a “*broken culture*” in management at Brook House.⁸⁰

39.5 At a meeting in August 2017, Mr Skitt and Mr Paul Gasson (Home Office Contract Monitor) said that they were seriously considering ending GDWG’s drop-in surgeries,⁸¹ and complained about emails from GDWG staff about a detained person with burn injuries and another detained person who they thought might be underage.⁸² Mr Wilson said that he was also told they should not be referring detained people to other agencies.⁸³ He described the meeting as being “*tantamount to bullying towards me and towards GDWG*” and described Mr Skitt and Mr Gasson as being very heated, shouting at points, and banging the table.⁸⁴ Immediately after the meeting, Mr Wilson emailed colleagues, describing

⁷³ [DPG000002_019](#) paras 43-45

⁷⁴ [GDW000003_027](#)

⁷⁵ [GDW000003_015](#)

⁷⁶ [James Wilson 10 December 2021 38/15-39/9](#); [GDW000001_013](#) para 39; [DPG000003_014](#) para 42

⁷⁷ [Anna Pincus 9 December 2021 28/8-29/4, 31/15-22](#); [DPG000002_017](#) para 39; [DPG000002_019](#) para 43

⁷⁸ [GDW000003_033](#)

⁷⁹ [GDW000001_014-015](#) para 44

⁸⁰ [Anna Pincus 9 December 2021 48/19-50/2](#); [VER000249_015](#); [DPG000002_062](#) paras 173-174

⁸¹ [James Wilson 10 December 2021 53/10-16](#); [GDW000001_014-015](#) paras 44-45; [GDW000001_18](#) paras 53-54

⁸² [James Wilson 10 December 2021 45/11-48/4](#); [GDW000003_036-037](#); [GDW000001_015-016](#) paras 46-48

⁸³ [James Wilson 10 December 2021 49/1-50/1](#); [GDW000001_017](#) para 50; [GDW000001_019](#) para 57; [GDW000003_045-46](#)

⁸⁴ [James Wilson 10 December 2021 53/21-54/20, 60/4-61/10, 78/15-79/6](#)

it as a “*gruelling meeting*” and saying that their drop-ins were on a “*knife-edge*” so staff should go through him with any concerns, even though that sounded “*quite draconian*”.⁸⁵ Mr Gasson rejected these allegations and thought his approach to GDWG was reasonable.⁸⁶

40. In circumstances when they should have welcomed GDWG’s input in providing welfare support to detained people and alerting them to concerns, the Home Office and G4S appeared reluctant to allow either. Although there were a number of occasions on which Mr Wilson referred to these meetings in fairly positive terms at the time, I am satisfied that this was an attempt by him to use “*positive and diplomatic*” language to try and build or maintain relationships.⁸⁷ In my view, it is likely that the behaviour of G4S and the Home Office towards GDWG had an impact on how it advocated for detained people, including generating fear about raising complaints in case it led to access being further restricted.⁸⁸ It is likely that this behaviour came as a result of a steer given by senior managers at Brook House and the Home Office.⁸⁹ Had a more open approach been taken, this would have benefited detained people and also those managing Brook House, as they might have been assisted in gauging the mood of detained people.⁹⁰

Awareness of concerns

41. There was evidence of issues arising at Brook House from at least 2012. These issues should have provided early warning signs for G4S senior management and the Home Office, but they were not heeded and they had a lasting impact during the relevant period.

External sources

42. Litigation regarding Brook House should have alerted the Home Office and G4S to possible problems. In 2012, two High Court judgments found that people detained there had been subjected to treatment that violated Article 3 of the European Convention on Human Rights.

42.1 In *R (HA (Nigeria)) v Secretary of State for the Home Department* [2012] an individual was detained at Brook House despite experiencing serious mental illness (his own condition causing him to display behaviour that violated his dignity).⁹¹ He was not given appropriate

⁸⁵ [GDW000008](#)

⁸⁶ [Paul Gasson 15 March 2022 215/11; HOM0332152_027](#) para 103

⁸⁷ [GDW000003_011; GDW000003_029; GDW000003_040; James Wilson 10 December 2021 13/1-22, 40/18-41/1, 59/4-60/3](#)

⁸⁸ [DPG000002_058](#) paras 163-164

⁸⁹ [SER000453_047-048](#) para 217a

⁹⁰ [Anna Pincus 9 December 2021 50/14-23; DPG000002_063](#) para 176

⁹¹ *R (HA (Nigeria)) v Secretary of State for the Home Department* [2012] EWHC 979

medical treatment while in detention, and force was authorised against him on several occasions.⁹²

42.2 In *R (D) v Secretary of State for the Home Department* [2012] a detained person was not given adequate psychiatric treatment while at Brook House for over five months, causing his mental state to deteriorate.⁹³ During this time, he was subjected to “*what were in effect disciplinary sanctions under rules 40 and 42 which were unsuitable for a person with his condition*”.⁹⁴

43. There does not appear to have been any adequate process for ensuring that these judgments were disseminated among Home Office or G4S staff with responsibility for immigration policy or Brook House specifically.⁹⁵

44. In January 2016, BBC *Panorama* broadcast a documentary entitled ‘Teenage Prison Abuse Exposed’ about Medway Secure Training Centre, which was also run by G4S. It showed vulnerable children in custody being physically and emotionally abused by those employed to care for them, and led to an investigation.⁹⁶ Ms Brown recalled that, shortly after this, she warned Mr Saunders and Mr Skitt, “*We’re going to have a Panorama on our hands here if we don’t learn from Medway.*”⁹⁷ She recalled no reaction or acknowledgement from either Mr Saunders or Mr Skitt.⁹⁸ Between January 2016 and July 2016, G4S seconded Mr Saunders to the role of Interim Director of Medway Secure Training Centre, because he had previously been a director there.⁹⁹ Mr Saunders told the Inquiry that he did not think that what had happened at Medway could happen at Brook House because he had “*no indication*” that it would.¹⁰⁰ However, if Ms Brown’s recollection is right, she forewarned him about the risk of similar abuse being uncovered at Brook House.

Internal sources

45. As the Inquiry focused on the relevant period, it did not hear detailed evidence about most allegations of misconduct during previous years.

46. There were examples of inappropriate behaviour (including bullying and goading of detained people, and racist comments by staff) prior to the relevant period that were reported or investigated at the time, as well as other matters

⁹² [INQ000060_286-289](#)

⁹³ [R \(D\) v Secretary of State for the Home Department \[2012\] EWHC 2501](#)

⁹⁴ [INQ000060_289-292](#)

⁹⁵ [Ian Cheeseman 16 March 2022 170/5-176/14](#); [Phil Schoenenberger 23 March 2022 71/6-76/23](#)

⁹⁶ The investigation was carried out by the Medway Improvement Board, appointed by the Secretary of State for Justice, which led to a report ([INQ000010](#))

⁹⁷ [VER000221_016](#) para 232

⁹⁸ [Stephen Skitt 17 March 2022 200/20-202/20](#); [INQ000164_057](#) para 119

⁹⁹ [KEN000001_002](#) paras 4-8

¹⁰⁰ [Ben Saunders 22 March 2022 109/6-22](#)

that demonstrated that there were problems at Brook House prior to the relevant period, of which G4S was aware.

- 46.1** In 2012, several DCOs and a DCM were found to have acted inappropriately when they were recorded playing games and loud music outside the cell of one vulnerable detained person, when they should have been carrying out constant observations. The following evening, the same members of staff carried out their duties wearing a mask of a celebrity in front of the detained person and then woke him up while wearing the mask.¹⁰¹ Several members of staff were later disciplined for dancing outside the cell of a second vulnerable detained person for whom they were carrying out constant observations, while staring at him and wearing masks of a different celebrity.¹⁰²
- 46.2** In 2013, a survey of staff members recorded that some felt that they had been subjected to racist remarks and treatment, while others reported staff bullying and management failures to take action, and inappropriate comments about control and restraint.¹⁰³
- 46.3** There were also reports about bullying of detained people by two DCOs who remained employed during the relevant period, DCO Luke Instone-Brewer and DCO Babatunde Fagbo.¹⁰⁴ In 2015, it was alleged that they had goaded a detained person by *“taking it in turn to give warnings, ignoring him and deliberately going to his room to remove items”* and coming into his cell while he was asleep to shout in his face.¹⁰⁵ This was reported by Ms Stacie Dean (Head of Tinsley House) to Mr Saunders and Mr Skitt in October 2015 and to Mr Lee Hanford (Interim Director of Gatwick IRCs at that time) in June 2016.¹⁰⁶ In evidence to the Inquiry, Mr Instone-Brewer and Mr Fagbo denied these allegations and said that they were never raised with them at the time.¹⁰⁷ A separate complaint against Mr Instone-Brewer and Mr Fagbo in 2016 for *“poor behaviour, bullying and inappropriate behaviour”* was apparently substantiated but did not lead to disciplinary action.¹⁰⁸ Again, Mr Instone-Brewer denied the allegations and said that they had not been raised with him.¹⁰⁹ Mr Fagbo said that he was not aware of the complaints or could not

¹⁰¹ [CJS005900; DL0000141_058-059](#) paras 165-167

¹⁰² [Callum Tulley 29 November 2021 61/13-64/12](#)

¹⁰³ [DL0000142_025; DL0000142_039; DL0000142_042-043](#)

¹⁰⁴ Other complaints against Mr Instone-Brewer and Mr Fagbo, as well as Ms Dean’s grievances, are addressed in Chapter C.9, and Chapter D.9 in Volume II

¹⁰⁵ [CJS0073677_001-002](#)

¹⁰⁶ [CJS0073677_001-002](#)

¹⁰⁷ [Luke Instone-Brewer 8 March 2022 21/5-24/5; Babatunde Fagbo 4 March 2022 75/23-78/16](#)

¹⁰⁸ [CJS0073671_003; INQ000164_019-020](#) para 30; [CJS005907_009](#) (2016 complaint and three complaints in 2015); [Daniel Haughton 16 March 2022 145/6-147/23; CJS0073671_003; INQ000164_019-020](#) para 30

¹⁰⁹ [Luke Instone-Brewer 8 March 2022 24/6-35/7](#)

recall them or any investigation into them, albeit he could remember “faintly” being spoken to about an incident in 2016.¹¹⁰ D687 had also alleged that both men had been provocative, abusive and racist towards him, which they denied in their evidence to the Inquiry.¹¹¹ (The failure to investigate these allegations properly was also part of a grievance raised by Ms Dean, discussed in Chapter D.9 in Volume II.)

46.4 Mr Owen Syred (a DCO and Welfare Officer during the relevant period) told the Inquiry of two incidents from 2014, during which he said he heard a DCO colleague, Mr Sam Gurney, making racist remarks, including use of the ‘N word’, and Mr Gurney describing himself as racist.¹¹² Mr Syred recalled attitudes changing between his initial period at Brook House from 2009 to 2012/2013 and his return in 2014, which he attributed to staff being “radicalised into becoming racist”.¹¹³ He reported Mr Gurney’s remarks to a DCM, leading to Mr Gurney being removed from contact with detained people. Mr Syred recalled that the consequences for reporting Mr Gurney were post-it notes being left on his locker, including one reading “Nigger lover” and another “Grass”.¹¹⁴ Someone had also written “Grass” across a poster of Mr Syred’s face.¹¹⁵ Mr Syred approached Mr Saunders about it, who said he would support him. However, Mr Syred described how “there was no real support”.¹¹⁶ He said that he did not hear anything about the outcome of any investigation into Mr Gurney.

46.5 In an SMT meeting in December 2016, Mr Skitt reported:

“Investigations - huge amount of investigations currently. There is a need to look at formal words of advice instead of conducting investigations.”¹¹⁷

47. These examples are likely to be only a fraction of the inappropriate behaviour that occurred prior to the relevant period. They provide a useful context for what happened during the relevant period and assist with the question of whether the relevant period was uniquely problematic for G4S.

¹¹⁰ [Babatunde Fagbo 4 March 2022 81/11-83/25; CJS005907_009](#)

¹¹¹ [Luke Instone-Brewer 8 March 2022 36/22-37/22; Babatunde Fagbo 4 March 2022 88/23-90/17; DPG000021_026-027 paras 83 and 86](#)

¹¹² [INN000007_030-032 paras 125-130](#)

¹¹³ [Owen Syred 7 December 2022 115/3-116/1](#)

¹¹⁴ [Owen Syred 7 December 2022 117/9-20](#)

¹¹⁵ [Owen Syred 7 December 2022 117/17-20](#)

¹¹⁶ [Owen Syred 7 December 2022 117/3-5, 121/2-11](#)

¹¹⁷ [CJS000580_004; CJS0073709_073 para 7.29](#)

The *Panorama* programme and its aftermath

48. The *Panorama* programme was broadcast on 4 September 2017. Shortly before the broadcast, the BBC made G4S aware of the matters the programme would cover, the specific allegations made, and the names of the staff who would be featured.¹¹⁸ Mr Petherick responded, confirming that he had referred the allegations to local police and safeguarding agencies, and started an internal investigation.¹¹⁹ He also shared the letter with the Home Office.¹²⁰

49. The Inquiry heard that nine DCOs had their certification revoked by the Home Office prior to the broadcast (meaning that they could no longer work in that role), with three more losing their certification afterwards.¹²¹ Eleven members of staff involved in the incidents shown on the *Panorama* programme were dismissed or left G4S soon after, followed by three further resignations.¹²² G4S commissioned an internal investigation and engaged Verita, an external company, to investigate and report (producing the 2018 Verita report).¹²³

50. On 25 September 2017, Mr Hanford became Interim Director of Brook House, after the departure of Mr Saunders following a settlement agreement with G4S.¹²⁴ The change of director was part of a “*recovery plan*” or “*action plan*” put in place by Mr Petherick and agreed by the Home Office.¹²⁵ The action plan contained 71 actions that G4S was to undertake and report on to the Home Office, across six areas: staff recruitment and retention; training and development; the management structure; reporting and governance; drug strategy; and detained people’s experience and environment.¹²⁶

Brook House today

51. In February 2020, Serco was awarded the contract for the management of the Gatwick IRCs and the pre-departure accommodation, following a competitive public procurement process.¹²⁷ Serco also holds the contract for Yarl’s Wood immigration removal centre, and has done so since 2007.¹²⁸

¹¹⁸ [BBC000031](#)

¹¹⁹ [CJS000793](#)

¹²⁰ [CJS0074047_034](#) para 180

¹²¹ [HOM00332005_004](#) para 9

¹²² [CJS0073709_007](#) para 1.8

¹²³ [CJS0074047_033](#) para 179; [CJS0073709](#)

¹²⁴ [KEN000003_013-014](#) para 70

¹²⁵ [INQ000119_019-020](#) para 86; [HOM0332166](#) para 11

¹²⁶ As summarised at [DL0000175_30](#) para 3.10

¹²⁷ [SER000226](#)

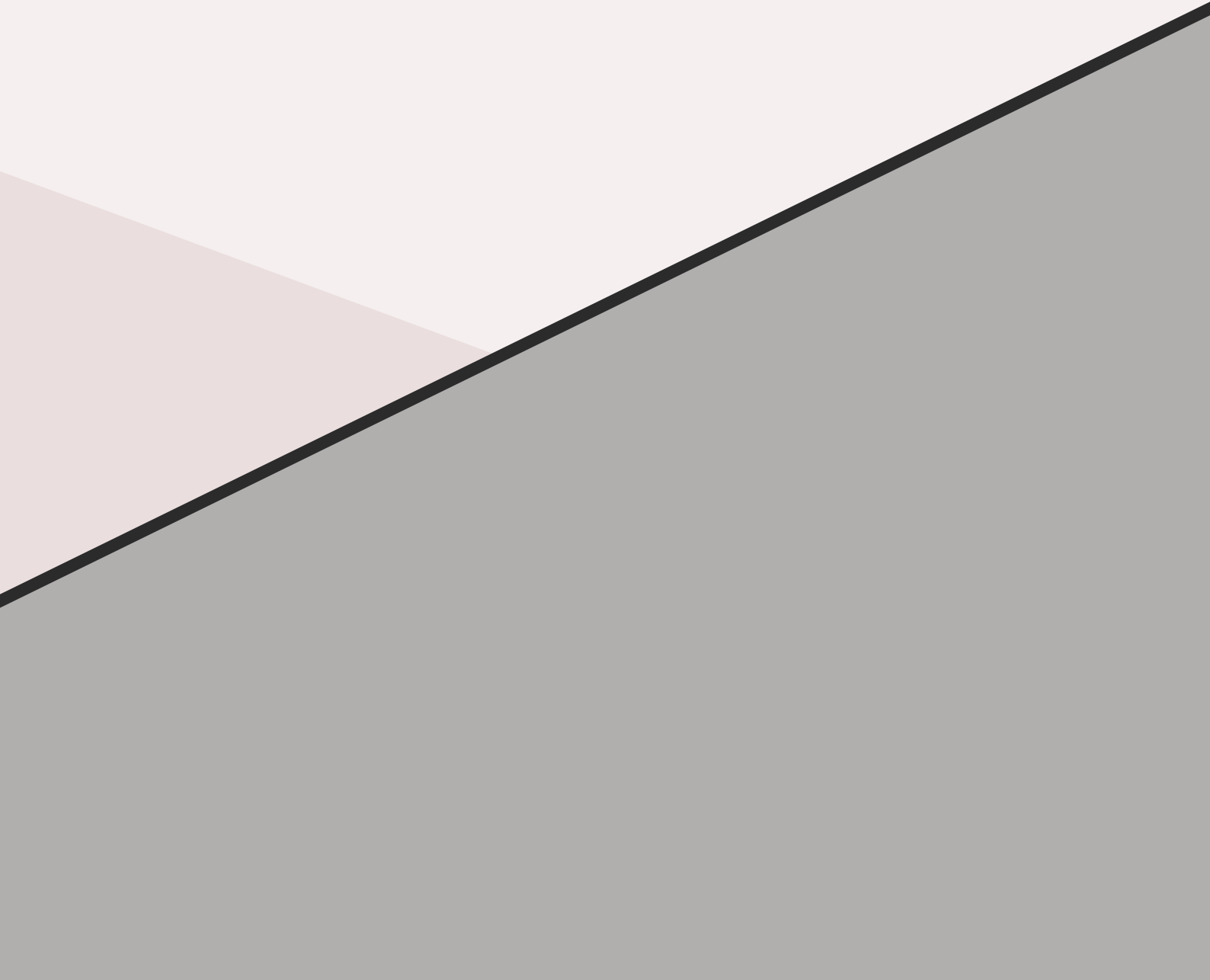
¹²⁸ [SER000451_001](#) paras 2-3

52. Serco took over the management of Brook House on 21 May 2020, and approximately 330 staff at Gatwick IRCs transferred from G4S to Serco, of which it was estimated that the majority (at least 200) remained employed by Serco at Gatwick IRCs at the time of the Inquiry’s hearings.¹²⁹ There have been some changes to personnel, staffing levels, Home Office involvement and the daily routine for detained people – and these are considered, where relevant, in Part D in Volume II of this Report.

¹²⁹ [Steven Hewer 1 April 2022 156/8-20](#)

Part C

Incidents of mistreatment



Chapter C.1:

The approach to factual findings

1. The Inquiry's Terms of Reference state that the purpose of the Inquiry is to:

"reach conclusions with regard to the treatment of detainees where there is credible evidence of mistreatment contrary to Article 3 ECHR".¹

Article 3 of the European Convention on Human Rights (Article 3) states: *"No one shall be subjected to torture or to inhuman or degrading treatment or punishment."*² It is an absolute right; it cannot be limited or restricted in any way.

2. Section 2 of the Inquiries Act 2005 makes clear that a chair of a public inquiry has no power to rule on or determine any person's civil or criminal liability.³ As a result, I am not permitted to make legal findings that any particular person breached another's Article 3 rights.

3. The Terms of Reference mirror the wording of section 2, stating under the heading 'Principles':

"It is not part of the Inquiry's function to determine civil or criminal liability of named individuals or organisations. This should not, however, inhibit the Inquiry from reaching findings of fact relevant to its terms of reference."⁴

Therefore, the Inquiry should not be inhibited in the discharge of its functions by the likelihood of liability being inferred from facts that it determines or recommendations that it makes.⁵

4. This chapter (which should be read in conjunction with Appendix 1, which sets out the Inquiry's methodology) deals with how I have arrived at conclusions about the mistreatment of detained people and my approach to assessing the evidence in order to fulfil the Terms of Reference.

¹ [Terms of Reference](#), Brook House Inquiry

² [European Convention on Human Rights](#), Article 3

³ [Inquiries Act 2005](#), section 2(1) read with section 3

⁴ [Terms of Reference](#), Brook House Inquiry

⁵ [Inquiries Act 2005](#), section 2(2)

Submissions from Core Participants

5. The Inquiry's Core Participants submitted Closing Statements about the findings that I am permitted to make in relation to Article 3.⁶ I have considered and been assisted by them all.

6. There were two viewpoints.

6.1 The first was argued by Deighton Pierce Glynn, solicitors representing D687 and Gatwick Detainees Welfare Group.⁷ In summary, they suggested that there is no prohibition preventing the Inquiry from making findings that treatment, conduct, omissions and/or conditions at Brook House were "*contrary to Article 3*" (which is a phrase used in the Terms of Reference set by the Home Secretary) or "*amounted*" to a breach of Article 3.⁸

6.2 In contrast, the Home Office and G4S argued that factual findings must be distinguished from legal findings. G4S stated:

"the Inquiry is prohibited from making substantive findings that any party has breached Article 3 ECHR or that any person has been subject to treatment in breach of Article 3 ECHR – or words to the equivalent effect that constitute, in substance, such a finding (e.g. that a person suffered inhuman or degrading treatment – as these are legal terms of art within the rubric of Article 3)".⁹

The Home Office acknowledged that the words "*inhuman*" and "*degrading*" may be used, not in the legal sense, but only in a "*non-technical*" and "*non-legal sense*".¹⁰ Deighton Pierce Glynn, the Home Office and G4S relied on findings made in previous inquiries and on the case law in relation to inquests.¹¹

⁶ Closing Statements: [DPG000048_021-022](#) paras 32-34; [HOM0332165_015-017](#) paras 45-56; [CJS0074153_067-074](#) paras 193-203

⁷ Deighton Pierce Glynn was the only firm representing detained people to make submissions on the issue

⁸ [DPG000048_021](#) para 32

⁹ [CJS0074153_072](#) para 196

¹⁰ [HOM0332165_016](#) para 51

¹¹ In particular the [Billy Wright Inquiry](#); the [Litvinenko Inquiry](#); [R \(Pounder\) v HM Coroner for North and South Districts of Durham and Darlington](#) [2009] EWHC 76 (Admin) paras 62, 70, 73 and 78; [R \(Pounder\) v HM Coroner for North and South Districts of Durham and Darlington](#) [2010] EWHC 328 (Admin) paras 3, 6, 15 and 53; [R \(Jamieson\) v North Humberside Coroner](#) [1995] QB 1 paras 25 and 53; [R \(GS\) v Wiltshire and Swindon Senior Coroner](#) [2020] EWHC 2007 (Admin) paras 52-56; [R \(Smith\) v Oxfordshire Assistant Deputy Coroner](#) [2008] EWHC 694 (Admin) paras 23-24

The approach taken by the Inquiry

7. The starting point is section 2 of the Inquiries Act 2005. In making my findings in this Report, I have not made any determination that any party has acted in “breach” or in “violation” of Article 3, or that any person has been subject to treatment in “breach” or in “violation” of it.

8. However, I am required to fulfil the Terms of Reference and so I must reach specific conclusions about the treatment of detained people, but – for the reasons explained below – I have formulated a two-stage test which I have applied to the incidents I have considered.¹² There is no ‘non-technical’ or ‘non-legal’ meaning of the phrase “*mistreatment contrary to Article 3 ECHR*”. To attempt any such definition would be artificial, and I have therefore considered the wording of Article 3, which is “*inhuman or degrading treatment or punishment*”. In any event, I have to identify the facts underlying that mistreatment and who is responsible for it.¹³ I can only arrive at any such conclusions where I have already found that there is credible evidence of mistreatment.¹⁴

9. The Home Office referred to a determination made by the Chair of the Billy Wright Inquiry that, where its Terms of Reference used the terms “*wrongful act or omission*” and “*intentional or negligent*”, these should be considered in a “*non-technical and non-legal sense only*”.¹⁵ That inquiry’s Terms of Reference did not provide any definition of “*negligent*” or “*wrongful act or omission*” by reference to a legal standard.¹⁶ By contrast, the Terms of Reference for this Inquiry do provide definitions. Consequently, I consider that it is permissible for me to rely on the legal definition of Article 3 as well as the case law.

10. It is important to highlight that section 2(2) qualifies section 2(1) in providing that a chair of a public inquiry must not be inhibited in discharging their functions by any likelihood of liability being inferred from the facts that are determined. In his report for the Azelle Rodney Inquiry, Sir Christopher Holland identified “*unreasonable*” and therefore “*unlawful*” use of fatal force by a police officer who shot and killed Mr Rodney.¹⁷ He explained the tension between section 2(1) and section 2(2) as being:

¹² [Terms of Reference](#), Brook House Inquiry, Purpose

¹³ [Terms of Reference](#), Brook House Inquiry, para 1

¹⁴ [Terms of Reference](#), Brook House Inquiry, Purpose

¹⁵ [HOM0332165_015-016](#) paras 48-49

¹⁶ [The Billy Wright Inquiry – Report](#), HC 431 (14 September 2010), p5

¹⁷ [The Report of the Azelle Rodney Inquiry](#), HC 552 (5 July 2013), paras 1.6.2, 19.1-19.11 and 21.13

*“at once a restrictive and a permissive provision. I am not given the task of determining civil or criminal liability, but neither am I inhibited from making findings which amount to the constituents of civil wrongs or criminal acts.”*¹⁸

11. Sir Christopher Holland made a direct finding that the force used by a police officer was disproportionate, unreasonable and unlawful.¹⁹ This provides an example of legal definitions being used and liability not being determined, although liability may be inferred from the Chair’s findings.

12. I considered Counsel to the Inquiry’s earlier suggestion that there are two essential questions to be answered before any finding regarding the ‘credibility’ of a claim of mistreatment can be made:

- Do the facts give rise to an identifiable incident of physical or verbal abuse capable of amounting to mistreatment contrary to Article 3?
- If so, does it amount to mistreatment contrary to Article 3?²⁰

13. However, I concluded that the second part of this test may be considered an invitation to make a finding of civil liability – that a certain act would amount to mistreatment contrary to Article 3. As I am not permitted to make such a finding under section 2 of the Inquiries Act 2005, I have instead formulated the following test, which I have applied to each of the incidents that I have considered in Part C:

- **Stage 1:** Is there ‘credible’ evidence of acts or omissions that are capable of amounting to mistreatment contrary to Article 3 – that is to say, torture, inhuman and/or degrading treatment or punishment?
- **Stage 2:** Where that evidence is ‘credible’, what are the underlying facts?

Stage 1 acts as a filter for incidents about which I then go on, at Stage 2, to make factual findings.

14. In considering whether there was credible evidence of mistreatment, I assessed whether the treatment attained *“a minimum level of severity”*.²¹

14.1 In respect of people who are detained, the minimum level of severity is distress or hardship of an intensity that exceeds the unavoidable level of

¹⁸ *The Report of the Azelle Rodney Inquiry*, HC 552 (5 July 2013), para 1.6.2

¹⁹ *The Report of the Azelle Rodney Inquiry*, HC 552 (5 July 2013), para 21.13

²⁰ *Counsel to the Inquiry 5 April 2022 3/4-14*

²¹ *Ireland v United Kingdom* (Application no. 5310/71) (1978) 2 EHRR 25 para 162; *Soering v United Kingdom* (Application no. 14038/88) (1989) 11 EHRR 439 para 100; *Vilvarajah v UK* (Application no. 13163/87) (1992) 14 EHRR 248 para 107; *Keenan v United Kingdom* (Application no. 27229/95) (2001) 33 EHRR 38 para 109

suffering inherent in detention.²² The ill treatment must be sufficiently severe to fall within the scope of Article 3, considering all the circumstances of the case, including the duration of the treatment or punishment, any physical or mental effects and, in some cases, the age and state of health of the victim.²³ Treatment may be “*inhuman and degrading*” in violation of Article 3 where the nature and extent of the injuries to which the applicant was subjected during police detention “*must have caused him mental and physical suffering*”, even though it did not result in any long-term damage to health.²⁴

14.2 If the mistreatment was sufficiently severe, I considered whether it was “*inhuman*”, “*degrading*” or both. The circumstances in which treatment may be considered “*inhuman*” include acts which are premeditated, applied over long periods and cause either actual bodily injury or intense physical and mental suffering.²⁵ Treatment may be considered “*degrading*” when it humiliates or debases an individual, showing a lack of respect for, or diminishing, their human dignity, or arouses feelings of fear, anguish and inferiority capable of breaking their physical or moral resistance.²⁶

14.3 Deliberate humiliation and debasement of a victim is a factor that may be taken into account when considering degrading treatment, but such a purpose is not required in law to find a breach of Article 3.²⁷ Case law has also established that the use of unnecessary force on a detained person can diminish human dignity and can be contrary to Article 3, even where there has been no injury caused as a result.²⁸ Evidence of the actual effect on the person may not be a major factor. For example, treatment of a mentally ill person may be incompatible with Article 3 in the protection of human dignity, even though that person may not be

²² *Kudła v Poland* (Application no. 30210/96) (2000) 35 EHRR 11 paras 92-94; *Tyrer v United Kingdom* (Application no. 5856/72) (1978) 2 EHRR 1 para 30; *Soering v United Kingdom* (Application no. 14038/88) (1989) 11 EHRR 439 para 100; and *T v United Kingdom* (Application no. 24724/94) (2000) 30 EHRR 121

²³ *Ireland v United Kingdom* (Application no. 5310/71) (1978) 2 EHRR 25 para 162; *Tyrer v United Kingdom* (Application no. 5856/72) (1978) 2 EHRR paras 29-30; *Soering v United Kingdom* (Application no. 14038/88) (1989) 11 EHRR 439 paras 89 and 100

²⁴ *Nadrosov v Russia* (Application no. 9297/02) 2008 paras 36-37

²⁵ *Labita v Italy* (Application no. 26772/95) 2000 para 120 and *Kudła v Poland* (Application no. 30210/96) 2000 para 92

²⁶ *Ireland v United Kingdom* (Application no. 5310/71) (1978) 2 EHRR 25 para 167; *Abdulaziz, Cabales and Balkandali v UK* (Application nos 9214/80; 9473/81; 9474/81) (1985) 7 EHRR 471 paras 90-91; *Soering v United Kingdom* (Application no. 14038/88) (1989) 11 EHRR 439 para 100; *Bouyid v Belgium* (Application no. 23380/09) ECHR 2015 para 87

²⁷ *Gäfgen v Germany* (Application no. 22978/05) ECHR 2010 para 89; *Ilaşcu and Others v Moldova and Russia* ECHR 2004 para 425; *M.S.S. v Belgium and Greece* ECHR 2011 para 220

²⁸ *Keenan v United Kingdom* (Application no. 22978/05) (2001) 33 EHRR 38 paras 112-113

able to point, or be capable of pointing, to any specific ill-effects.²⁹ Even without evidence of actual bodily injury or intense physical or mental suffering:

*“where treatment humiliates or debases an individual, showing a lack of respect for or diminishing his or her human dignity, or arouses feelings of fear, anguish or inferiority capable of breaking an individual’s moral and physical resistance, it may be characterised as degrading and also fall within the prohibition set forth in Article 3”.*³⁰

- 14.4** Although subjective suffering will often be ‘crucial evidence’, the test is an objective one.³¹ Treatment may also be degrading due to its intrinsic character.³²
- 14.5** If the treatment passes the “*minimum level of severity*” threshold, but goes further than “*inhuman or degrading treatment*”, consideration will be given to the definition of “*torture*”. “*Torture*” encompasses deliberate, inhuman treatment causing very severe and cruel suffering, whether physical or mental.³³
- 14.6** Detained people with mental disorders are more vulnerable than other detained people.³⁴ Certain aspects of life in detention pose a greater risk to their health, as these are a source of stress and anxiety.³⁵ A vulnerable detained person may be unable to complain coherently, or at all, about how they are being affected by any particular treatment.³⁶ This exacerbates the risk that such detained people suffer from a feeling of inferiority. It also means that they are more vulnerable to being mistreated. The authorities are under a duty to protect them.³⁷
- 15.** In considering the evidence relating to the incidents discussed in this part of the Report, even if not expressly referred to in relation to specific incidents, I have had regard to the following non-exhaustive list of questions:
- Did the treatment attain a minimum level of severity, such that there is credible evidence that it was inhuman or degrading treatment or punishment?

²⁹ *Keenan v United Kingdom* (Application no. 27229/95) (2001) 33 EHRR 38 paras 112-113

³⁰ *Bouyid v Belgium* (Application no. 23380/09) ECHR 2015 para 87

³¹ *The Queen on the Application of ASK (by his Litigation Friend the Official Solicitor) v SSHD* [2019] EWCA Civ 1239 paras 70-71

³² Separate Opinion of Judge Sir Gerald Fitzmaurice in *Ireland v United Kingdom* (Application no. 5310/71) 1978 para 28

³³ *Ireland v United Kingdom* (Application no. 5310/71) (1978) 2 EHRR 25. See in particular paras 162-164

³⁴ *Rooman v Belgium* (Application no. 18052/11) (2019) ECHR 105 para 145

³⁵ *Rooman v Belgium* (Application no. 18052/11) (2019) ECHR 105 para 145

³⁶ *Rooman v Belgium* (Application no. 18052/11) (2019) ECHR 105 para 145

³⁷ *Rooman v Belgium* (Application no. 18052/11) (2019) ECHR 105 para 143

- Was it degrading – did it humiliate or debase an individual, showing a lack of respect for or diminishing the detained person’s human dignity, or arouse feelings of fear, anguish or inferiority capable of breaking the individual’s moral and physical resistance?
- Was it inhuman – was it premeditated or applied for long periods, and did it cause actual bodily injury or intense physical or mental suffering?
- If a minimum level of severity was attained, did the treatment in fact amount to torture, ie did it amount to deliberate, inhuman treatment causing very serious and cruel suffering?
- Was the treatment or punishment physical or verbal?
- What was the severity of the treatment or punishment?
- What was the context of the treatment or punishment? (For example, what was the apparent reason for the treatment? Did it take place in front of other members of staff? Did it take place in front of other detained people?)
- Did the severity of the treatment or punishment go beyond the inevitable element of suffering or humiliation connected with legitimate detention?
- What was its duration?
- If physical force was used, was this strictly necessary?
- Was there any discriminatory, racist, religious or homophobic element to it?
- Was there an intention to humiliate and degrade?
- What was the physical or mental effect of the treatment or punishment, if any?
- If there was a physical effect, did the detained person sustain actual bodily injury (although the absence of injury is not determinative) or did the treatment involve intense physical suffering?
- If there was a mental effect, did the treatment involve intense mental suffering (although the absence of intense mental suffering is not determinative)?
- Was the detained person’s state of physical or mental health such that it made them more vulnerable to the treatment or punishment?
- Did the detained person suffer from a physical or mental illness which was exacerbated by the treatment or punishment?
- Did the detained person’s age make them particularly vulnerable to the treatment or punishment?

16. As noted above, the Inquiry’s approach to the standard of proof and relevant weight of evidence is set out in detail in Appendix 1, reflecting key principles established in other public inquiries and case law.³⁸

17. I have not considered in isolation whether there is credible evidence that general and/or systemic failures in policy and procedure are capable of amounting to mistreatment contrary to Article 3. However, where general and/or systemic failures have caused or contributed to an individual act of mistreatment, I have considered them in my overall conclusion in relation to that particular incident. I have also taken account of these types of failures where they may have contributed to an individual act of mistreatment, even though they alone would not have met the threshold for such a finding.

Factual findings on specific incidents

18. In my view, having taken into consideration all the factors set out above, there is credible evidence of acts or omissions that are capable of amounting to mistreatment contrary to Article 3 in the following incidents:

- D1234 on 28 March 2017;
- D2416 on 11 April 2017;
- D1527 in April and May 2017;
- D687 on 13 May 2017;
- D1914 on 27 May 2017;
- D149 on 31 May 2017;
- D390 and D1851 on 5 June 2017;
- D1538 on 3, 6 and 28 June 2017, and D1538 and D865 on 4 July 2017;
- D2953 on 10, 11 and 16 June 2017;
- D1275 on 14 June 2017;
- D313 on 15 June 2017;
- D2054 on 28 June 2017; and
- D728 on 6 July 2017.

My factual findings regarding each incident are set out in detail in subsequent chapters within this part of the Report.

³⁸ See, for example, *Undercover Policing Inquiry: Standard of Proof Ruling*, 13 January 2016, paras 10-12 and in particular Annex 1 (the submissions of Counsel to the Inquiry – see paras 35-39); *The Report of the Baha Mousa Inquiry* Volume 1 paras 1.114-1.115; *Adali v Turkey* (Application no. 38187/97) ECHR 2005, particularly paras 216 and 239; *Ananyev v Russia* (Application nos 42525/07; 60800/08) (2012) 55 EHRR 18 paras 121-122; *Varga v Hungary* (2015) 61 EHRR 30 para 68; and *Mursic v Croatia* (2016) 10 WLUK 454 paras 127-128

19. I have considered a number of incidents that the Inquiry investigated, as well as others about which Core Participants made submissions. Only incidents that passed Stage 1 of the test outlined above have been considered under Stage 2.

Chapter C.2:

D1234 on 28 March 2017

1. D1234 is a Nigerian national.¹ The Inquiry did not receive a witness statement from him or any medical records dated before 28 March 2017. As such, relatively little is known about his history.

2. I have made factual findings in relation to this incident, despite the fact that it occurred three days prior to the start of the relevant period. I have done this for the following reasons:

- The incident occurred only marginally outside of the relevant period; D1234 was detained during the relevant period; and a referral was made on behalf of D1234 to the Home Office Professional Standards Unit (PSU) on 30 June 2017, during the relevant period.²
- This complaint raised very serious allegations about D1234's treatment: D1234 complained of multiple injuries being caused by staff – by the use of handcuffs, hitting his head on the floor, violently turning his head causing his neck to crack, holding his throat, and violently stamping on his toes.³
- Video footage was received by the Inquiry about the incident.⁴

The underlying facts

3. The Inquiry understands that on 28 March 2017 D1234 was due to leave Brook House on escorted removal directions. (These are directions given by an immigration officer or the Secretary of State for the removal of a person from the UK, in accordance with section 10 of the Immigration and Asylum Act 1999.⁵)

4. Detention Custody Manager (DCM) Steven Dix held a briefing at 20:00 for officers to be involved in the use of force. In this briefing, the officers were informed that Mr Dix and DCM Graham Purnell had spoken to D1234 several times, but that D1234 had refused to leave his cell compliantly, citing ill health, and had stripped naked.⁶ Despite this, D1234 had refused offers to see

¹ [HOM002496_001](#)

² [HOM002750_003](#) para 1.1

³ [HOM002492_002](#)

⁴ [CJS0073730 \[Disk 23 S1940003\]](#); [CJS0073731 \[Disk 23 S1940004\]](#); [CJS0073732 \[Disk 24 28 March 2017\]](#); [CJS0073729 \[Disk 23 S1940002\]](#)

⁵ [Immigration and Asylum Act 1999](#), section 10

⁶ [CJS0073729 \[Disk 23 S1940002\]](#)

Healthcare and a medic from another contractor, Tascor. Mr Dix briefed officers that Ms Michelle Brown, Duty Director, had approved the use of force as a last resort.⁷

5. The Inquiry saw footage relating to a use of force on D1234 on 28 March 2017.⁸

6. One piece of footage was filmed with a handheld camera and lasts for 17 minutes 30 seconds.⁹ It begins with Mr Dix opening the door to D1234's cell. D1234, who was sitting on the edge of a bed, was naked, shouting and in clear distress. For approximately 15 seconds, Mr Dix attempted to persuade D1234 to leave the cell.

7. Thereafter, Mr Dix authorised four officers wearing Personal Protective Equipment (PPE), who had been waiting outside the cell, to enter and use force on D1234. Three officers – Detention Custody Officer (DCO) Derek Murphy, DCO Jordan Rowley and DCO Gus Olyaie – entered the cell. Mr Murphy entered first and was carrying a shield.

8. The officers immediately restrained D1234 on the ground and a fourth officer, DCO Sean Sayers, then entered the cell and moved towards D1234 holding a sheet. As this happened, D1234 called out for "Allah" and "Jesus". Mr Dix instructed the officer holding the handheld camera to direct it away from D1234 because he was naked.

9. The camera was directed to the ceiling for approximately 30 seconds. D1234 was screaming in apparent pain, and continually calling out for Jesus and Allah. After approximately 11 seconds, one of the officers shouted over D1234.

10. When the camera was directed back to D1234, he was lying on his back on the floor of the cell with Mr Olyaie restraining his head, Mr Murphy and Mr Rowley restraining each of his arms and Mr Sayers restraining his legs. D1234 was visibly distressed, wailing and shouting "fire".

11. Mr Dix, who was not wearing PPE, walked into the cell and held a sheet over D1234's genitals while he attempted to talk the officers through the use of force. The officers tried to move D1234 to his feet, but were unable to do so. As they made their attempt, Mr Dix dropped the sheet. D1234 was screaming in apparent pain and then continued to call out. At one point, while the officers had their hands on D1234's arms, head and legs, he appeared to be breathless.

⁷ [HOM002485_001](#)

⁸ [CJS0073730 \[Disk 23 S1940003\]](#); [CJS0073731 \[Disk 23 S1940004\]](#); [CJS0073732 \[Disk 24 28 March 2017\]](#); [CJS0073729 \[Disk 23 S1940002\]](#)

⁹ [CJS0073730 \[Disk 23 S1940003\]](#)

- 12.** Mr Dix instructed the officers to sit D1234 up. As they did so, D1234's protests became louder. Mr Purnell entered the cell and attempted to demonstrate to the officers how to bring D1234's hands around to his back. As this was happening, Mr Olyaie appeared to be trying to force D1234's head down.
- 13.** Approximately two minutes after Mr Dix first entered the cell, he applied handcuffs to D1234, behind his back. The position of the officers' helmets prevented an unobstructed view of D1234, but it is clear from the footage that he was in a seated position. Again, Mr Purnell leaned in to provide direction.
- 14.** Mr Dix then directed the officers to move D1234 into a standing position, and cautioned Mr Olyaie and Mr Sayers that only one person should be at D1234's head. Mr Olyaie let go of D1234 and backed out of the cell. Mr Purnell moved outside the door of the cell, but maintained his observation of the incident.
- 15.** The officers moved D1234 to his feet, and held him bent forwards at a 90-degree angle. Mr Dix picked up a sheet and crouched down to speak to D1234. At that time, D1234 was calling out "*oh Lord*". Mr Dix asked D1234 if he wanted to get dressed, but D1234 did not respond or acknowledge the question. He continued to shout "*oh Lord*". Mr Olyaie then re-entered the cell and Mr Dix instructed him to tie a sheet around D1234's waist. Mr Olyaie struggled to do this and so Mr Dix assisted, resulting in five officers surrounding and controlling D1234 at once.
- 16.** The officers struggled with D1234 in this position for another minute before they moved him out of the cell. Mr Sayers, Mr Murphy and Mr Rowley were controlling D1234, while Mr Olyaie was holding the sheet around his genitals. D1234 was still bent over but appeared to be holding his own weight rather than being lifted. Shortly after, D1234 screamed out repeatedly in apparent pain. The officers looked tired. Mr Murphy, who was wearing a balaclava underneath his helmet, called over to someone called 'Steve' and appeared to gesture for his balaclava to be removed. After leaning in to clarify what Mr Murphy was saying, 'Steve' and Mr Dix removed Mr Murphy's helmet and balaclava before replacing his helmet.

Figure 5: Mr Murphy wearing a balaclava during the restraint of D1234



17. D1234, who was still bent forward, continued to cry out and shouted, *"I don't want to die" and "you are killing me"*.

18. Mr Sayers, who was controlling D1234's head, leaned towards D1234's ear and shouted that if he did not walk compliantly he would be lifted. The officers then tried to walk forwards with D1234, who was still crying out. The group stopped after a few seconds and D1234 was lifted into the air in a seated position with his legs held apart and outstretched in front of him. He continued to cry out as he was carried out of the wing and spat on the ground.

19. The officers carried D1234 off the wing and through a corridor. Approximately 30 seconds after the officers first picked up D1234, Mr Dix told the officers that he could be given the opportunity to walk but that if he did not reply they should continue to carry him. D1234 did not respond to the officers and continued to cry out, so they continued to carry him.

20. Approximately eight minutes after force was first used, the officers who were carrying D1234 appeared to need to rest and Mr Dix instructed them to pause and to take their time. D1234 was placed on the floor in a seated position for approximately 50 seconds while the officers briefly rested, and two of them switched their positions before continuing the restraint.

Figure 6: D1234 being restrained on the floor with his hands handcuffed behind his back



21. Mr Dix explained to D1234 that if he was not going to get up and walk, *"then the lift will have to continue"*. D1234 continued to call out. As the officer attempted to pick D1234 back up, his screams intensified.

22. The footage then shows D1234 being carried through a series of doors into an area referred to as 'Detainee Discharge' (another area away from the wing), where staff from Tascor were waiting to escort him to his removal flight.

Figure 7: G4S officers carrying D1234 into Detainee Discharge



23. D1234 repeatedly stated “*it is over*” and called out to “*almighty God*” as they did so. The footage shows at least 14 members of staff present while D1234 was carried in and placed on the floor. At least one member of staff, who may have been a member of the Tascor escort team, could be seen smirking. D1234 was still handcuffed with his hands behind his back and was naked except for a sheet draped over his genitals. Tascor officers took over restraining D1234, applying their own handcuffs to him before Mr Dix removed the handcuffs that he had applied earlier in the restraint. One member of staff, who might have been from Tascor, could be seen holding a waist restraint belt.

24. The Inquiry also saw closed-circuit television (CCTV) footage of E Wing.¹⁰ The footage shows officers approaching and entering D1234’s cell, and then carrying him from his cell to Detainee Discharge. The footage ends before D1234 was carried through the door.

25. A further piece of footage shows Mr Dix leading a debrief following the use of force on D1234.¹¹ The debrief lasted for approximately 1 minute 30 seconds. Mr Dix said that D1234 had been loudly chanting, had not engaged with the team and had “*presented himself naked*”. He said that there had been no option other than the use of force on D1234, who had resisted throughout and had had to be carried. Mr Dix said that he considered the restraint to have been a “*job well done*” by the staff, but added that he had spoken to some of the team individually about learning points. Mr Dix did not elaborate on the learning points that he had identified and none of the staff in attendance asked any questions. The officers other than Mr Dix only spoke to confirm their names and state that they had not sustained injuries. The member of Healthcare in attendance, Ms Grace Sihlali (a Registered General Nurse), spoke only to confirm that she had no concerns about the restraint.

26. While the Inquiry did not receive a witness statement from D1234, he did make a complaint about the force used against him, which was investigated by the PSU. In the written account he provided on 25 April 2017, D1234 said that two G4S officers had held his head and turned it violently. D1234 said that he felt a “*crack*” in his neck and that, despite telling the officers about this, they took no notice of him. D1234 described being pushed and hitting his head on the floor. He also said that one officer held his throat and another stamped violently on his toes. D1234 said that he was in “*extreme pain*” and asked the officers to stop, but that he was ignored. Although I make no findings in relation to Tascor, D1234 also described being handcuffed and having the straps of a waist restraint belt placed over a lump in his stomach for which he was awaiting surgery. He said that he was thrown into an escort van and was screaming in pain.¹²

¹⁰ [CJS0073732 \[Disk 24 28 March 2017\]](#)

¹¹ [CJS0073731 \[Disk 23 S1940004\]](#)

¹² [HOM002492_002-003](#)

27. D1234's medical records show that he was seen by a Staff Nurse, Ms Janina Wingert, when he returned to Brook House at 04:03 the following morning. D1234 complained of pain all over his body, and Ms Wingert recorded the following signs of physical injury:

- redness on both of his wrists;
- a small skin peel on his right wrist;
- some redness on the right side of his trunk; and
- a skin tear on his left toe.¹³

D1234 was seen by Dr Husein Oozeerally at 15:30, who recorded that D1234 had a "*tender bilateral chest wall*", both anteriorly and posteriorly, and diagnosed him with a "*soft tissue injury*".¹⁴

28. Mr Sayers, Mr Dix, Mr Olyaie, Mr Rowley and Mr Murphy, who had all been involved in the restraint of D1234, recorded that he had actively resisted or refused to comply and that it had therefore been necessary to carry D1234.¹⁵ In his statement to the Inquiry, Mr Murphy acknowledged that the "*cuff carry*" was "*poorly executed*". Mr Murphy wrote that he did not think that the officers should have been instructed to carry out the lift, as it was clear that they were tired. He added that there was no second restraint team available to relieve them.¹⁶ Mr Dix failed to mention in his Use of Force report that D1234 had complained of feeling unwell in earlier conversations, prior to the use of force.¹⁷

29. The PSU carried out an investigation into D1234's complaint, led by Ms Jana Schwab.¹⁸ Mr Dix, Mr Sayers, Mr Murphy and Mr Olyaie were interviewed by the investigators, and their responses were summarised in the report.¹⁹ Each of the officers said that they did not recall D1234 saying that he was in pain during the restraint.²⁰ However, Mr Dix accepted that D1234 "*may have been in pain due to the officers having to carry him in handcuffs as this was a painful process*".²¹

30. The investigation found that there was insufficient evidence to prove that the officers involved had acted unprofessionally, stating that the use of

¹³ [HOM002492_006](#)

¹⁴ [HOM002492_005](#)

¹⁵ [HOM002496_009](#); [HOM002496_012-013](#); [HOM002496_016-017](#); [HOM002496_020](#); [HOM002496_023-024](#)

¹⁶ [INQ000121_008](#) para 28d

¹⁷ [HOM002496_009](#)

¹⁸ [HOM002750](#)

¹⁹ [HOM002750_007-014](#) paras 6.2-6.5

²⁰ [HOM002750_009](#) para 6.2.15; [HOM002750_011](#) paras 6.3.14-16; [HOM002750_013](#) para 6.4.9; [HOM002750_014](#) para 6.5.10

²¹ [HOM002750_009](#) para 6.2.15

force on D1234 was reasonable, necessary and proportionate.²² The report noted that the technique of handcuffing a detained person behind their back when the detained person was seated had been “removed”.²³ The report did not clarify what was meant by this, but in a letter to D1234 dated the same day, the technique was described as having been “removed from Home Office approved techniques”.²⁴ The PSU did not criticise the use of the technique on D1234. The investigation did not find any evidence that D1234 hit his head on the floor, was restrained by the throat or experienced a cracking of his neck. The report made no criticism of how D1234 was carried.²⁵ In respect of D1234’s nakedness, the PSU concluded in its letter to D1234:

“The video also showed that great efforts were made to protect your dignity throughout the incident by placing a sheet around you.”²⁶

31. The Inquiry heard evidence of other occasions where detained people were restrained when naked or near-naked. I consider two other specific incidents (see Chapter C.3 and Chapter C.13), and discuss the issue of restraint on naked detained people more extensively in Chapter D.7 in Volume II.

32. In his oral evidence to the Inquiry, Mr Dix accepted the criticisms of Mr Jonathan Collier, the Inquiry’s use of force expert, regarding the force applied to D1234’s head, the application of the handcuffs and the carry technique.²⁷ Mr Dix said that he had not received any specific training on how to lead other officers in carrying out a restraint.²⁸

33. Mr Rowley said that he was not aware that the technique of handcuffing detained people behind their back had been removed from authorised practice.²⁹

Relevant expert evidence

34. Mr Collier was asked to examine the use of force on D1234 on 28 March 2017. He found that the use of force was necessary, but was critical of its execution.³⁰

34.1 Mr Collier noted that, when the staff took D1234 to the ground while still inside his cell, the officers appeared to be pushing D1234’s head down.

²² [HOM002750_031-032](#) paras 7.2.18-21

²³ [HOM002750_026](#) para 6.16.10; [HOM002750_029](#) para 7.26; [HOM002750_036](#) para 8.1

²⁴ [CAP000519_002](#)

²⁵ [HOM002750_029-032](#) para 7.2

²⁶ [CAP000519_003](#)

²⁷ [Steven Dix 9 March 2022 33/12-34/17](#)

²⁸ [Steven Dix 9 March 2022 33/12-34/12](#)

²⁹ [SER000438_010](#) para 48

³⁰ [INQ000111_043](#) para 160

Mr Collier said that this was more force used than necessary, excessive, and ought to have been identified and stopped immediately by the supervising officer.³¹ Mr Collier also explained that the actions of the officers risked causing a musculoskeletal injury to D1234's neck.³²

- 34.2** D1234 was handcuffed with his hands behind his back while he was seated.³³ Mr Collier explained that this technique puts undue pressure around the restrained person's torso and can interfere with their breathing. He confirmed that this technique had previously caused the death of a restrained person.³⁴ I discuss this further in Chapter D.7 in Volume II.
- 34.3** Mr Collier observed that the officers did not appear to understand how to execute the carry technique, which should only be used for the minimum amount of time necessary, and that this was poorly managed.³⁵ Specifically, Mr Collier said that the starting position for this carry was incorrect and that the person controlling D1234's head was in the incorrect position, meaning that D1234 was bent forwards rather than being in a straightened position.³⁶
- 34.4** Mr Collier stated that Mr Murphy should not have been wearing a balaclava, as this was not within the authorised list of PPE for this type of incident.³⁷
- 34.5** In his written report, Mr Collier was originally complimentary of the officers' attempts to preserve the decency of D1234.³⁸ When this issue was explored in his oral evidence, Mr Collier accepted that the officers had not produced clothing for D1234 to wear, attempted to persuade or to command D1234 to get dressed, or prioritised the provision of clothes for D1234. Mr Collier then stated that having clothing available for detained people ought to be "*an automatic part of any removal process*".³⁹

³¹ [INQ000111_039](#) para 143

³² [Jonathan Collier 30 March 2022 50/15-22](#)

³³ [INQ000111_038](#) para 141; [INQ000111_042](#) para 151

³⁴ [Jonathan Collier 30 March 2022 51/24-52/17](#)

³⁵ [INQ000111_039](#) para 142

³⁶ [Jonathan Collier 30 March 2022 55/1-56/10](#)

³⁷ [INQ000111_042](#) para 153; [Prison Service Order 1600: Use of Force \(INQ000185\)](#), HM Prisons Service, August 2005

³⁸ [INQ000111_040](#) para 145

³⁹ [Jonathan Collier 30 March 2022 71/24-73/1](#)

35. Mr Collier summarised his views regarding this incident as follows:

“Lawful under Detention Centre Rule(s) – Rule 43(10).

Last resort – all reasonable efforts had been made to facilitate a passive removal and for compliance. Force only used when all failed.

Necessary, reasonable, proportionate – It was necessary to forcibly remove D1234 and the selection of removal techniques reasonable. Although proportionate to the circumstances to apply handcuffs and carry D1234, the execution of techniques was poor. It was not proportionate to allow staff to wear a balaclava and not within authorised PPE for local interventions.

No more than was necessary – More force than necessary resulted from poor technique, this would have been avoided if the correct procedures had been carried out.”⁴⁰

Conclusions

36. The handheld camera footage of the use of force on D1234⁴¹ is particularly upsetting to watch. D1234 was plainly in severe distress for the duration of the incident, which was 17 minutes 30 seconds long. He was desperately and repeatedly calling out to “Jesus” and screaming in apparent pain.

37. Mr Dix instructed officers to use force 15 seconds after he opened the door to D1234’s cell. Notwithstanding Mr Collier’s view, and regardless of what conversations had taken place with D1234 in advance, I consider that Mr Dix should have made more meaningful attempts to engage with D1234 and persuade him to comply with instructions immediately prior to any use of force. Mr Dix could not be sure that further attempts to persuade D1234 to engage would not have achieved a different outcome in circumstances where D1234’s removal was imminent.

38. Mr Dix did not command or persuade D1234 to get dressed prior to using force and only offered him one opportunity to do so during the use of force, which lasted over 15 minutes. There is no evidence from the footage that any subsequent attempts were made to allow D1234 to get dressed before his removal. He was carried into Detainee Discharge with only a sheet held around his genitals; there was a large group of staff there, some of whom appeared simply to be watching the incident and to be amused by it. This was demeaning, humiliating and disproportionate in the circumstances. At least one member of staff could be seen smirking as he observed D1234 being restrained on the floor of Detainee Discharge.

⁴⁰ [INQ000111_043](#) paras 158-161

⁴¹ [CJS0073730 \[Disk 23 S1940003\]](#)

39. The footage shows a group of officers who were clearly tired and struggling to carry out the restraint of D1234 effectively. Mr Dix, as the supervising manager, should have identified a number of problems and sought immediately to remedy them. These problems included:

- inappropriate handcuffing of a detained person with their hands behind their back while seated;
- D1234's head being pushed down with too much force;
- the incorrect execution of a carrying technique; and
- Mr Murphy wearing a balaclava.

40. It should have been obvious to Mr Dix that the staff were struggling to carry out the restraint due to their physical exertion and their inability to apply the techniques appropriately.

41. I find it completely inadequate that Mr Dix had no specific training on how to lead other officers in carrying out a restraint. That notwithstanding, I note that Mr Dix was not the only manager involved in the incident, although he was the supervising officer as recorded in the Use of Force report. Mr Purnell was also present for the duration of the incident, and even stepped in at times to provide direction to the officers using force. In light of the problems that the Inquiry has identified with the execution of the use of force, I find it unacceptable that he also failed to identify the problems that I listed. He should have done so, and should have intervened in the use of force to ensure that it was executed safely. Specifically, it is very concerning that neither manager corrected staff as they handcuffed D1234 with his hands behind his back when he was seated, a technique that had been removed from the Use of Force Training Manual because it is unsafe (as discussed in Chapter D.7 in Volume II).

42. It is concerning that Mr Murphy's addition of a balaclava to his PPE went unchallenged by Mr Dix. In my opinion, the wearing of a balaclava was inappropriate because it had the effect of concealing Mr Murphy's face from D1234, thus preventing D1234 from identifying him if he had wanted to complain about the restraint. It also hindered communication between Mr Murphy and those around him. This was a loud incident, with D1234 and the officers all shouting over each other. The balaclava hid Mr Murphy's mouth, so no one involved was able to understand what he was saying by watching his lips. It is clear that 'Steve' did not initially know what Mr Murphy was saying when Mr Murphy asked him to remove his balaclava, as he leaned in towards Mr Murphy and raised his hand to his ear. Furthermore, while D1234 did not specifically address the balaclava in his complaint, he was clear that he found this incident frightening and that he suffers from flashbacks as a result. In the circumstances, I consider that Mr Murphy's use of a balaclava is also likely to have appeared frightening to D1234.

43. The debrief led by Mr Dix was superficial.⁴² While he identified that there had been some lessons to be learned, he did not elaborate. It is therefore impossible for anyone reviewing the debrief, or the staff present, to know what Mr Dix believed those lessons to have been or what remedial action ought to have been taken. This was a missed opportunity for the officers to reflect on the incident as a team, and to discuss, share and benefit from the learning that Mr Dix had identified or that the officers may have identified themselves. Moreover, in light of the issues with the use of force that have been identified in the course of this Inquiry, I consider that the manner in which Mr Dix presented the debrief minimised the importance of the lessons that ought to have been identified and learned from. While I recognise that it is important for a manager to preserve the morale of their team, this was not a “*job well done*”, and that ought to have been communicated.

44. It is not clear from the footage whether D1234 did suffer the injuries to his neck that he described, or whether he hit his head on the floor. There are various points where there is not a clear view of D1234’s neck or head. It is also not discernible whether Ms Sihlali would herself have had a clear view of D1234’s airway in order to ensure he was not at any medical risk. If she was unable to see D1234’s face, she should have told the officers that this was the case and put herself in a position to be able to see it. Ms Sihlali should also have alerted staff to the dangers of a handcuffing technique that is associated with positional asphyxia. D1234 cannot be heard to specifically mention his neck or head on the footage of the restraint, but much of what he said is indecipherable and so I cannot be sure that he did not make reference to them. However, it is plain from D1234’s medical records following the incident that he did suffer some injuries, even if they were not as he described in his complaint.

45. Given the errors and technical misapplications that are visible on the footage, it is possible that pain was caused to D1234’s neck during the restraint. It is also possible that his head did make contact with the floor. D1234 did not report injuries to his head or neck in the immediate aftermath of the incident, but he did complain of “*pain all over*” and was subsequently noted to have injuries to his wrists, right side and left toe. He was also diagnosed with a soft tissue injury to his chest. I cannot be sure how these injuries were caused because force was used by officers from both G4S and Tascor.

46. In relation to the force used by G4S officers, I consider that handcuffing D1234 behind his back while he was seated, combined with the incorrect technique used to carry him, is likely to have caused him pain (as recognised by Mr Dix in his interview with the PSU) as well as exposed him to unnecessary risk. This treatment was avoidable, and was capable of causing him intense physical and mental suffering. I also consider that the force used against

⁴² [CJS0073731 \[Disk 23 S1940004\]](#)

D1234 was likely to humiliate him. Force was used while he was naked or near-naked, and he was at times surrounded by a large number of staff. The use of force also continued for a long period of time. I therefore find that the facts of this incident provide credible evidence of acts capable of amounting to inhuman and degrading treatment.

Chapter C.3:

D2416 on 11 April 2017

1. D2416 is from Germany. He was detained in Brook House for approximately one week in April 2017. He did not provide a witness statement to the Inquiry, and the Inquiry received very little documentation about him during the disclosure process.

The underlying facts

2. The Inquiry received body worn camera footage capturing a planned use of force involving D2416 on 11 April 2017.¹

3. The footage shows officers entering D2416's cell at around 06:00, while D2416 was still in bed.² Detention Custody Manager (DCM) Shane Farrell, the manager in charge of the other G4S officers involved in the incident, told D2416 to get up and put his clothes on so that the escort staff could carry out the removal instructions. When D2416 responded "*I won't*", Mr Farrell stated: "*Well, it is happening, I have got a team of officers and they will take you by force if necessary.*" D2416 said quietly, while still lying in bed, "*Yeah I'm not going*". Mr Farrell asked, "*You're not going?*", and D2416, as he began to sit up, responded, "*Nope, why should I go?*". Mr Farrell then authorised the other officers to use force on him. The footage shows that there were 26 seconds between Mr Farrell starting the conversation with D2416 and authorising the use of force.

4. As soon as Mr Farrell authorised officers to use force on D2416, Detention Custody Officer (DCO) Ben Shadbolt rushed into the cell and pinned D2416 onto his bed with a shield. He was supported by DCO Neil Timms and DCO Ben Wright. DCO Mohammed Shaukat also entered the cell. All four officers were wearing full Personal Protective Equipment (PPE). The shield was removed after around seven seconds.

5. As the officers restrained D2416, Mr Farrell turned and informed someone in the corridor that D2416 was not wearing any clothes. D2416 said that he needed to see his solicitor. He repeated this multiple times, and also mentioned that he needed to use the toilet. The officers did not respond. D2416 was naked. When the officers brought D2416 to his feet, Mr Farrell asked them to get something to "*cover his modesty*". Mr Farrell turned his

¹ [CJS0074115 UOF 88.17 BWC](#)

² The footage time stamp indicated that the time was 05:10, but Detention Custody Manager Shane Farrell stated the time to be an hour later

camera to the wall, and explained that he had done so *“to save the modesty of the detainee”*.

6. The camera was turned away from the incident for 2 minutes 15 seconds. During this time, D2416 informed the officers that he needed to use the toilet and repeated that he needed to see his solicitor. One of the officers commented that he *“should have sorted out the solicitor before now”*, and D2416 confirmed, *“I have an appointment on the 19th”*. D2416 also complained that he had not received any paperwork for the removal. The officers did not respond to D2416 and one officer spoke over him to give instructions to the other officers regarding how to execute the restraint. The officers asked D2416 to stand up and to lift or raise his head. They then confirmed that handcuffs had been applied and that a towel had been placed around D2416’s waist, so Mr Farrell angled the camera back towards D2416.

7. The officers walked D2416 out of the cell into the corridor. A female member of Healthcare staff was stationed outside D2416’s cell. Officers asked D2416 to raise his head and said that he was not complying. D2416 gently said, *“but you are not complying sir”*. D2416 complained that the officers were hurting his wrists. At that moment, Mr Farrell turned his camera away and Mr Shadbolt can be heard repeatedly asking D2416 whether he wanted to put boxer shorts on. The question was asked four times within eight seconds. D2416 calmly replied, *“sir, you are not listening to me”*, and repeated that the officers were hurting his wrists. He said, *“you are breaking my wrists”*. Mr Farrell explained that he had angled the body worn camera away from D2416 because the towel had dropped from around D2416’s waist. The camera returned to D2416 once he was covered again. This happened intermittently and the camera was therefore angled away from D2416 for much of the incident. D2416 being uncovered also meant that the female member of Healthcare was not able to watch large portions of the incident.

8. The footage shows that D2416 walked compliantly along the corridor surrounded by four officers, two on either side holding his arms, one in front and one following behind.

Figure 8: D2416 walking compliantly with Mr Timms and Mr Shadbolt controlling his arms, and Mr Wright walking ahead



9. As the towel fell again, Mr Wright moved towards D2416 who said, *"please do not fucking touch me"*. The officers placed the towel back around D2416's waist, and he continued to walk through the wing. D2416 continued to complain that the officers were hurting his wrists and demanded that they let go; however, he did not physically resist the restraint. He was taken through a door leading to a stairwell and the officers, still surrounding D2416, discussed how to escort him down the stairs.

10. Mr Farrell instructed Mr Wright to take control of D2416's head *"for his safety"*, but D2416 responded that he could *"fucking walk"* and protested at the restraint being carried out while he was naked. Mr Farrell commented that D2416 had a towel around him to protect his *"modesty"*, and an officer explained to D2416 the procedure for moving him down the stairs while he was under restraint. D2416 appeared to confirm that he understood, and moved into position.

11. As the officers started to move D2416 down the stairs, the towel dropped to the floor again. Mr Farrell turned the camera away from D2416 and told the officers to take control of D2416's head *"because he's not being compliant"*.

12. The camera remained directed away from D2416 for almost nine minutes while the restraint continued, which means that it is not possible to see when restraint techniques were applied or what those techniques were. However, as the group moved down the stairs the officers can be heard directing D2416 to *"get your feet off"* and *"put your head down"*. They can also be heard saying to each other, *"if he does it again, we go down"*, and *"lift his legs, grab his legs"*. D2416 can be heard asking, *"Are you trying to break my fucking body?"*, and saying, *"would you please let go of my wrists"*.

13. After approximately 2 minutes 30 seconds, the officers and D2416 appeared to reach the foot of the stairs, as they can be heard speaking to the escort staff. One member of the escort staff asked if the officers could get some clothes for D2416, after which Mr Farrell requested a clothing pack (a pack of clothing provided to detained people who arrive at Brook House without any clothing of their own) over his radio. By this time, D2416 had been naked for approximately nine minutes. As Mr Farrell made this request, D2416 can be heard speaking to the escort staff. He said, *"please let go of my wrists, you are breaking them"*, and again mentioned that he was waiting for an appointment with his solicitor. D2416 did not respond to questions regarding whether he wanted to get dressed. One officer appeared to offer to remove the handcuffs, although this is not clear. When D2416 asked the officers a second time to let go of his wrists, Mr Farrell responded, *"that's not going to happen because you're currently under restraint ... We're keeping hold of you for your own protection."* D2416 said, *"sir, I'm not doing anything, the people here are trying to break my wrists"*. Mr Farrell responded, *"I'm sure they're not, they're there to support you."* One officer quietly laughed, which agitated D2416. Mr Farrell denied that it was him, and an officer said, *"the quickest way to get out of the handcuffs is to put some clothes on compliantly"*.

14. The conversation continued for a further six minutes, during which time D2416 repeated that the officers were trying to break his wrists when he had not acted or spoken violently towards them. He also complained that during his time in Brook House he had been poisoned by other detained people repeatedly going into his cell and smoking drugs, and that he was not given the opportunity to use a toilet before he was taken from his cell. Mr Farrell requested an update on the clothing, and requested a bedsheet in case D2416 refused the clothing pack.

15. Approximately 18 minutes after the officers first arrived at D2416's cell, clothing and a bedsheet were handed to Mr Farrell for D2416 to put on. Mr Farrell then passed these to the staff directly next to D2416 at the bottom of the stairwell. The footage ends with D2416 still speaking to escort officers at the foot of the stairs.

16. The Inquiry did not receive a witness statement from D2416, and it does not appear that he complained about this treatment at the time.

17. In his Use of Force report, Mr Timms wrote that D2416 became agitated and resistant as the officers walked with him towards the stairs. He wrote that the group proceeded down the stairs but that D2416 started to put his foot on the stair railings and become more non-compliant. He wrote that Mr Wright took control of D2416's head so that *"we could safely continue down the stairs"*.³ Mr Wright himself recorded that he took control of D2416's head before the group started to walk down the stairs as D2416 was not complying

³ [CJS005630_014](#)

with instructions.⁴ It was more than three months before DCM Stephen Webb, a Use of Force instructor at Brook House, completed a Use of Force review meeting form on 18 July 2017. (As explained in Chapter D.7 in Volume II, these were handwritten, single-page forms completed following a review of documentation for each use of force.) Mr Webb indicated on the form that body worn camera footage of the incident was available, but he did not indicate whether he had watched it. His review identified no lessons to be learned or training needs.⁵

18. In his witness statement to the Inquiry, Mr Shadbolt explained that the officers did not try to put any clothing on D2416 due to his demeanour and the risk that he was posing at the time. He asserted that D2416 “*did not de-escalate throughout the intervention*”.⁶

19. The Inquiry did not hear oral evidence from any of the officers involved about this incident.

Relevant expert evidence

20. When Mr Jonathan Collier, the Inquiry’s Use of Force expert, prepared his first report to the Inquiry, he did not have access to the body worn camera footage of this incident. He therefore based his opinion about the appropriateness of the use of force on the written reports of the officers involved. In summary, he found that:

“the descriptions would indicate that the force used was reasonable and proportionate. Attempts at de-escalation were used.”⁷

21. By the time Mr Collier provided the Inquiry with a second, supplementary report, he had seen the body worn camera footage of the incident and his opinion had changed. He said:

“I question why the DCM insisted for the head support to be applied for moving down the stairs when D2416 was compliant, although he was verbally challenging but not offering a threat or risk at the time.”⁸

Mr Collier also noted that there were inaccuracies in the Use of Force reports, which indicated that a head support was only applied on D2416 because he had attempted to disrupt his removal by inserting his feet into the staircase railings.⁹ However, as explained above, the audio from the body worn camera footage indicated that D2416 resisted the restraint only once the head support

⁴ [CJS005630_019](#)

⁵ [CJS000902_025](#)

⁶ [SER000441_023](#) para 158

⁷ [INQ000111_103](#) para 423

⁸ [INQ000177_009](#) para 35

⁹ [INQ000177_009](#) para 35

had been applied. In his oral evidence, Mr Collier confirmed that the application of the head support was disproportionate.¹⁰

22. Mr Collier considered that it appeared from the footage as though D2416 was left naked in the presence of at least seven staff while a sheet was being found to cover him. If correct, Mr Collier said that this was “*unacceptable and degrading*”. He stated:

“There was ample opportunity to arrange for clothing to be made available beforehand and for only the necessary staff to be present whilst D2416 was undressed.”¹¹

23. In his oral evidence to the Inquiry, Mr Collier was critical of the length of time between the officers entering the cell and using force. He stated that the officers should have allowed D2416 an opportunity to wake up and process what was happening. They should then have attempted to engage him in conversation and explain what was happening and what he was being required to do.¹²

Conclusions

24. The footage of this incident was very uncomfortable to watch.

25. Given the early hour of the day, and the fact that D2416 was in bed and more than likely asleep when the officers entered his cell, they should have anticipated that D2416 may have been undressed. Therefore, they should have formulated a plan for how to deal with this over and above placing a towel around his waist.

26. In my opinion, the use of force against D2416 was unjustified and disproportionate in the circumstances; I agree with Mr Collier’s assessment. Insufficient attempts were made to persuade D2416 to cooperate before the use of force was authorised. Force was therefore not used as a last resort. The short amount of time taken to engage with D2416 before using force (26 seconds) rendered the negotiations artificial, and the officers did not attempt any other de-escalation techniques prior to the use of force. Taken together, these factors suggest that the officers had a lack of understanding of how to de-escalate a situation and of the techniques which could be used to avoid the use of force. Indeed, it appeared as though they assumed that a restraint was inevitable.

27. The officers made no effort to engage with D2416 regarding the concerns that he was raising and instead shouted over the top of him. This escalated the situation and caused D2416 to be frustrated. Indeed, he only

¹⁰ [Jonathan Collier 30 March 2022 66/8-23](#)

¹¹ [INQ000177_009](#) para 36

¹² [Jonathan Collier 30 March 2022 67/16-68/1](#)

started swearing at the officers once they had repeatedly ignored his concerns about his wrists, his stated need to use the toilet, and his appointment with his solicitor.

28. D2416 was left naked while restrained for an unacceptable amount of time. He was naked for over 18 minutes, which led Mr Farrell to avoid capturing the majority of the incident on camera, a situation that could and should have been avoided. There should have been more meaningful attempts to supply D2416 with clothes before he was removed from the cell. In my opinion, repeatedly asking whether D2416 was going to put on boxer shorts (a question asked four times in the space of eight seconds) when he was already on the landing did not constitute a reasonable attempt to persuade him to get dressed. Notably, at that point there were no clothes available for D2416 to put on and he was attempting to speak to the officers about an appointment that he had with his solicitor. Insufficient consideration was given to his dignity and opportunities were missed to de-escalate the situation and to ensure that D2416 was provided with clothes. I also find that it was unacceptable for a large group of at least seven officers and escort staff, many of whom were wearing PPE, to surround D2416 while he was naked or only covered by a towel at the bottom of the stairwell. He was not physically resisting or posing a risk to himself or staff, and there is no evidence that any consideration was given to whether or not all of the officers present were required.

29. The Use of Force reports were contradictory regarding the time at which the head support was applied to D2416. Mr Shadbolt and Mr Shaukat failed to mention the use of the head support at all.¹³ Mr Farrell did not complete a Use of Force report; Mr Timms said that the head support was only applied part-way down the stairs; and Mr Wright, the officer who took control of D2416's head, said he did so at the top of the stairs.¹⁴ While the head restraint is not shown on the footage, it is my view that Mr Wright must be correct in this regard. Mr Farrell told him to take control of D2416's head on three separate occasions before the officers started moving down the stairs, and Mr Wright is likely to have been able to accurately record his own actions in his report.

30. The application of the head support was not justified by D2416's actions. The footage shows that D2416 compliantly walked with the officers to the stairwell and moved into the appropriate position to be escorted down the stairs. While he told the officers at the top of the stairs that he could "*fucking walk*", he did not shout at the officers or struggle against them. Indeed, he only raised his voice when an officer tried to speak over the top of him. In the circumstances, I agree with Mr Collier that D2416 ought to have been permitted to move down the stairs without his head being restrained.

¹³ [CJS005630 009-010](#); [CJS005630 024-025](#)

¹⁴ [CJS005630](#); [CJS005630 014](#); [CJS005630 019](#)

31. I consider that the written reports submitted by Mr Timms and Mr Wright gave a misleading account of D2416's demeanour. Mr Timms described D2416 as "*refusing to comply*" or "*resisting*" the removal, and Mr Wright said that he took control of D2416's head because D2416 started not to comply prior to being escorted down the stairs.¹⁵ However, the footage demonstrates that it was only when the officers began to move D2416 down the stairs that he offered any physical resistance (in the form of putting his feet onto the stair railings).¹⁶ Mr Timms also described D2416 as agitated, but failed to mention why (for example, because the restraint was hurting D2416's wrists). This gave the inaccurate impression that D2416 was resisting the removal.¹⁷ It is concerning that, despite knowing that the restraint was being recorded, the officers appear to have been unconcerned that their written accounts justifying the use of force could be proven to be misrepresentative. This is an example of a culture at Brook House during the relevant period in which the use of force was not sufficiently scrutinised and staff did not expect their accounts to be challenged, which I discuss further in Chapter D.7 in Volume II.

32. I consider that the force used against D2416 while he was naked or covered only by a towel was likely to be humiliating. The force was not justified; D2416 was naked or near-naked for over 18 minutes; the incident was witnessed by a large number of people; and PPE was used in circumstances that did not appear to warrant it. Moreover, D2416 stated at least three times during the incident that he needed to urinate and was not given the opportunity to do so. In my view, there is credible evidence that this was capable of amounting to degrading treatment.

¹⁵ [CJS005630_014](#); [CJS005630_019](#)

¹⁶ [CJS0074115 UOF 88.17 BWC](#)

¹⁷ [CJS005630_014](#)

Chapter C.4:

D1527 in April and May 2017

1. D1527 was born in Egypt.¹ He told the Inquiry that he came to the UK in January 2014 to claim asylum and that he had experienced “*horrible abuse and torture in Egypt*”.² He was detained at Brook House from April 2017 to June 2017.

2. D1527 had several vulnerabilities. On 12 April 2017, Ms Karen Churcher, a Registered Mental Health Nurse (RMN), completed a mental health assessment of D1527. During this assessment, D1527 disclosed that he was a victim of torture, was taking medication for depression, had recently self-harmed and had active suicidal ideations. He described to Ms Churcher how he planned to kill himself and stated that he “*just wants to die*”.³ D1527’s extremely low mental state was recorded contemporaneously in his medical records as persisting throughout his stay at Brook House. He struggled to sleep, suffered from flashbacks, regularly committed acts of self-harm (including food and fluid refusal) and tried to commit suicide.⁴

3. In this chapter, I consider the degree to which three separate events that took place throughout April and May 2017 are capable of amounting to mistreatment of D1527:

- **24 April 2017:** D1527 was on constant supervision. He was being supervised by Detention Custody Officer (DCO) Calvin Sanders, who later asserted that he had bent D1527’s fingers back as D1527 attempted to harm himself.
- **25 April 2017:** D1527 attempted to kill himself by use of a ligature and then by using his hands to strangle himself. As a number of officers restrained him, DCO Ioannis (Yan) Paschali put his hands around D1527’s neck and applied pressure. D1527 was also verbally abused by Mr Paschali, Detention Custody Manager (DCM) Nathan Ring and DCM Stephen Loughton. This incident became a centrepiece for the BBC’s *Panorama* programme.

¹ [DL0000144_001](#) para 1

² [DL0000144_0058](#) para 141; [DL0000144_045](#) para 106

³ [CJS001002_033](#)

⁴ [CJS001002_030-055](#)

- **4 May 2017:** D1527 jumped onto the safety netting (netting installed as a measure to protect an individual from falling from a balcony) on D Wing. He was later forcibly moved to the Care and Separation Unit (CSU).

24 April 2017

The underlying facts

4. Footage covertly recorded by DCO Callum Tulley on 4 May 2017 shows a group of officers in an outside smoking area talking about a restraint of D1527 that had taken place earlier that day (discussed below).⁵ Mr Sanders, who was one of the group but who had not been involved in the restraint, joined in the discussion and described an incident on 24 April 2017 when D1527 was on constant supervision having attempted to self-harm by digging his fingers into his neck.⁶

5. Mr Sanders demonstrated D1527's actions by gripping his right hand around his throat and pressing his index fingers into either side of his neck. In order to prevent D1527 from doing this, Mr Sanders said that he had bent D1527's fingers back.

6. Later in the footage from 4 May 2017, Mr Tulley, Mr Sanders, DCO Aaron Stokes and other officers were in Reception. Mr Tulley explained that he had been on constant supervision of D1527 about a week earlier because D1527 had tried to swallow batteries.⁷ Mr Sanders then repeated the same account about D1527, explaining that he had bent D1527's fingers back while he had been constantly supervising him on 24 April. Again, he gave a demonstration of his actions and was smiling as he did so.

7. There was a brief pause, and then Mr Tulley asked the other officers how best to deal with a detained person like D1527. Mr Stokes replied, "*turn away and hopefully he's swinging*". Mr Sanders sniggered, and suggested that he had also deliberately forced D1527's head down against a table as D1527 was attempting to self-harm. Mr Sanders, Mr Stokes and another officer appeared to joke about D1527's head repeatedly moving up and down against the table, and Mr Stokes made a bobbing motion with his head. Mr Stokes then said, "*did you not have the urge to just punch him in the face as he's gone up*" and demonstrated how Mr Sanders may have done this. Mr Stokes and Mr Sanders laughed.

⁵ [KENCOV1012 - V2017050400026](#)

⁶ The term 'constant supervision' is used to refer to the frequency of observations required on a detained person who is considered to be at high risk of self-harm or suicide

⁷ [KENCOV1012 - V2017050400028](#)

Figure 9: Mr Stokes demonstrating how Mr Sanders might have punched D1527 in the face



8. The Inquiry also saw footage covertly recorded by Mr Tulley on 8 May 2017, 14 days after the incident.⁸ During the footage, which shows Mr Tulley and Mr Sanders in a staff office, Mr Tulley asked Mr Sanders, “*you been head-slamming detainees down here and all?*”. Mr Sanders laughed and then said, “*yeah mate*”. He then confirmed that the detained person involved was D1527. The conversation was interrupted for five minutes as detained people came into the office with queries, but, when the detained people had left, Mr Tulley asked whether the incident had taken place after D1527 was on the netting. Mr Sanders said that it:

“was before ... He was on E-wing, on constant, and I was in the room with him. And normally you’re set up, sat across, sitting outside watching him ... But I still couldn’t see what he was doing. So, I sat in there, on the table right next to him. Literally I was talking to him and obviously, looked around to make sure no one was looking, banging his head and as he was banging it I went ...”

He then gestured slamming his hand down hard onto the desk in front of him, making a loud bang. Mr Sanders laughed.

9. Mr Sanders explained that he had held D1527’s head in place, and D1527 had then tried to push his fingers into his own neck. Mr Sanders continued, “*So I got his finger and thumb and went ‘told you I stop you doing it’*” and demonstrated how he had bent D1527’s fingers back. Mr Sanders appeared unashamed and amused by this anecdote, and later added that he

⁸ [KENCOV1014 - V2017050800017](#)

thought D1527 respected him as a result of what he had done. Finally, Mr Sanders said, *“If you’re hurting yourself, you’re attention seeking aren’t you, little prick”* and *“haven’t got no sympathy for any of them”*.

10. D1527’s Assessment Care in Detention and Teamwork (ACDT) record for 24 April 2017 shows that Mr Sanders was in fact undertaking constant supervision of D1527 between 15:40 and 17:47 that day, and then again between 18:30 and 20:55.⁹ In his statement to Sussex Police, Mr Tulley said that on 24 April 2017 he saw D1527 *“lying face down on his bed, motionless”* in his cell on E Wing, and that Mr Sanders, who was sitting on the desk between the two beds in the cell, told him that D1527 *“keeps digging his fingers into his neck”* and that he would *“get through to him eventually”*. Mr Tulley said that he took no notice of the remark and left the cell.¹⁰

11. D1527’s account to the Inquiry was that he could not remember the events that Mr Sanders related to the other officers. However, he said in his statement:

*“I do not recall this incident, which does not mean it did not happen. I should explain that I have flashes of memories of force being used against me ... a lot of the incidents are a blur for me, however I find it very difficult to recall the difference between the events or the order in which they happened.”*¹¹

12. In his oral evidence, Mr Sanders told the Inquiry that his claim to have pulled D1527’s fingers back and banged his head was *“just lies that I made up to try and fit in with some people who weren’t even, like, great people”*.¹² He also said that:

“in the moments I said I was banging his head down, in reality, I was actually placing a pillow under his head to stop him hurting it ... and, rather than using restraints to remove his hands, I actually, just like he was a child, just tried to pull his hands away”.¹³

13. Mr Owen Syred, a DCO and Welfare Officer during the relevant period, told the Inquiry in his closing submission that he believed Mr Sanders to be a caring person.¹⁴ He also stated that *“the strain of working at Brook House led some officers to hide their lack of confidence with bravado or to act out of character in order to fit in”* and that Mr Sanders was an example of such an officer.¹⁵ Another officer, DCO Ryan Harkness, told the Inquiry that he thought

⁹ [CJS001085_003-005](#)

¹⁰ [SXP000120_007](#)

¹¹ [DL0000144_010](#) para 32

¹² [Kalvin Sanders 4 March 2022 124/13-125/15](#)

¹³ [Kalvin Sanders 4 March 2022 129/18-23](#)

¹⁴ [Closing Statement by Mr Stanton on behalf of Owen Syred 5 April 2022 172/2-6](#)

¹⁵ [Closing Statement by Mr Stanton on behalf of Owen Syred 5 April 2022 169/22-170/1](#)

Mr Sanders “said what he felt he needed to say to fit in ... He was not in my experience a violent guy or a guy built for violence.”¹⁶

14. Mr Stokes told the Inquiry that he thought Mr Sanders was just “letting off steam” when he talked about what he had done to D1527 and that he had not genuinely assaulted a detained person.¹⁷ In relation to his own comment that the right response to a suicidal detained person was to “turn away and hopefully he’s swinging”, Mr Stokes told the Inquiry:

*“I can see it now that it was in very poor taste ... but it’s my belief that I was just young, naive and just trying to deal with stress the way I could.”*¹⁸

15. Following the broadcast of the *Panorama* programme, the Home Office Professional Standards Unit (PSU) carried out an investigation into Mr Sanders’ claim that he had assaulted D1527 while he was responsible for constantly supervising him.¹⁹ The PSU concluded that Mr Sanders did assault D1527 and that his statements to colleagues about hurting D1527 and about him being “an attention seeking ... little prick” were “derogatory and were likely to have degraded [D1527]”.²⁰

Conclusions

16. I find it probable that Mr Sanders did pull D1527’s fingers back and bang his head on a table. While I took account of the ‘macho’ culture that I found persisted in Brook House during the relevant period (see Chapter D.9 in Volume II), in this case Mr Sanders offered his accounts of these incidents spontaneously, repeatedly, and with apparent pride in his actions. Indeed, it is plain from the footage that he thought what he was describing was funny. Furthermore, people do not ordinarily admit to things they have not done.

17. I considered the views of some of the staff witnesses who worked with Mr Sanders and who did not think that he would have mistreated D1527 in the way that he described. It is, though, important to acknowledge that, throughout the Inquiry, many staff said that they were shocked by evidence of abusive conduct by colleagues. For example, DCM Stephen Webb said that he was shocked to hear DCO John Connolly refer to a detained person as a “nigger”. He said, “that’s not the John I know”.²¹ DCM Daniel Haughton (Support Services Manager during the relevant period) said that he thought what was shown on *Panorama* was “horrific” and that prior to watching it he

¹⁶ [SER000440_028](#) para 96d

¹⁷ [Aaron Stokes 9 March 2022 191/19-192/4](#)

¹⁸ [Aaron Stokes 9 March 2022 193/7-15](#)

¹⁹ [CJS001107_008](#) para 6.2; [CJS001107_011-012](#) paras 6.28-6.36; [CJS001107_018-20](#) paras 7.2-7.21

²⁰ [CJS001107_020](#) para 7.21

²¹ [Stephen Webb 8 March 2022 144/10-145/4](#)

had not been aware of an abusive culture at Brook House.²² Furthermore, DCO Clayton Fraser said that he had never witnessed any bullying towards detained people.²³ However, as discussed in Chapter D.9 in Volume II, there was undeniably a culture of aggression, bullying and bravado at Brook House during the relevant period.

18. There was also, in my opinion, some residual denial of the seriousness of the treatment of some of the detained people in Brook House, and reluctance to accept that fellow members of staff had acted as they did. For example, DCM Christopher Donnelly said that there was no abuse of detained people at Brook House during the relevant period, despite what had been shown on *Panorama*, and that it was instead a small minority of detained people abusing staff.²⁴ Mr Fraser suggested that threats made to D1527 by Mr Paschali (see below) may have been an attempt by him to de-escalate the situation.²⁵ Regardless of the reason, I do not accept the scepticism of other staff who knew Mr Sanders as sufficient evidence to counter his own repeated claims to have mistreated D1527.

19. Throughout the Inquiry, there was evidence that aggressive language was normalised and that officers felt able to talk freely about detained people in derogatory and abusive terms without fear of consequence.²⁶ The Inquiry has seen evidence that compassion was not highly valued, and a narrative developed among some staff that their job was solely about managing risk and maintaining security rather than providing a safe and respectful environment for the men detained there. I discuss related issues – such as staffing levels, the experience of staff and the lack of supervision – in detail in Chapter D.9 in Volume II.

20. Mr Sanders was the officer personally responsible for constantly supervising D1527 at the time of this incident. As such, he was responsible for the wellbeing of a highly vulnerable man whose risk of self-harm was deemed so high as to warrant him being supervised constantly. However, Mr Sanders abused his position of power over D1527 by inflicting further harm upon him. It is particularly troubling that this harm was inflicted on a man so clearly in mental distress.

21. Given D1527's heightened vulnerability, I consider it likely that this incident caused him intense physical or mental suffering, fear and anguish. Consequently, there is credible evidence that it was capable of amounting to inhuman and degrading treatment.

²² [Daniel Haughton 16 March 2022 148/13-149/2](#)

²³ [Clayton Fraser 28 February 2022 7/23-6/1](#)

²⁴ [Christopher Donnelly 23 February 2022 82/11-19](#)

²⁵ [Clayton Fraser 28 February 2022 7/12-8/2](#)

²⁶ For example, see Chapter D.9 in Volume II under the heading 'Abusive and derogatory language'

25 April 2017

22. D1527 has provided four consistent accounts of what happened to him on 25 April 2017.²⁷

23. On the afternoon and evening of 25 April 2017, D1527 remained on constant supervision on E Wing. During that time, D1527 made two separate attempts to harm himself while inside his cell. As set out below, some members of staff were involved in responding to both incidents while others were present for only one or the other. For clarity, I refer to the two incidents that day as ‘the first incident’ and ‘the second incident’.

The first incident

The underlying facts

24. Mr Fraser, the officer constantly supervising D1527 at the time, recorded in D1527’s ACDT record that, at 19:01, he was “*kicking and banging*” the cell door.²⁸ Mr Loughton, who was attending E Wing in his capacity as ‘Oscar 1’ (the operational manager on duty) that day, approached D1527’s cell to carry out a routine management check of detained people refusing food and fluids.²⁹ Mr Fraser told Mr Loughton that he had not seen D1527 for a few minutes.³⁰ They went into D1527’s cell and found D1527 curled around the toilet, which was separated from the rest of the cell by a solid screen (a ‘privacy screen’), holding a ripped T-shirt around his neck.³¹

25. In his witness statement to the police and in response to questions asked by the Inquiry under Rule 9 of the Inquiry Rules 2006, D1527 described cutting his T-shirt and tying it around his neck because he did not want to live anymore.³²

26. Mr Tulley was also on E Wing that day, constantly supervising another detained person. He heard noises coming from D1527’s cell and went over to try to assist.³³ The Inquiry saw footage recorded covertly by Mr Tulley, which

²⁷ The first of these statements was given to Sussex Police on 11 December 2017 (SXP000145), after it had started an investigation into some of the events shown on the *Panorama* programme. The second statement was provided in support of D1527’s application for permission for judicial review (HOM032221_010-013 paras 39-49). The third statement was D1527’s evidence to this Inquiry, dated 19 November 2021 (DL0000144_018-023 paras 49-61). Finally, D1527 provided a response to questions asked by the Inquiry under Rule 9 of the Inquiry Rules 2006; this document is undated (DL0000209), but was received by the Inquiry on 12 November 2021

²⁸ [CJS001085_017](#)

²⁹ [CJS004316_004](#)

³⁰ [SER000447_016](#) para 70

³¹ [CJS004316_004](#)

³² [SXP000145_001](#); [DL0000209_0027](#)

³³ [SXP000120_004](#)

shows a continuous period of approximately 18 minutes on E Wing.³⁴ The footage begins with Mr Tulley walking a short distance across E Wing and into D1527's cell. The time at that point was approximately 19:08. Mr Fraser was standing in the middle of the cell, and Mr Loughton was leaning over the toilet area. Mr Tulley shouted, "*get staff, we need some help in here*" to officers outside the cell. Mr Loughton appeared to be unable to loosen the ligature around D1527's neck and asked for a fish knife, which Mr Fraser provided. Mr Loughton used this to cut the ligature off, and the officers pulled D1527 out of the toilet area and told him to get up and sit on the bed.³⁵

Figure 10: Mr Loughton removing the ligature from around D1527's neck



27. D1527 does remember that an officer cut the T-shirt away from him, and he remembers being forcefully moved into the centre of the cell. However, he says that he was having flashbacks at the time, which he describes as seeing himself somewhere else and not noticing what the people around him were saying or doing. As such, he recognises that he does not remember everything that was happening.³⁶

28. D1527 explained in his witness statements that he remained there for a few minutes before getting up onto the bed, taking a battery out of his phone

³⁴ Day 2 AM 24 November 2021 00:34:29-00:53:24 (KENCOV1007 - V2017042500020 08:47-26:36)

³⁵ As Mr Tulley was involved in the restraint, this is not entirely clear from the footage. However, it is recorded in an incident report completed by Mr Loughton (CJS004316_004) and in Mr Tulley's statement to Sussex Police (SXP00120_004), both of which I consider to be an accurate description of what is being shown

³⁶ SXP000145_001; HOM032221_010-011 para 39; DL0000209_027

and putting it in his mouth.³⁷ D1527 does not remember much about putting the battery in his mouth, but remembers that it was taken out by force.³⁸ He said:

“I know that people were talking about me and being rude to me, but I don’t remember any of this. I wasn’t listening to them, I did not feel like I was there in that room. I felt like I was somewhere else. I just wanted to die, I didn’t care about anyone else or what they were saying.”³⁹

29. The footage shows D1527 get up off the floor after a couple of seconds and start pacing in the cell.⁴⁰ A female member of staff, who appeared to be from Healthcare, stood in the doorway and DCO Charles Francis joined the other officers inside the cell. Mr Loughton and Mr Francis asked D1527 what he had inside his mouth. Mr Loughton radioed for Healthcare staff to attend immediately and both officers continued to ask D1527 what was in his mouth. D1527 did not respond to the officers, and continued to pace the width of the cell. Mr Francis then moved towards a table underneath a window at the back of the cell, said the word “battery” and appeared to hold up a small item in the direction of Mr Loughton before placing it back down. Mr Loughton responded but his words are not audible on the footage.

30. Mr Loughton instructed D1527 to sit down, which he did briefly before he stood back up and started shouting at officers:

“I will die here today ... I asked nicely for everything, you said no ... Don’t believe it? I will go there ... noose on my head, pull the knot here ... I will die here. Don’t worry ... I will die, I will die again.”

As D1527 shouted he raised his arms above his head and paced back and forth; he was obviously distressed. After around a minute, D1527 put one hand to his chest and sat back down on the bed, which appeared not to have a mattress on it.

31. Within 10 seconds of D1527 sitting down, Mr Loughton said, “He’s got a battery. Give me the battery”, and, seconds later, “Don’t put it in your mouth. He’s got a battery in his mouth.” A conversation then took place between Mr Loughton and other staff regarding the battery, which Mr Loughton described as a phone battery. Ms Joanne Buss, a Registered General Nurse (RGN), walked into the cell and asked D1527 if he would talk with her. However, he did not respond and remained seated on the bed.

32. Over the course of around six minutes, Mr Loughton, Mr Tulley and Ms Buss attempted to engage with D1527, but he did not respond. Mr Tulley

³⁷ [HOM032221_011](#) para 40; [SXP000145_001-002](#)

³⁸ [HOM032221_011](#) para 41; [SXP000145_002](#)

³⁹ [HOM032221_011](#) para 41

⁴⁰ [Day 2 AM 24 November 2021 00:34:29-00:53:24 \(KENCOV1007 - V2017042500020 08:47-26:36\)](#)

moved to sit opposite D1527, meaning that the others in the cell were no longer visible on the footage, though their voices could clearly be heard. Mr Loughton repeatedly told D1527 to remove the phone battery from his mouth and remarked, *"It isn't going to get you out of this wing though, is it?"* and *"When all we do is stuff like this, the longer you're going to stay in here."* D1527 did not respond. Mr Loughton instructed D1527 to take the battery from his mouth again but then moved to leave the cell while complaining that he would now have to complete a Use of Force report. As he was leaving, Mr Loughton remarked, *"got a battery in his mouth now, the cock"*. Mr Ring, who had arrived at the cell, commented that D1527 would be *"Going all night like a Duracell bunny"* and said, *"Swallowing batteries? You're full of it."* Ms Buss appeared to reply *"yes"*. Shortly afterwards, Mr Ring said to Mr Tulley, *"what are you waiting for?"* and Mr Tulley left the cell with the other officers.

33. Mr Tulley, Ms Buss, Mr Loughton, Mr Fraser and Mr Ring remained standing on the E Wing landing near D1527's cell, the door to which was left open. A conversation took place between staff outside the cell, where Mr Ring referred to D1527 as *"a child"* and *"just a dick"*. He also remarked, *"they just sit and sulk"*. Mr Loughton gave the instruction, seemingly to Mr Fraser as the officer assigned to constantly watch D1527, *"You need to keep an eye on him. When he goes in there, we need to be able to keep an eye on him ... what's he doing now? sulking."* Mr Fraser asked whether the cell door should be left open.

34. Mr Tulley and Ms Buss moved back into D1527's cell, where D1527 had returned to the toilet area and was talking with a member of Healthcare staff. Mr Loughton, who must have re-entered the cell out of view of Mr Tulley's covert camera, was standing in the middle of the cell. D1527 asked the member of Healthcare staff to leave him alone and said, *"I will die. No you don't need to do this."* He then gestured towards Mr Loughton and said, *"He doesn't care he tried to put me here and locked me up."* D1527 said, *"please, please, please let me"*. A voice off-camera could then be heard saying, *"bellend might be off my wing"*.

35. Mr Tulley walked away from the cell and towards the E Wing staff office. D1527 could still be heard talking to Healthcare. Mr Tulley engaged in conversation with other detained people who were on E Wing and then talked with Mr Paschali about D1527's attempted self-harm. As they were talking, the two officers walked back towards D1527's cell. Mr Tulley said:

"what I think he tied something around his neck, he was trying to strangle himself ... Nobby [a nickname for DCM Stephen Loughton] had to get hands on ... he got into – when I got into the cell, he was in the toilet. I don't know how he got in, I don't know how he got around into the toilet and onto the floor, do you know what I'm saying?"

Mr Paschali asked if he meant that D1527 had managed to get behind the toilet itself, but Mr Tulley clarified that he meant that D1527 had positioned himself behind the privacy screen.

36. Mr Paschali and Mr Tulley joined Mr Ring and Mr Fraser at D1527's cell door. Mr Ring said:

"He aint got a battery in his mouth has he – nah I said to you it's all good ... He put the battery 'round his mouth and pretended to chew it up ... and when I checked it, it was all in the drain. He picked it up, put it 'round his face and [inaudible] chucked it all down the drain to look like he'd, like he'd [inaudible] the toilet."

37. In response to Mr Tulley asking D1527's age, Mr Paschali said, *"It's kind of like he's fucking three."*

38. After approximately five minutes, Mr Tulley went into the staff office where Mr Francis was sitting at a desk. They discussed D1527, who Mr Tulley described as having calmed down. Mr Francis asked if D1527 had given up the phone battery to staff. Mr Tulley responded:

"I didn't see it happen, but I believe he has done, yeah because he's chatting away in there, so."

39. Mr Loughton submitted a Use of Force report in relation to restraining D1527 (in order to remove the ligature) at approximately 19:08.⁴¹

40. In his oral evidence to the Inquiry, Mr Fraser described D1527 placing a ligature around his neck while he was constantly observing him from outside the cell through the viewing panel. He said that he was *"probably going over [his] notes"* when D1527 moved from his bed to the toilet area and attached the ligature to his neck.⁴²

41. In his oral evidence to the Inquiry, Mr Ring said that he viewed his comments about D1527 as *"facetious"* and *"silly"*. He claimed that his comments were born of frustration with D1527's behaviour, which he told the Inquiry he considered to be *"childish"*.⁴³ Mr Ring also emphasised that his comments had been directed at other staff and not at D1527 himself.⁴⁴ When Counsel to the Inquiry asked if Mr Ring believed that D1527's actions that day may have been a manifestation of his mental illness, Mr Ring at first refused to comment because he said he was not medically trained. He then added that he was unsure why D1527 had been acting *"childishly"* because he was not trained in mental health.⁴⁵

⁴¹ [CJS005534](#)

⁴² [Clayton Fraser 28 February 2022 48/17-50/3](#)

⁴³ [Nathan Ring 25 February 2022 77/14-81/16](#)

⁴⁴ [Nathan Ring 25 February 2022 77/14-78/17](#); [Nathan Ring 25 February 2022 83/24-84/20](#)

⁴⁵ [Nathan Ring 25 February 2022 79/13-80/5](#)

42. Mr Loughton told the Inquiry that he thought it was putting too much emphasis on the use of language at Brook House in the relevant period.⁴⁶ However, he accepted that calling D1527 a “cock” was inappropriate and apologised for it.⁴⁷ Mr Loughton did also seek to explain that he had made the comment to another officer and not directly to D1527, and that he had done so as a result of the stress of the situation:

“You’ve just got to take into consideration, my adrenaline was going, I’d just potentially saved this guy’s life, removed a ligature from his neck. He was screaming in my face. I was, you know, my feelings were raised at the time.”⁴⁸

43. Mr Loughton also told the Inquiry that he did not believe that he could distinguish between a detained person being disruptive because they were mentally unwell or because they were being disruptive for some other reason. He said that he had received no training on this.⁴⁹

Conclusions

44. The footage of the first incident on 25 April 2017 shows D1527 in clear distress and was hard to watch.

45. Both Mr Tulley and Mr Loughton expressed concern to other staff that D1527 had managed to attach a ligature to his neck while under constant supervision.⁵⁰ However, the Inquiry did not receive any evidence to enable me to determine how quickly D1527 moved to the toilet area and applied the ligature. I cannot therefore draw any conclusion as to whether Mr Fraser might reasonably have noticed what D1527 was doing sooner than he did.

46. Mr Ring sought to minimise the seriousness of his use of disrespectful and abusive language as a coping mechanism to deal with the sometimes traumatic nature of working at Brook House.⁵¹ He described it as “*banter between officers that have been dealing with [D1527] for some time*”.⁵² Mr Ring did not consider that staff using the terms ‘cock’ and ‘dick’ to refer to a detained person was problematic when said in private between staff.⁵³ I disagree. The pervasiveness of derogatory and abusive language by staff at Brook House in the relevant period, and the impact it had on their treatment of the detained people in their care, is discussed in Chapter D.9 in Volume II. In any event, and regardless of who Mr Ring may have been intending to address,

⁴⁶ [Stephen Loughton 1 March 2022 96/20-25](#)

⁴⁷ [Stephen Loughton 1 March 2022 89/23-90/4](#)

⁴⁸ [Stephen Loughton 1 March 2022 90/4-11](#)

⁴⁹ [Stephen Loughton 1 March 2022 103/5-9](#)

⁵⁰ [TRN0000001_002](#) at 24 rows 37-40; [TRN0000001_011](#) at 170 rows 21-25

⁵¹ [Nathan Ring 25 February 2022 101/3-14](#)

⁵² [Nathan Ring 25 February 2022 78/11-17](#)

⁵³ [Nathan Ring 25 February 2022 83/20-84/24](#)

he made unacceptable comments within earshot of D1527 and other detained people, and it is probable that D1527 heard what was said.

47. Mr Ring appeared to view the events of that day through the lens of how they impacted on staff. For example, in his oral evidence he referred to staff “*dealing with [D1527] for some time*” and to his perception that D1527 would do “*something to get a reaction*” when he wanted something, which he described as similar behaviour to his children.⁵⁴ However, Mr Ring was an experienced officer and he should have appreciated the heightened sense of vulnerability likely to be felt by someone who had just tied a ligature around his neck. I was alarmed by the lack of compassion that he displayed towards D1527 in his interactions with him on 25 April 2017. In my view, all staff working with vulnerable detained people, such as those on E Wing, should have been trained in mental health awareness to a level that enabled them to appreciate that disruptive behaviour may be a manifestation of mental ill health, requiring a referral to a medical professional.

48. While I make no criticism of Mr Loughton’s actions during the incident itself, his treatment of D1527 in the aftermath was far below what should be expected from any member of staff, and was particularly concerning from a manager. In his oral evidence to the Inquiry, Mr Loughton admitted to having been frustrated by the fact that Mr Fraser had not been observing D1527 as closely as constant observation requires.⁵⁵ Rather than addressing this apparent failure with Mr Fraser, the footage shows that Mr Loughton directed his frustration at D1527, seemingly blaming him for causing extra work and delaying the end of his shift.⁵⁶ I do not underestimate the impact on staff who carry out restraint in order to prevent self-harm or suicide by someone in their care. The potential for this to desensitise them to the distress of the people being restrained is addressed in Chapter D.9 in Volume II. However, given Mr Loughton’s role as Oscar 1, a position with authority and influence over junior staff, it is concerning that he did not conduct himself with more compassion and professionalism. Moreover, Mr Loughton’s evidence to the Inquiry was that he did not think it was possible to train staff to develop coping mechanisms in order to deal with highly stressful events.⁵⁷ As Mr Loughton is a current Assistant Director at Brook House, and therefore someone with considerable influence over how Brook House operates now, I found that this demonstrated a worrying lack of insight.

49. I considered whether D1527’s mental or physical health made him especially vulnerable to mistreatment during this incident. He had just self-harmed and, in order to remove the ligature from his neck, staff had restrained him. Given the distress that this was likely to have caused, the abusive words

⁵⁴ [Nathan Ring 25 February 2022 78/16-17](#); [Nathan Ring 25 February 2022 79/16-20](#)

⁵⁵ [Stephen Loughton 1 March 2022 98/3-10](#)

⁵⁶ [Day 2 AM 24 November 2021 00:34:29-00:53:24 \(KENCOV1007 - V2017042500020 08:47-26:36\)](#)

⁵⁷ [Stephen Loughton 1 March 2022 139/12-140/4](#)

that were used towards him were particularly unacceptable. In my view, the words were humiliating and debasing. I consider that there is credible evidence that his treatment during this first incident was capable of amounting to degrading treatment.

The second incident

The underlying facts

50. The footage covering the second incident recorded by Mr Tulley is approximately 28 minutes long.⁵⁸ It begins at approximately 20:30 with Mr Tulley sitting in the staff office, talking to another member of staff about D1527's earlier attempt to self-strangulate with a ligature. Mr Tulley then walked through E Wing to D1527's cell, the door to which was closed. There were four staff members, including Ms Buss and Mr Fraser, standing directly outside the door looking in and discussing D1527's attempts to smash the light in his cell.

51. Mr Tulley asked Ms Buss what D1527's problem was and she replied, *"He's an arse, basically. He can't get what he wants and I can't get what he wants."* Ms Buss speculated that D1527 might be attempting to get water into the light fitting, at which point Mr Ring asked if the cell still had running water.⁵⁹

52. After approximately three minutes, Mr Ring, Mr Tulley, Mr Fraser and Ms Buss went into D1527's cell. The footage does not show D1527 but, from the positions of Mr Tulley and the other staff, it is evident that he was on the floor in the toilet area where he had previously attempted to self-strangulate. D1527 did not speak. Mr Ring leaned over him and said:

"Still breathing, nothing 'round his neck, I've checked. If he's sucking a battery, he's sucking a battery."

He added, in a mocking tone of voice, *"So he wants to use it as his dummy, fine, I'm okay with that."* Mr Ring then asked Mr Tulley to watch D1527, which he agreed to do.

53. Shortly after the other staff left the cell, Mr Tulley heard D1527 choking, heaving and gasping for breath with his hands around his throat – he was trying to choke himself.⁶⁰ The footage demonstrates that Mr Tulley asked D1527, *"what are you doing?"*, and then repeatedly told him, *"Stop it. Stop. Mate, don't – don't do that. Don't do that."* He tried pulling D1527's hands

⁵⁸ [Day 2 AM 24 November 2021 00:53:55-01:23:53 \(KENCOV1007 - V2017042500021\)](#)

⁵⁹ It appears that staff had the ability to turn off power in a detained person's cell (see Chapter C.8 and [Callum Tulley 1 December 2021 54/7-56/3](#)), although it is unclear whether they could turn off running water

⁶⁰ [SXP000120_005](#)

away and pulled him into the middle of the cell. He then called out for assistance from other staff, who entered the cell shortly afterwards.

54. D1527 was still heaving, and Mr Fraser appeared behind him but did nothing. D1527 was on his back with his hands clasped around his neck. Mr Tulley and Mr Francis attempted to pull them away by taking hold of D1527's arms. Mr Fraser then took hold of D1527's legs. D1527 was struggling against the officers and making choking sounds.

55. At this point, Mr Paschali entered the cell. He knelt on the floor, straddling D1527, with D1527's head between his knees, and placed his hands either side of D1527's neck. D1527 stopped struggling but remained on his back, at which point Mr Paschali released his grip, removed his hands from D1527's neck and placed his left hand on his own left thigh. D1527 began breathing heavily and sounded distressed. Mr Tulley told him to relax, but D1527 started to scream and resist as Mr Paschali leaned forward over him, with his hands around D1527's neck and his chest over D1527's face. The footage shows Mr Paschali's hands placed firmly around D1527's neck, with his thumbs on the front of the throat around the area of the Adam's apple, and he appeared to be applying pressure. His fingers were down the side and back of D1527's neck. D1527 suddenly stopped screaming and started to make a guttural sound. Mr Paschali looked back to D1527, who was underneath him, and said to D1527 in a low voice:

"You fucking piece of shit, because I'm going to put you to fucking sleep."

It was only when Mr Tulley said, "Yan, Yan, easy", approximately 14 seconds later that Mr Paschali released his grip and D1527 gasped for breath. At this time, Ms Buss's shoes are visible in the footage where she is walking around behind Mr Paschali.

56. Mr Tulley told Sussex Police that Mr Paschali had:

"exerted an extremely high amount of pressure on to [D1527's] neck. It was a phenomenal amount of pressure which appeared to be concentrated on to [D1527's] airways."⁶¹

⁶¹ [SXP000120_006](#)

Figure 11: Mr Paschali applying pressure to D1527's neck

57. Mr Francis then said, *"Right, you're going to stop being a tool now, yeah? You're going to stop being an idiot? Yes or no? Yes or no? Yes or no?"* Mr Paschali was still holding D1527's neck. D1527 said, *"my neck"*, to which Mr Francis responded, *"Are you going to stop being a tool? Yes? Yes, or no?"* D1527 referred twice more to his neck but some of what he said is not audible on the footage. He was breathing deeply, and making whimpering and crying sounds. D1527 was then put into the recovery position and held there by Mr Paschali and Mr Francis. He began screaming and appeared to be in significant distress; he was still breathing heavily and making noises which suggested he was panicking. Both Mr Francis and Mr Paschali instructed him to calm down, but D1527 did not respond and continued to scream out unabated. He was plainly in severe distress.

58. Mr Fraser, Mr Tulley and Ms Buss were also in the cell. D1527 remained on the floor of the cell surrounded by the staff, during which time his top was removed. This was presumably so Ms Buss could carry out medical observations, albeit the only evidence of any observations was an attempt to obtain an oxygen saturation reading by placing a pulse oximeter on D1527's finger. Mr Francis repeatedly talked to D1527, shouting so that he could be heard over D1527's screams. On some occasions Mr Francis told him to calm down, but he also said, *"Come on, stop being a baby"* and *"Come on, we're*

getting bored.” He also asked, *“What are you, a man or a mouse?”* Mr Tulley commented, *“It would be nice if we had a manager in.”*

59. Approximately seven minutes after D1527 was put into the recovery position, the staff turned him onto his back and exited the cell. D1527 was left lying on the floor. Only then did he stop crying and screaming. Mr Tulley then left E Wing; he went to a staff toilet and cried.

60. When Mr Tulley returned to E Wing he discussed the incident with Mr Paschali, who said, *“no use of force, as it stands”*. Shortly afterwards, Ms Buss approached Mr Tulley and he relayed Mr Paschali’s words to her.

61. None of the officers involved submitted a Use of Force report in relation to this incident. Ms Mariola Makucka, an RGN, completed section 3 of a F213 form on behalf of Ms Buss (who had an injured hand and was unable to write – such forms were completed in hard copy at Brook House).⁶² It recorded:

*“Seen on E Wing room by RGN Jo. Detainee had placed a ligature around his neck, removed by staff. After this he went to [sic] toilet and attempt [sic] to self-strangulate. Hands removed from his neck. Slight redness noted on his neck.”*⁶³

62. Ms Buss also made an entry in D1527’s medical records:

“Examination: placed on rule 40 constant supervision as he refused to return to E wing.

called to E wing at approx 19.00

constant watch.

had placed a ligature around his neck. removed by staff

staff trying to engage with him.

RMN Dalia tried to engage with him with minimal effect.

put mobile phone battery in his mouth which he later removed battery removed from his room.

went to toilet and attempted [sic] to self-strangulate.

angry and not engaging with staff.

hands removed from his neck by staff.

salivating ++

unable to take any observations

visual obs resps 16

⁶² Section 3 of the F213 form is used to record healthcare staff’s observations of a use of force incident from a clinical perspective, as well as any injuries to the detained person. It is usually attached to the Use of Force report

⁶³ [CJS005534_010-011](#)

slight redness noted on his neck.

20.00 got up and walked around room

taken a small drink

restless. constant watch continues

not engaging with staff.

Plan: pls review later this evening.”⁶⁴

63. In the ongoing observations section of D1527’s ACDT record, Ms Buss recorded for 19:40:

“Seen in room 7. Constant watch. D1527 had tied a T-shirt around his neck. Angry, upset. Had mobile phone battery in his mouth. Attempted to self-strangulate in toilet. Visual obs due to demeanour. Resp 16.”⁶⁵

64. According to D1527, he tried to strangle himself shortly after the battery had been removed from his mouth.⁶⁶ He said that, after he tried to strangle himself, one member of staff called “Yan” sat on his head and that Yan strangled him.⁶⁷ As he was being strangled, D1527 explained that someone said something threatening to him, but that he does not remember what it was.⁶⁸ At that time, D1527 thought:

“that I was going to die, that the man doing this to me was going to kill me. I remember having a panic attack, and hyperventilating. I felt like I was having a heart attack.”⁶⁹

65. After this incident, D1527 stated that he was left on the floor of his cell, where he remained for about 30 minutes.⁷⁰ No one said anything to him, and only a nurse checked on him for a minute or so.⁷¹ He said:

“I just thought to myself after this that I wanted to die. I wanted to die more than I had before. I was already making regular attempts to try and end my life, but I just felt more and more hopeless. I felt so hopeless and alone in my cell after all the officers left.”⁷²

66. D1527 said that he did suffer some injuries as a result of the use of force, including “stiffness, soreness, and pain and redness in [his] neck”.

⁶⁴ [CJS001002_038](#)

⁶⁵ [CJS001085_017](#). ‘Resp 16’ is shorthand for ‘respiratory rate 16’ ([Dr Rachel Bingham 14 March 2022 17/4](#))

⁶⁶ [DL0000144_021](#) para 53

⁶⁷ [DL0000144_019](#) para 42

⁶⁸ [DL0000144_019](#) para 43

⁶⁹ [DL0000144_019](#) para 43

⁷⁰ [DL0000144_019](#) para 44

⁷¹ [DL0000144_019](#) para 43; [SXP000145_002](#)

⁷² [DL0000144_022](#) para 57

However, he explained that the more serious injury had been to his mental health. He described his symptoms as follows:

“I still suffer from flashbacks to this day, and to being [sic] strangled. He said he was going to kill me. I thought I would die. It was so traumatic for me. This is inside my head and isn’t going to leave any time soon. Anything that happens to the outside of the body can heal easily, but anything inside your head is very difficult to get better.”⁷³

67. Two weeks later, Mr Tulley covertly recorded a conversation between himself, Mr Paschali and another officer, DCO Derek Murphy. Mr Paschali described the use of force on D1527 as “so funny” and then said:

“I’m choking him and I thought ten more seconds and you’re going to sleep. He’s like ‘Yan, Yan, I think that’s enough’ and I’m like ‘no, I’ve got this, it’s proper, don’t worry about it.’”

Mr Paschali mimicked what he had done to D1527. Mr Tulley laughed and said, “I shat myself, I’m not going to lie but the nurse was right behind you Yan”, to which Mr Paschali responded “that’s why I didn’t though so yeah obviously that’s good”.⁷⁴

68. Mr Paschali provided the Inquiry with the same explanation he had given to both the PSU and Sussex Police in his interviews with them as part of their investigations following the broadcast of the *Panorama* programme, ie that he placed his hands on D1527’s neck in order to brace it.⁷⁵ He explained that he did so to prevent D1527 from swallowing whatever was in his mouth.⁷⁶ Mr Paschali said that he did not believe it was necessary to communicate with the other officers during the restraint because D1527 had self-harmed by attempting to swallow items before, and the staff therefore “all knew what we were dealing with”.⁷⁷ He sought to rely on Mr Francis’s question during the restraint – “Has he swallowed the battery?” – as evidence of the fact that he was not alone in believing that D1527 had something in his mouth.⁷⁸

69. Mr Paschali explained that he initially released his grip because D1527 had “calmed down”,⁷⁹ but also said that he did not know at what point the battery came out of D1527’s mouth.⁸⁰ Mr Paschali’s oral evidence was that he used the words “You fucking piece of shit, because I’m going to put you to

⁷³ [DL0000144_022](#) para 56

⁷⁴ [KENCOV1015 - V2017050900018](#)

⁷⁵ [CPS000019_016](#); [CJS001107_010](#) paras 6.24 and 6.25; [IPA000002_003](#) para 15; [Ioannis Paschali 24 February 2022 83/15-84/15](#)

⁷⁶ [CJS001107_010](#) paras 6.24 and 6.25; [IPA000002_003](#) para 15; [Ioannis Paschali 24 February 2022 83/15-84/15](#)

⁷⁷ [Ioannis Paschali 24 February 2022 113/7-114/5](#)

⁷⁸ [Ioannis Paschali 24 February 2022 120/16-22](#)

⁷⁹ [Ioannis Paschali 24 February 2022 117/5-6](#)

⁸⁰ [Ioannis Paschali 24 February 2022 119/16-17](#)

fucking sleep” as a command to gain D1527’s compliance, although he did also accept that the language was *“provoking, disrespectful and unprofessional”*.⁸¹ Mr Paschali said that he had deliberately given a false impression of what had happened on 25 April 2017 when he described *“choking”* D1527 two weeks later in order to *“wind up”* Mr Tulley, who was always seeking out stories.⁸²

70. Under questioning by Counsel to the Inquiry, Mr Paschali alleged that the footage of the incident had been edited to present a misleading picture of the events.⁸³

71. Mr Tulley told the Inquiry that he had interpreted Mr Paschali’s words – *“no use of force, as it stands”* – as an instruction from a more experienced officer.⁸⁴ Mr Paschali said he merely meant that the documentation did not need to be completed there and then.⁸⁵ Mr Paschali also told the Inquiry that he had completed a Use of Force report and left it in the E Wing office. He alleged that Mr Tulley had removed this to give a misleadingly negative impression.⁸⁶

72. Mr Francis told Sussex Police that, although he thought someone had mentioned a battery during this incident, he did not see it or know of its location.⁸⁷ He told the Inquiry that he recognised the inappropriateness of the way he spoke to D1527.⁸⁸ He described his approach to D1527 as trying to *“shake him back to reality, get him back to reality, so he’s not focusing on what had happened and trying to get him – a response out of him”*.⁸⁹ Mr Francis told the Inquiry that the account Mr Tulley gave to Sussex Police was accurate and that he did not agree with Mr Paschali’s assertion that he was bracing D1527’s neck.⁹⁰ Reflecting on why he did not report Mr Paschali’s actions, he could not explain other than to say *“my only answer would be I was shocked, I was shocked and mortified what I’d just seen”*.⁹¹

73. Mr Fraser told the Inquiry that he did not see Mr Paschali put his hands on D1527’s neck and did not hear him use verbally abusive words towards D1527.⁹² He explained that he mistakenly held D1527’s legs while facing with

⁸¹ [Ioannis Paschali 24 February 2022 73/5-16](#); [Ioannis Paschali 24 February 2022 113/18-114/1](#)

⁸² [Ioannis Paschali 24 February 2022 164/10-166/6](#)

⁸³ [Ioannis Paschali 24 February 2022 117/6-118/4](#)

⁸⁴ [Callum Tulley 9 March 2022 106/14-107/13](#)

⁸⁵ [Ioannis Paschali 24 February 2022 148/3-16](#)

⁸⁶ [Ioannis Paschali 24 February 2022 149/6-154/4](#)

⁸⁷ [SXP000105](#)

⁸⁸ [HOW000001_011](#) para 13bi

⁸⁹ [Charles Francis 3 March 2022 63/23-64/10](#)

⁹⁰ [HOW000001_014](#) para 13ki

⁹¹ [Charles Francis 3 March 2022 53/4-10](#)

⁹² [Clayton Fraser 28 February 2022 62/11-64/1](#)

his head towards D1527's feet (rather than facing towards his head as he had been trained to do).⁹³

74. Mr Francis and Mr Fraser told the Inquiry that they accepted that they had not completed Use of Force reports, but that this was not because Mr Paschali, or anyone else, had instructed them not to.⁹⁴

75. Ms Buss accepted that the pair of shoes seen on the footage walking around Mr Paschali were hers.⁹⁵ Despite this, she maintained that she was unaware of what was taking place.⁹⁶ Ms Buss told the Inquiry that she did not see Mr Paschali put his hands on D1527's neck, did not hear any choking noise, did not hear Mr Paschali say, "*I'm going to put you to fucking sleep*", did not hear D1527 repeatedly refer to his neck, and did not hear Mr Tulley saying to Mr Paschali, "*Yan, Yan, easy*".⁹⁷ Ms Buss said that, had she witnessed any of these things, she would have stopped the restraint.⁹⁸

Relevant expert evidence

76. The Inquiry's use of force expert, Mr Jonathan Collier, confirmed in a report to Sussex Police that the position of Mr Paschali's knees alongside D1527's head was as described and taught during use of force training. He described Mr Paschali's hands, however, as being around D1527's neck and his thumbs being driven into D1527's "*neck/throat area*".⁹⁹ Mr Collier considered whether Mr Paschali could have been misapplying an approved mandibular angle technique, but ultimately concluded that this is not evidenced by the footage.¹⁰⁰

77. Mr Collier explained to the Inquiry:

*"There is no guidance within the 2015 version of the training manual on how to either forcibly remove an object from the mouth, or how to prevent swallowing an object in the mouth."*¹⁰¹

However, he said that all members of Brook House staff would have been shown a medical DVD in their use of force training, which states that pressure should not be put on the throat or neck area during a restraint.¹⁰² Mr Collier

⁹³ [Clayton Fraser 28 February 2022 60/14-61/23](#)

⁹⁴ [Charles Francis 3 March 2022 71/12-74/19](#); [Clayton Fraser 28 February 2022 85/7-92/15](#)

⁹⁵ [Joanne Buss 14 March 2022 137/17-138/3](#)

⁹⁶ [Joanne Buss 14 March 2022 138/4-14](#)

⁹⁷ [Joanne Buss 14 March 2022 132/16-137/11](#); [Joanne Buss 14 March 2022 139/14-141/2](#); [INN000025_013-014](#) at 00:08:23, 00:08:30 and 00:09:09

⁹⁸ [Joanne Buss 14 March 2022 132/16-137/11](#); [Joanne Buss 14 March 2022 139/14-141/2](#); [INN000025_013-014](#) at 00:08:23, 00:08:30 and 00:09:09

⁹⁹ [SXP000133_003-004](#) para 11

¹⁰⁰ [SXP000133_004](#) para 12

¹⁰¹ [INQ000158_029](#) para 10

¹⁰² [SXP000133_003](#) para 9; [INQ000111_018](#) para 41

explained that doing so *“can result in serious injury and techniques of this type form no part of the restraint syllabus”*.¹⁰³

78. Mr Collier was clear that, in the circumstances, he would have expected Mr Paschali to communicate with the other members of staff present, and with D1527 himself, to explain that he was placing pressure on D1527’s throat in order to prevent D1527 from swallowing a battery. Mr Paschali did not do this. Mr Collier said that such communication was *“vital so that all parties understand what is happening and what needs to be done”*.¹⁰⁴

79. Dr James Hard, the Inquiry’s medical expert, was critical of Ms Buss’s failure to intervene in this incident. He observed that, during the use of force, he would have expected a reasonably competent nurse to be:

- *“observing the process of restraint/use of force for any signs of injury arising from any form of excessive control or restraint. This would include, but not be limited to, observing for any hold or application of pressure resulting in excessive pain or injury, i.e. that which went beyond what was necessary in order to obtain compliance from the detained person in submitting to the instructions being provided by the custodial officers”*;
- *“observing for anything that might indicate or suggest any form or signs of life-threatening injury, including but not limited to signs or symptoms of chest pain or airway compromise and be prepared to intervene accordingly”*;
- *“monitoring the heart rate and respiratory rate as a minimum and to have been making a record of the observations she had obtained. Given the level of distress of the detained person, it may have been too difficult to obtain peripheral oxygen saturation and blood pressure readings, but these should have been obtained as soon as practicably possible following the de-escalation of the incident. In the event that the nurse did not monitor the detained person as outlined then this would fall below the expected standard”*; and
- in the event that inappropriate or unauthorised techniques were being utilised, *“providing a verbal command to the member of staff to adjust, withdraw or stop the observed manoeuvre in order to make clear to that member of staff and any other witnesses to the event that the guidance was not being adhered to properly”*.¹⁰⁵

¹⁰³ [INQ000111_020](#) para 52

¹⁰⁴ [INQ000158_030](#) para 10

¹⁰⁵ [INQ000075_058](#)

80. Dr Hard also stated that, given the complexity of what was happening, Ms Buss’s duty as a nurse was to:

*“get amongst it and see what was going on and to take the relevant actions and the relevant steps at the relevant points, rather than to be a passenger in the situation”.*¹⁰⁶

He agreed with Counsel to the Inquiry that Ms Buss had a duty to intervene in this incident, and that this should have been at the forefront of her mind when Mr Paschali said, *“I’m going to put you to fucking sleep”*; when Mr Tulley said, *“Yan, Yan, easy”*; and when Mr Paschali put his hands around D1527’s neck. Such interventions could, and should, have included stopping the restraint.¹⁰⁷

Conclusions

81. The footage of the second incident on 25 April 2017 is among the most disturbing I have seen during the Inquiry. D1527 appeared profoundly distressed for a long period but was most acutely so following the application of Mr Paschali’s hands around his neck. For the reasons set out below, I am sure that Mr Paschali applied pressure to D1527’s neck.

82. Mr Paschali’s account that he believed D1527 to be attempting to swallow a battery does not stand up to scrutiny. I am sure that Mr Paschali did not believe that D1527 had any item in his mouth at the time that he placed his hands around D1527’s neck. It was a dishonest invention by him in a vain attempt to excuse why he had done so.

82.1 While it is clear from the conversations between staff throughout the afternoon and early evening of 25 April 2017 that many of them were aware that D1527 had placed a battery into his mouth at some point that day, I do not think Mr Tulley, Mr Fraser or Mr Paschali believed that he still had a battery in his mouth as he attempted to manually self-strangulate. Mr Francis asked, *“has he swallowed the battery?”* after Mr Paschali had already released D1527’s neck, and Mr Francis told Sussex Police that, although he thought someone had mentioned a battery during this incident, he did not see it or know of its location. No one else present mentioned a battery until after Mr Paschali had released the pressure on D1527’s neck.

82.2 If Mr Paschali had genuinely been trying to brace D1527’s neck to prevent him from swallowing a foreign object, it makes little sense for him to have removed his hand unless the object was clearly no longer in D1527’s mouth. Mr Paschali accepted that he did not know when the battery came out of D1527’s mouth, and was unable to provide an explanation as to why he felt it safe to remove his left hand from

¹⁰⁶ [Dr James Hard 28 March 2022 123/1-7](#)

¹⁰⁷ [Dr James Hard 28 March 2022 121/6-122/23](#)

D1527's neck in response to D1527 calming down, if his intention had been to brace his neck to prevent him from swallowing a foreign object.¹⁰⁸ This is illogical if he was genuinely bracing D1527's neck to prevent him from swallowing something. Moreover, Mr Paschali did not tell D1527 not to swallow or instruct him to stop struggling. Nor did he communicate with the other officers about what he was doing. In a situation where there is a genuine belief that a detained person's life is in imminent danger from choking on a foreign object, and there is no known technique to safely remove it, it is unfathomable that no conversation took place between staff about what they should do.

82.3 Mr Paschali provided no evidence to support his allegation that the footage of this incident had been edited, and I do not accept that there is any credibility to his claim.

83. I consider that D1527's screaming after Mr Paschali took control of his head caused Mr Paschali to become angry with D1527 and to exert pressure on his neck. I am sure that the words Mr Paschali used – *"You fucking piece of shit, because I'm going to put you to fucking sleep"* – bore a particular connotation. In my opinion, Mr Paschali's remark to D1527, given his extreme vulnerability at that moment, amounted to a deliberate threat to harm him. My impression is that Mr Paschali was seeking to punish D1527 for what Mr Paschali considered to be poor behaviour; indeed, he referred to him as *"a piece of shit"*. I do not accept that Mr Paschali released the pressure on D1527's neck because he believed that the risk of him swallowing an object had subsided; he stopped because Mr Tulley exclaimed, *"Yan, Yan, easy"*. Moreover, I do not find Mr Paschali's explanation of his conversation with Mr Tulley two weeks later, in which he described *"choking"* D1527, credible. There is no logic to fabricating a story about an event at which Mr Tulley was present. Rather, I am sure that Mr Paschali's comments accurately conveyed his actions and words during the restraint of D1527 on 25 April 2017.

84. Mr Paschali's actions towards D1527 on 25 April 2017 were the most extreme and disturbing example of mistreatment of any of the detained people at Brook House during the relevant period.

85. Even if I had accepted Mr Paschali's explanation, placing hands onto the neck of a detained person cannot be considered an authorised technique in any circumstances. I note that Mr Collier states that there are no approved methods in the 2015 Use of Force Training Manual for the removal of objects from the mouth. In the circumstances, I agree with Mr Collier that Mr Paschali ought to have been communicating with both the staff and D1527.

86. As was the case with many of the other officers involved with D1527 that day, I consider that Mr Francis's words demonstrate that he considered D1527 to be disruptive and difficult, and that he was frustrated with the

¹⁰⁸ Ioannis Paschali 24 February 2022 119/16-17

additional pressure that the staff were under as a result. He viewed D1527's actions through the lens of how they impacted on him and his colleagues, and had a disregard for D1527's mental distress.

87. Given Mr Fraser's position, I accept his account. He probably did not hear the words used by Mr Paschali or witness his hands around D1527's neck. However, as discussed in my analysis of the incident on 4 May 2017 below, Mr Fraser clearly became aware of what had taken place soon afterwards.

88. Given her position in the cell at the time of the restraint, I do not find Ms Buss's explanation that she was unaware of what was taking place credible. Based upon both the video and documentary evidence, I conclude that Ms Buss was in a position to see or hear the incident as set out above, and I consider it probable that she did witness this inappropriate conduct without challenging it or reporting it. She had a duty to do both. If, as she maintained when questioned by Counsel to the Inquiry, she could see "*hardly anything*", she should have intervened to stop the restraint until she was in a position to observe and monitor D1527's welfare.¹⁰⁹ I agree with Dr Hard that a reasonably competent nurse should observe the process of restraint or use of force for any signs of injury or danger to life arising from any form of excessive control or restraint.¹¹⁰ Ms Buss clearly failed in that duty. I believe that her failures in this regard showed that she was desensitised to the needs of detained people, who were her patients, to an alarming degree.

89. Ms Buss's entries in D1527's various records did not accurately capture the reality of the event, the fact that D1527 was restrained or his distress. The medical response to D1527's restraint on 25 April 2017 is discussed in Chapter D.8 in Volume II.

90. In relation to the missing Use of Force reports, Mr Paschali did not offer any plausible explanation as to why Mr Tulley would have removed his Use of Force report, or any evidence to support this allegation. I do not consider Mr Paschali's account credible and, therefore, I am sure that Mr Paschali did not in fact complete a Use of Force report. That notwithstanding, I accept the evidence of Mr Francis and Mr Fraser that Mr Paschali did not tell them not to complete a Use of Force report in relation to this incident. There were widespread weaknesses in the governance of the use of force, discussed in Chapter D.7 in Volume II. I find it likely that, in that climate, Use of Force documentation was not taken sufficiently seriously and that it was not unusual for staff not to complete the documentation that was required.

91. It is concerning that D1527's repeated and sustained attempts to self-harm that day did not prompt any of the Healthcare staff involved in his care to consider that there was an urgent need to refer D1527 to a GP for a Rule 35 report. The wing staff responding to D1527's self-harm were seemingly left to

¹⁰⁹ [Joanne Buss 14 March 2022 135/17-23](#)

¹¹⁰ [INQ000075_058](#)

manage these incidents as they arose, without any guidance or support from senior managers and with no input from clinical staff on how to safely manage the specific nature of D1527's self-harm and the risks this presented.

Mr Tulley's recognition that "*it would be nice if there was a manager*" is all the more significant for the fact that none of the staff involved with the incident appeared to even consider that a manager would come to assist. I discuss the impact of the absence of management and support further in Chapter D.9 in Volume II.

92. I carefully considered D1527's physical and mental health during the second incident on 25 April 2017 and whether it made him more vulnerable to mistreatment. He had just attempted to self-harm for the second time in a matter of hours and was extremely distressed. The experience of being restrained by staff and having pressure applied to his neck must have been terrifying. I am of the view that the words Mr Paschali used while his hands were around D1527's neck were particularly menacing, and I accept D1527's evidence that he feared for his life. Moreover, I find that the way Mr Francis spoke to D1527 was demeaning and, in the context of D1527's highly vulnerable state, more than likely exacerbated his distress. I find that there is credible evidence that his treatment in this second incident was capable of amounting to inhuman and degrading treatment.

93. I carefully considered whether there is credible evidence that D1527's treatment is capable of amounting to torture. Mr Paschali's hands were around D1527's neck for approximately two minutes and he was applying pressure for 14 seconds. This is likely to have caused D1527 intense physical and mental anguish. Given his vulnerabilities, this would have been highly traumatic. I took account of the exceptionally high threshold that mistreatment capable of amounting to torture would require. In my view, although this was an extremely serious incident, Mr Paschali's placement of his hands around D1527's neck and the application of pressure are not capable of meeting that threshold because they did not cause very serious and cruel suffering. This is because of their short duration and because of the lack of significant physical injury to D1527.

4 May 2017

The underlying facts

94. D1527 gave an account of the events that took place on D Wing on 4 May 2017 in his written statements to the Inquiry.¹¹¹ He said that he had asked DCO Precious Okolie Nwokeji for a plate and that she had mistakenly thought he was asking for more food, had refused him and had been

¹¹¹ [DL0000144_025-029](#) paras 68-80; [DL0000209_033-058](#) lines 47-49

confrontational and aggressive.¹¹² D1527 said that her reaction had made him angry and so he returned to his cell, threw his food into the bin and closed the door. D1527 said that an officer brought him a plate that he then broke and put into the bin.¹¹³ He then left his cell and was surrounded by officers, which made him anxious. He panicked and jumped onto the safety netting to escape. D1527 described holding a piece of the broken plate to his neck and telling Mr Tulley that if he came up the stairs towards him, he would jump from the netting.¹¹⁴ He described officers and nurses running to speak to him and that this had the effect of making him more stressed.¹¹⁵

95. The Inquiry saw footage covertly recorded by Mr Tulley on 4 May 2017. The first piece of footage is approximately 12 minutes long and begins with Mr Tulley asking Ms Okolie Nwokeji what was causing all the noise on D Wing.¹¹⁶ A substantial amount of commotion and shouting can be heard in the background. Ms Okolie Nwokeji responded that D1527 was “[inaudible] *like a bitch because he was told about a plate*”. Mr Tulley then walked on to D Wing to where the second-floor railings met the safety netting. D1527 was distressed. He was on the netting, shouting and screaming in both Arabic and English, making gestures with his arms and intermittently running and pacing around the netting. The wing was noisy with both staff and detained people leaning on the railings surrounding the netting and shouting to D1527. As a result, much of what D1527 was saying is not decipherable, although he can be heard repeatedly shouting “*Leave me alone*” and “*Nobody talk to me*”. Some staff and detained people talked to D1527 and appeared to be trying to persuade him to come down from the safety netting, while other detained people can be heard laughing at D1527 and making jokes about the situation. There were a large number of people, both detained people and staff, present on the wing and no one appeared to know what to do.

96. Approximately six minutes after he arrived on D Wing, Mr Tulley and other officers discussed whether the wing should be ‘locked down’ (meaning that the detained people would be locked into their cells). Mr Tulley asked the manager in attendance, DCM Steven Dix, whether this should happen. Mr Dix’s response cannot be heard on the footage but he did not appear to agree that the wing should be locked down. In response, an officer identified to the Inquiry only as ‘Sunil’ said to Mr Tulley, “*ridiculous, we should be locking up*”. Mr Tulley responded, “*I know.*” Mr Tulley and Sunil continued to stand where the second-floor railings met the safety netting and watched D1527. Other officers and detained people can be seen on the footage leaning on the railings

¹¹² [DL0000144_025-026](#) paras 69-70

¹¹³ [DL0000144_026](#) para 70

¹¹⁴ [DL0000144_026](#) para 71

¹¹⁵ [DL0000144_026](#) para 72

¹¹⁶ [Day 2 AM 24 November 2021 3:01:52-3:24:08 \(KENCOV1012 - V201705040021 17:45 - V201705040022 09:08\)](#)

of the second floor, also watching and shouting to D1527. D1527 continued to shout and pace around the netting.

97. Approximately 10 minutes into the footage, Sunil commented to Mr Tulley that he had attempted to start locking up the wing but had been told not to. Sunil commented to Mr Tulley that the presence of other detained people was *"Making it worse"*. Mr Tulley responded, *"Yeah, I suppose."*

98. The Inquiry saw a further piece of footage, which is nine minutes long, beginning with D1527, Mr Tulley and Sunil in the same locations they were in at the end of the earlier footage.¹¹⁷ The wing was still extremely loud and a large number of detained people were milling around. There remained some confusion among the officers regarding whether or not they ought to have been locking the wing down. After approximately 4 minutes 25 seconds a detained person began loudly singing the lyrics of the song 'I Believe I Can Fly'. This continued intermittently for four minutes.

99. After approximately nine minutes, Mr Dix told Mr Tulley to go to C Wing. When Mr Tulley returned to D Wing, as shown in another piece of footage, it was quieter and all the detained people appeared to have been locked into their cells.¹¹⁸ D1527, however, was still standing on the netting, shouting and screaming in Arabic. While he could not be seen, he sounded as though his distress had increased as his shouting was louder and the speed at which he was speaking had significantly increased. Mr Tulley spoke to Mr Fraser, one of the officers who had been involved in the restraint of D1527 nine days earlier on 25 April. Mr Tulley asked, *"What is the best way to deal with someone like this?"* Mr Fraser laughed and said, *"What Yan did."*

100. Mr Tulley then walked towards Mr Dix and other staff, who were leaning on the railings of the wing and discussing D1527, who was still on the safety netting in front of them. Next to the staff, two detained people were talking in Arabic to D1527, who was still shouting. Mr Tulley said to Mr Dix, *"What if he jumps?"*, to which Mr Dix replied, *"It's his own choice, isn't it?"*. Mr Dix told Mr Tulley to go with Sunil to Reception to assist DCM Shane Farrell, the manager based in that unit. Mr Farrell then arrived on D Wing and told Mr Tulley that he should remain there and assist with locking detained people in their cells. As Mr Tulley and Sunil discussed the confused directions that they had been given, a large group of staff were standing staring at D1527.

101. After approximately four minutes, another group of staff, including Mr Dix, then walked down to the lower landing. Mr Dix addressed the group of staff and, although some of what he said was inaudible, he can be heard saying, *"Rule 40 [of the Detention Centre Rules 2001], bring him down, let him know about the escorts."*

¹¹⁷ [KENCOV1012 - V201705040022 clip 1](#)

¹¹⁸ [KENCOV1012 - V201705040022 clip 2](#)

102. While the group of staff were standing with Mr Dix on the lower landing, D1527 left the safety netting. Several officers moved quickly up the stairs towards the second floor and can be heard discussing which officers were to act as a team. Mr Dix asked if someone could locate D1527's ACDT record. A small number of officers were outside a cell on the second-floor landing. Ms Churcher had arrived on D Wing and she asked Mr Tulley, "*Is he okay? Do we know?*" and laughed. Mr Tulley replied, "*I don't know. Your guess is as good as mine.*" Sunil, Mr Tulley and Ms Churcher talked with another member of staff about the event that led to D1527 climbing onto the netting. Ms Churcher said, "*If he didn't have to do the washing up, he didn't have to go that far, did he?*" Sunil told the other staff that D1527 had wanted a clean plate and Ms Churcher asked incredulously, "*Is that what this has been about?*"

103. Mr Tulley called up to DCO Ryan Bromley, one of the officers on the second-floor landing, and asked what was happening. Mr Bromley replied that D1527's ACDT observations were being increased to 'constant'. The footage ends with Mr Tulley leaving D Wing.

104. The Inquiry also saw footage of two conversations about D1527, both of which were covertly recorded by Mr Tulley on that same day, 4 May 2017.¹¹⁹ These conversations included Mr Sanders telling other officers that he had assaulted D1527, and Mr Stokes saying that the best way to deal with D1527 was to "*turn away and hopefully he's swinging*". These conversations, and the related findings, are discussed at the beginning of this chapter.

105. The closed-circuit television (CCTV) footage does not cover the restraint itself, as this took place within the cell.¹²⁰ It does show Mr Dix, Mr Bromley, DCO Mohammed Shaukat and DCM Michael Yates assembled outside the cell that D1527 was in. Mr Dix and Mr Yates entered the cell first, and the other officers waited outside. They were then joined by DCO Ben Wright and one other officer. Some 8 minutes 30 seconds later, Mr Bromley, Mr Wright and Mr Shaukat entered the cell. Healthcare arrived two minutes later, and the officers left the cell with D1527 walking in handcuffs and held by Mr Bromley and Mr Yates. Mr Dix was walking alongside the group.

106. The footage then shows the officers walking D1527 through the corridors to the stairs. D1527 walked compliantly with the officers, but appeared to be agitated. At the top of the stairs, D1527 appeared to focus his frustration on Mr Yates. Mr Dix appeared to try to engage with D1527 for roughly 1 minute 40 seconds. However, when this did not work, Mr Dix replaced Mr Yates on D1527's right arm. D1527 then moved compliantly down the stairs with the officers. When the group arrived in E Wing, D1527 appeared

¹¹⁹ [KENCOV1012 - V2017050400026](#); [KENCOV1012 - V2017050400028](#)

¹²⁰ [Disk 41 05 May 2017 1727](#) (this footage is out of sequence due to a technical issue, and shows D1527 being moved from the stairs to E Wing first, and then leaving his cell with the officers much later)

calmer and waited patiently with Mr Dix and Mr Bromley for an officer to open a cell.

107. A Use of Force report was completed by four officers, who reported attending the cell where D1527 went after he had climbed down from the safety netting.¹²¹ These officers were Mr Dix, Mr Bromley, Mr Shaukat and Mr Yates.

108. In his Use of Force report, Mr Dix wrote that he had explained to D1527 that he could not leave him alone due to his behaviour. Mr Dix said that D1527 had refused to comply with his instructions (ie to accompany staff to E Wing) and became irate. Mr Dix said that D1527 had started to fiddle with his pockets, refusing to empty them out or remove his hands. Mr Dix wrote that, knowing D1527 had a significant history of self-harm, he feared that he might have something in his possession that could be used to harm himself or others. Force was therefore initiated to prevent this and to relocate D1527 to E Wing. Mr Dix said that he took hold of D1527's right arm and then handed over this role to Mr Yates before placing handcuffs on D1527. He added that he took over from Mr Yates as they were leading D1527 down the stairs because *"D1527 has an issue with DCM M Yates"*.¹²²

109. Mr Yates recorded that Mr Dix had explained to D1527 that he would need to go to E Wing while there was an investigation into him having climbed onto the safety netting. Mr Yates wrote that D1527 refused and reached into his right pocket. In response to the instruction to remove his hands, Mr Yates recorded that D1527 said, *"You'll see what's in my pocket"*, and then stood up with his hands clenched. Mr Yates wrote that he took control of D1527's right arm during the restraint. He wrote that D1527's *"level of aggression escalated"* as the officers tried to lead him from the cell and that, as they were about to leave D Wing, D1527 began struggling. Mr Yates wrote that he applied a thumb flexion (a pain-inducing technique or PIT) to D1527 and that once they reached the top of the stairs Mr Dix took over his role in the restraint. Mr Yates did not describe what procedure he followed, if any, prior to using the PIT.¹²³

110. Mr Bromley wrote that he and Mr Shaukat waited outside the cell while Mr Dix and Mr Yates went inside to talk to D1527. He said that he went into the cell in response to hearing D1527 shouting aggressively, and saw that D1527 was reaching for his right pocket while attempting to swallow his phone. Mr Bromley recorded that he took hold of D1527's left arm during the restraint.¹²⁴

111. Mr Shaukat also recorded that he and Mr Bromley were waiting outside the cell and went inside in response to D1527's loud and aggressive tone

¹²¹ [CJS005530](#)

¹²² [CJS005530_008](#)

¹²³ [CJS005530_018](#)

¹²⁴ [CJS005530_014](#)

towards Mr Dix. Mr Shaukat wrote that D1527 was uncooperative and described him standing up with both fists closed. He also wrote that D1527 tried to reach for something in his right pocket while attempting to swallow his phone. He wrote that he took control of D1527's head during the restraint.¹²⁵

112. In his witness statement to the Inquiry, D1527 said that several officers came into the cell. He said that Mr Dix and Mr Yates came in first and that they were then joined by Mr Bromley, Mr Shaukat and Mr Wright. D1527 said that the officers told him that he had to go to E Wing, but he did not want to go. He said that there was no attempt to negotiate with him.¹²⁶ D1527 said that he believed he may have threatened to swallow his phone but that at no time did he put his hands into his pockets.¹²⁷ At the time he provided his statement as part of judicial review proceedings, D1527 said that he put the back cover of his phone into his mouth, and the officers forcibly removed it.¹²⁸ D1527 said that Mr Bromley was the first to use force against him and that Mr Shaukat grabbed his neck.¹²⁹ He added that Mr Yates had been aggressive and had twisted his arm back, which he believed was a deliberate attempt to hurt him.¹³⁰ D1527 also stated that Mr Wright was present throughout the restraint.¹³¹ D1527 said that the officers dragged him from his cell to E Wing.¹³²

113. Mr Dix recorded the following reasons for removing D1527 from association on the Rule 40 documentation:

*"[D1527] has been relocated to CSU on rule 40 after jumping on Delta [D] wing netting. [D1527] removed himself after approximately 30 minutes, he went to a friend's room to calm down. I spoke to [D1527] about his behaviour and the consequences of his actions. He refused to comply with the instructions given. [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 onto E008 and watched constantly for a couple of hours after the use of force, A [sic] full search was also conducted and nothing was found."*¹³³

¹²⁵ [CJS005530_011](#)

¹²⁶ [DL0000144_027](#) para 75

¹²⁷ [DL0000144_027](#) para 75; [DL0000144_028](#) para 78

¹²⁸ [HOM032221_013](#) para 48

¹²⁹ [DL0000144_027-028](#) paras 76-77; [DL0000144_028](#) para 79

¹³⁰ [DL0000144_027](#) para 76

¹³¹ [DL0000144_028](#) para 77

¹³² [DL0000144_027](#) para 77

¹³³ [CJS001026_007](#). A 'full search' is a search of an individual that requires the removal and inspection of all clothing and footwear. The search must be conducted by two officers of the same sex as the individual, and the individual must not be completely naked at any stage or in the view of others not involved in conducting the search. See [CJS000713_004](#) para 7

114. In her evidence to the Inquiry, Ms Churcher said that she could not recall whether she had been called to attend D Wing because D1527 had jumped onto the safety netting, or whether she was already there for another reason.¹³⁴ She said that she decided to stay on D Wing after D1527 had come down from the netting because she had a relationship with him.¹³⁵ She told the Inquiry that she could not remember any conversations with Mr Dix about making D1527 subject to Rule 40 (removal from association) and did not believe that she had been involved in the decision to do so.¹³⁶ In her written statement to the Inquiry, Ms Churcher said that it did not take much to upset D1527.¹³⁷ Under questioning from Counsel to the Inquiry, she accepted that D1527's apparently disproportionate reactions should have been taken seriously as they were a potential sign of increasing vulnerability.¹³⁸

115. In his evidence to the Inquiry, Mr Fraser said that he regretted the words he had used and the fact that he had laughed when saying them.¹³⁹ He told the Inquiry that, by 4 May 2017, it was "*common gossip*" among officers that Mr Paschali had "*restrained the guy, the gentleman, by his neck*".¹⁴⁰ Mr Fraser maintained that he learned this from other officers and had not witnessed Mr Paschali's actions at the time.¹⁴¹

116. Following the *Panorama* broadcast, the PSU carried out an investigation into the circumstances of the incident on 4 May 2017.¹⁴² D1527 said that he was assaulted by six officers who came to his cell on 4 May 2017.¹⁴³ He also complained that Rule 40 was inappropriately used to manage his mental illness and to punish him for his disturbed behaviour.¹⁴⁴ The PSU found neither of these complaints to be proven.¹⁴⁵

Relevant expert evidence

117. Mr Collier took the view that Mr Dix's control of the incident while D1527 was on the netting was "*very poor*". He said that staff appeared uncertain of what to do, and that allowing the detained people to remain free to roam around the wing made communication between staff very difficult. He criticised

¹³⁴ [Karen Churcher 1 March 2022 32/4-9](#); [DWF000022_018](#) para 83

¹³⁵ [DWF000022_018](#) para 83

¹³⁶ [DWF000022_018](#) paras 84-86

¹³⁷ [DWF000022_018-019](#) para 91

¹³⁸ [Karen Churcher 1 March 2022 31/9-25](#)

¹³⁹ [Clayton Fraser 28 February 2022 99/2-19](#); [Clayton Fraser 28 February 2022 101/1-9](#)

¹⁴⁰ [Clayton Fraser 28 February 2022 100/4-6](#); [Clayton Fraser 28 February 2022 102/11-103/1](#)

¹⁴¹ [Clayton Fraser 28 February 2022 100/11-20](#)

¹⁴² [CJS001107](#)

¹⁴³ [CJS001107_008-009](#) paras 6.1 and 6.13

¹⁴⁴ [CJS001107_008](#) paras 6.1 and 6.8

¹⁴⁵ [CJS001107_030](#) para 7.90; [CJS001107_035](#) para 7.126

the lack of a negotiation strategy to facilitate D1527's removal from the netting.¹⁴⁶

118. Mr Collier deduced from Mr Dix's decision to take three additional staff with him to speak to D1527 that Mr Dix anticipated the conversation would be difficult. In those circumstances, and given the earlier events of the day, Mr Collier considered it unacceptable that Mr Dix did not activate his body worn camera.¹⁴⁷

119. Mr Collier said in his first report to the Inquiry that *"the level of force used, and the necessity are all justified and there is no evidence that anything other than reasonable force was used"*. However, in his second report he raised concerns that a PIT was used when D1527 was handcuffed and that no information was provided by Mr Yates.¹⁴⁸ In his oral evidence to the Inquiry, Mr Collier said that there was no evidence to suggest that D1527 was posing such a risk to staff, or to himself, that use of the thumb flexion would have been warranted.¹⁴⁹ Mr Collier commended Mr Dix for taking over control of D1527's arm from Mr Yates, and considered this to be an *"excellent example of removing a trigger from an already frustrated and angry young man"*.¹⁵⁰

Conclusions

120. Mr Dix was the DCM who responded to D1527 climbing onto the safety netting. He was responsible for directing staff and making decisions about how to manage and resolve the incident. I agree with Mr Collier's assessment that Mr Dix's control of the incident scene was *"very poor"*. The covertly recorded footage shows a loud, chaotic scene where multiple staff were present but appeared unsure of their roles. Several sought instructions from Mr Dix and could not understand why they were not told to lock down the wing. It is clear from the footage that the uncontrolled environment on the wing was preventing any productive efforts to de-escalate the situation and persuade D1527 to climb down. Detained people shouted to and at D1527, and one man sang loudly for several minutes.

121. There is no evidence that an appropriate command structure was considered or implemented, as it should have been for such an incident.¹⁵¹ This may have assisted Mr Dix in taking control of the situation. For example, it would have enabled him to communicate with a senior manager about what resources were needed to bring the incident to a safe conclusion. In the event,

¹⁴⁶ [INQ000111_071](#) para 282

¹⁴⁷ [INQ000111_069](#) para 270

¹⁴⁸ [INQ000111_073](#) para 219; [INQ000158_043](#) para 17.4

¹⁴⁹ [Jonathan Collier 30 March 2022 133/3-136/8](#)

¹⁵⁰ [INQ000111_071](#) para 277

¹⁵¹ [Lee Hanford 15 March 2022 62/16-66/7](#); [INQ000111_154](#) para 656. See also [Detention Services Order 05/2015: Reporting and Communicating Incidents Out of Hours in the Immigration Detention Estate](#), Home Office, April 2016 (updated most recently in [April 2021](#)), para 16

Mr Dix did not call on the support or expertise of Ms Churcher, an RMN who was present at the time, and therefore missed an opportunity to de-escalate the incident sooner. Mr Dix's inappropriate and insensitive reference to it being D1527's "*choice*" to jump was unacceptable. As he was the manager in charge, this both displayed intolerance to D1527's distress and also suggested to more junior staff that there was no safe strategy to manage the situation.

122. It is plain from Rule 40 documentation that Mr Dix made the decision to make D1527 subject to Rule 40 as an automatic consequence of his behaviour (being on the netting).¹⁵² There is no explanation as to why this was in and of itself sufficient for D1527 to meet the criteria, which gives the impression that Rule 40 was being used as punishment. In any event, by the time that D1527 was moved to the CSU, he was off the netting and had returned to his cell. In the circumstances, Mr Dix ought to have reassessed the situation and come to a clear recorded decision as to whether it remained necessary in the interests of security or safety for D1527 to be made subject to Rule 40 and, if so, why.

123. Mr Dix's decision to carry out a full search of D1527 once they were on E Wing was not unreasonable because of D1527's history of self-harm and the fact that he had said he intended to swallow his phone earlier that day.

124. I consider that Mr Yates did not provide an adequate explanation in his Use of Force report as to why the use of a PIT on D1527 was justified. It is notable that none of the other officers involved in the use of force recorded that a PIT was used – even Mr Dix, whose role as supervising officer was to monitor any force used. I agree with Mr Collier that there is no evidence to warrant the use of this technique. The explanation as to why D1527 protested against Mr Yates in particular is not sufficiently explored in the Use of Force reports submitted by any of the staff involved, but it can be clearly seen from the CCTV footage that D1527 was expressing his frustration verbally only. Mr Yates's use of a PIT was not reasonable or proportionate in the circumstances. I consider that the appropriate course of action was to replace Mr Yates in the restraint, which Mr Dix subsequently did.

125. Mr Fraser's comment that "*what Yan did*" was the best way to deal with D1527 was wholly inappropriate, and had the effect of suggesting that he condoned Mr Paschali's actions. I cannot be sure about what Mr Fraser saw during the events on 25 April 2017. However, he had clearly become aware of Mr Paschali's actions in the meantime. Mr Fraser's comment was made to Mr Tulley and not in the presence of D1527 or any other detained people. However, his joking reference to what amounted to a terrifying ordeal for a highly vulnerable man was callous, unprofessional and demonstrated a lack of compassion towards D1527.

126. Ms Okolie Nwokeji's reference to D1527 as a "*bitch*" was disrespectful and unprofessional. While her comment was also made to Mr Tulley and not in

¹⁵² [HOM000319_003](#)

front of D1527, there were other detained people in the vicinity. This casual use of derogatory terms to refer to someone in distress accords with the other evidence the Inquiry has seen and heard: abusive and dismissive language was routine and ingrained. I discuss this in more detail in Chapter D.9 in Volume II.

127. Given Ms Churcher’s explanation that she remained on D Wing because she had a relationship with D1527, it is regrettable that she did not attempt to accompany the officers who went to speak with him once he had climbed down from the safety netting. Ms Churcher should have taken the opportunity to discuss the potential that D1527’s reaction indicated the need for a mental health assessment. Instead, she entered into a casual conversation with officers during which they mocked D1527’s behaviour as irrational. As a regulated and trained healthcare professional, her behaviour was particularly inappropriate.

128. Mr Yates was the only staff member involved in this use of force to be interviewed by the PSU. The investigator chose not to invite Mr Dix to interview on the basis that his written reports were sufficiently detailed and video footage was available,¹⁵³ but in my view this did not obviate the need to question him about his control of the incident while D1527 was on the netting. There is no evidence of whether the other staff involved were invited to interview and, if not, why not.

129. Despite the evidence of D1527’s mental health issues and his significant self-harm history, D1527’s decision to climb onto the netting was dealt with as one of wilful disruption rather than a manifestation of mental illness. In its written Closing Statement to the Inquiry, G4S describes staff at the time as being “*in a bind*” in relation to where to locate D1527 following this incident.¹⁵⁴ I accept that, by the time D1527 climbed down from the netting, staff were likely to have felt that they had limited options about where he could safely be located. However, the series of decisions by those in charge of managing the incident contributed to the lack of options. For example, D Wing ought to have been locked down and staff ought to have included Ms Churcher in meaningful negotiations with D1527 while he was still on the netting. Such actions may have had the effect of de-escalating the situation, offering staff the opportunity to determine the real cause of D1527’s actions and bring the incident to a prompt and peaceful conclusion. The failure to take such actions led to a situation in which there was no opportunity to calmly resolve the incident and ultimately ended with D1527 being forcibly moved to the CSU. In Chapter D.7 in Volume II, I discuss the issue of force being used too readily in response to incidents of self-harm, to manage the behaviour of those with mental health issues, and to move detained people to E Wing or the CSU. The response to D1527 during this incident is an example of such an issue.

¹⁵³ [CJS001107_008](#) para 5.14

¹⁵⁴ [G4S Closing Statement](#) 20 May 2022 para 393

130. The failure to lock down the wing led to D1527 being taunted by other detained people. In addition, there was no strategy to persuade D1527 to leave the netting (such as involving mental health colleagues or initiating a command structure). The excess time he spent on the netting surrounded by other detained people was unacceptable. Taking account of D1527's particular vulnerabilities, I consider that this incident would have been experienced by him as humiliating. The management of the incident on 4 May 2017 resulted in D1527 being exposed to a distressing and humiliating experience for longer than was necessary. In my view, there is credible evidence that these facts are capable of amounting to degrading treatment.

Chapter C.5:

D687 on 13 May 2017

1. D687 told the Inquiry that he was born in Somaliland and came to the UK with his family in 1994 as a child.¹ He said that he spent 987 days in immigration detention from March 2015 to November 2017. D687 was detained at Brook House between October 2015 and May 2017.²

The underlying facts

2. On 7 March 2017, Ms Daliah Dowd, a Registered Mental Health Nurse (RMN), completed a mental health assessment of D687 during which he disclosed that he had been a victim of childhood sexual abuse. D687 remained under the review of the mental health team at Brook House; however, his mental health appeared to deteriorate.³ On 24 April 2017, D687 reported that he had considered suicide and had started writing a note.⁴ On 5 May 2017, D687 threatened to take an overdose.⁵ He was placed on an Assessment Care in Detention and Teamwork (ACDT) plan, and was to be assessed hourly by a Detention Custody Manager (DCM).⁶

3. On 6 May 2017, observations of D687 were reduced to once every three hours during the day and once every two hours at night.⁷ On 8 May 2017, D687 disclosed that he had thoughts of harming himself but said that he would not act on those thoughts.⁸ He subsequently missed three scheduled follow-up appointments, two with the Brook House GP and one with an RMN.⁹ His observations were not increased.

4. The Inquiry saw footage covertly recorded by Detention Custody Officer (DCO) Callum Tulley on 13 May 2017.¹⁰ The footage begins with Mr Tulley

¹ [DPG000021_002](#) para 2

² [DPG000021_002](#) para 5

³ [CJS001139_007-009](#)

⁴ [CJS001139_009](#)

⁵ [CJS001139_010](#)

⁶ [CJS000993_006-007](#). [Detention Services Order 01/2022: Assessment Care in Detention and Teamwork \(ACDT\) \(INQ000214\)](#), Home Office, October 2022, provides mandatory operational guidance for implementing “a holistic approach to self harm and suicide prevention within the broader context of decency and safety”; see p5

⁷ [CJS000993_012](#)

⁸ [CJS000993_013](#)

⁹ [CJS001139_011](#)

¹⁰ [KENCOV1016 - V2017051300011](#)

approaching an accessible toilet in the Reception of Brook House. DCM Christopher Donnelly, DCM Shane Farrell and DCO Jonathan Martin were standing at the door to the toilet. D687 was inside the toilet and can be heard saying:

“I have had enough, I’m taking my own life, you lot can put me in a body bag and take me out of here, that’s the only way I’m leaving this toilet.”

5. Mr Tulley moved into the accessible toilet. D687 reacted strongly and shouted:

“what the fuck you doing, I swear to God I’ll kill myself ... don’t come near me, I swear to God I’ll let myself go”.

He was sitting on the edge of the toilet with a ligature around his neck. The ligature was secured to the wall behind him at a point approximately one foot above his head. D687 was holding onto the ligature with his right hand and had an unlit cigarette in his left hand.

Figure 12: D687 in the accessible toilet with a ligature around his neck



6. For approximately 11 minutes, D687 told the staff that he no longer wanted to live and explained why. He said that he did not want to be transferred to another immigration centre (he was about to be moved to The Verne immigration removal centre in Dorset) and expressed frustration at the length of time he had been detained. He also complained that he had not had access to a doctor and that his mental health had deteriorated since he arrived at Brook House. He said that his identity had been taken away from him, that he had been moved away from his loved ones, and that he felt alienated. He repeated multiple times that he had had enough and explained to the officers where he wanted to be buried.

7. The footage shows that D687 was upset but coherent. He remained sitting on the toilet with the ligature around his neck while the officers engaged him in conversation and attempted to de-escalate the situation. D687 told the staff not to come near him and that, if they did, he would allow himself to drop onto the ligature. In response, Mr Donnelly said:

“Well, we’ll wait for a minute until you pass out and then we’ll cut you down.”

8. Approximately 11 minutes into the footage, Mr Daniel Haughton (the G4S Support Services Manager who was acting as Duty Director) can be heard speaking to D687. Approximately one minute later, Mr Haughton walked into the accessible toilet, where he offered D687 a light for his unlit cigarette. D687 stood, but kept hold of the ligature. Mr Haughton then made a sudden movement towards D687 and appeared to take hold of him. The other officers in the accessible toilet immediately joined in the restraint and, as Mr Tulley was involved in the struggle, it is not clear from the footage exactly what took place. Mr Haughton did not say anything to D687 or to his colleagues. After four seconds, an officer said, *“ok, it’s off”*, but this was shortly followed by another officer saying that *“it”* was in fact still around D687’s neck.

9. Thirty-four seconds after the restraint began, Mr Haughton said, *“Right, the ligature is away.”* Shortly afterwards, both D687 and the staff stopped moving. D687 calmly and repeatedly told staff to get off him, and that it was still his intention to die. He said *“This ain’t over”* and promised *“I will be leaving here in a box.”* At this time, the camera was angled towards the basin of the toilet and D687 and the other officers cannot be seen, as Mr Tulley was still involved in the restraint.

10. Approximately 90 seconds after force was first initiated, there was a sudden change to D687’s tone of voice. He said, with some urgency and in a raised tone, *“Get off my fucking arm, bruv! Get off bruv. Look, I’m on the cuffs.”* For a period of approximately 40 seconds, D687 repeatedly referred to his arm, asking one of the officers to stop resting on it and telling him, *“you’re breaking my fucking arm”*. D687’s tone changed from being calm and polite, saying *“can you get off my arm please”*, to making threats to bite and spit if the officer did not do so. There was no audible response. D687 also complained that his head was in the toilet.

11. After some movement, the camera reveals that D687 was restrained face down on the floor. Later, as Mr Tulley stands up, it becomes clear that he was restraining D687’s legs. D687 was then helped to his feet and led from the accessible toilet into an adjoining area within Reception. His hands were still handcuffed behind his back and Mr Haughton told him to sit down on a chair, which he did without physical resistance.

12. Once seated in Reception, D687 continued to voice his frustrations and also repeated his intention to take his own life.

13. An F213 form (a form completed by healthcare staff following the use of force, to record any injuries that have been sustained by the detained person) was completed by Ms Emily Parr, a Registered General Nurse. Ms Parr recorded:

“Minimal force used, refused to show hands/ arms, slight red mark to neck. No other physical health issues when seen.”¹¹

14. Later that day, D687 was taken to Dorset County Hospital with a suspected rib fracture.¹² In his witness statement to the Inquiry, D687 explained that he did not tell Ms Parr about his ribs, as the pain was not initially noticeable, but that he started to experience bad pain about one hour into his transfer to The Verne.¹³ D687’s medical records indicate that officers informed healthcare staff at The Verne that D687 had been diagnosed with bruised ribs when he returned there after being discharged from hospital.¹⁴

15. Following the *Panorama* broadcast, D687 complained to the Home Office Professional Standards Unit (PSU) about the use of force against him on 13 May 2017.¹⁵ He alleged that he was verbally abused, including being told to “*Fuck off back to your own country*”, and that, in response to his threats to hang himself, an officer told him, “*Do it if you are going to do it.*”¹⁶ D687 also said that he was physically abused during the restraint and that his arms were twisted, his legs pinned down, his neck grabbed and his face pushed into the ground. He also said that he had been kned,¹⁷ and then later punched, in the ribs.¹⁸ D687 added that he told a nurse that his chest was hurting and that he could not breathe.¹⁹ The PSU carried out an investigation and determined that the restraint was reasonable, necessary, proportionate and used for the minimum amount of time.²⁰ The PSU commented that it found D687’s account to lack credibility.²¹

16. In his written statement to the Inquiry, D687 said that he was told on 13 May 2017 that he was being transferred to another immigration centre. He was moved to Reception in preparation for the transfer and placed in an area with an adjacent accessible toilet. D687 described sitting alone for at least

¹¹ [CJS005652_028](#)

¹² [DPG000014_061](#)

¹³ [DPG000021_075](#) para 213

¹⁴ [DPG000014_062](#)

¹⁵ [HOM002725_011](#) paras 6.1.17-6.1.32

¹⁶ [HOM002725_012](#) para 6.1.21; [HOM002725_013](#) para 6.1.24

¹⁷ [HOM002725_011](#) para 6.1.20

¹⁸ [HOM002725_011](#) para 6.1.26

¹⁹ [HOM002725_011](#) para 6.1.21

²⁰ [HOM002725_045-046](#) paras 7.5.37-7.5.42

²¹ [HOM002725_040](#) para 7.5.10; [HOM002725_041](#) para 7.5.13

30 minutes and thinking about the events in his life that had led to this situation.²² He said:

“I felt worthless and scared. I didn’t know anything about the centre where I was being taken except that it was far away. I had had enough of it all. I felt I’d been through too much.”²³

17. In his statement, D687 described entering the accessible toilet and believing that he had locked the door. He then used the T-shirt that he was wearing as a ligature, attaching one end to the support rail on the wall and placing the other end around his neck.²⁴ D687 described saying prayers in preparation to hang himself but that, before he could do so, Mr Martin came into the toilet area. D687 recalled Mr Martin calling for other staff to assist. Mr Tulley arrived first and then left to locate other officers, with whom he returned.²⁵

18. D687 wrote in his statement that the officers made efforts to talk with him but that he felt *“None of them got it.”* He described some of the officers as calm but recalled Mr Donnelly’s comment that, if D687 dropped his weight onto the ligature, *“Then we’ll wait for a minute until you pass out and then we’ll cut you down.”* D687 said in his statement that this remark *“added to my feeling of worthlessness”*.²⁶

19. In his statement, D687 described his recollection of the use of force. He said that an officer who he now knew to be Mr Haughton offered him a light for his cigarette and then, as he got closer, *“Lunged for my neck”*. D687 stated that all the other officers then *“instantly charged”* at him.²⁷ He said that he felt unable to breathe while the ligature was being removed from his neck and that, even once the T-shirt had been removed, the weight of the officers upon him meant that he still felt unable to breathe.²⁸ He described the incident as *“frightening”*.²⁹ D687 said that he did not understand why the officers were still on top of him when he was calm and already handcuffed. He wrote that it appeared to him that the officers were *“prolonging the incident, during which I was in pain and struggling to breathe”* and recalled that he said, *“Get off my fucking arm ... look I’m on the cuffs.”*³⁰ D687 added that it was at this point that he recalled *“Someone putting what felt like all their body weight through my arm, which is behind my back.”* He added:

²² [HOM002725_071-072](#) paras 202 and 203

²³ [DPG000021_071-072](#) para 203

²⁴ [DPG000021_072](#) para 204

²⁵ [DPG000021_072](#) paras 205 and 206

²⁶ [DPG000021_073](#) para 209

²⁷ [DPG000021_073-074](#) para 210

²⁸ [DPG000021_074](#) para 211a

²⁹ [DPG000021_074](#) para 211b

³⁰ [DPG000021_074](#) para 211b

“The pain was really intense and completely unnecessary. As I say, I had already been restrained and was in handcuffs. I think it was done just to cause me pain.”³¹

20. Mr Haughton wrote in his Use of Force report that there had been concerns that D687 would be resistant to the transfer that was planned for 13 May 2017.³² He described seeing D687 sitting on the toilet with a T-shirt tied loosely around his neck, with part of it attached to the handrail on the wall. He wrote that, if D687 had dropped his weight onto the ligature, the knot would have dropped to the lowest part of the rail and would not have applied pressure.³³ Mr Haughton did not explain in his report that he offered D687 a light for his cigarette in order to get closer to him. Mr Haughton described in his report how he had asked another officer, DCO Darren Bulled, for his fish knife (a knife with a protected blade that can be used to cut a ligature without any hazard to the operator or the person restrained) while out of D687’s sight in order to prepare to remove the T-shirt from D687’s neck. He said that he then tried to engage with D687 and asked if he wanted a light for his cigarette. When D687 said yes, he moved a little closer and, as D687’s *“attention was on the lighter [I] grabbed the knot attached to the handrail. With this [D687] dropped to the floor and the knot attached to the handrail came away.”* He added that he removed the ligature from around D687’s neck when the other officers restrained D687, without the need for the fish knife.³⁴

21. Mr Haughton said that his motivation to get closer to D687 was to remove the ligature from his neck and not to instigate force against him.³⁵ In his oral evidence, Mr Haughton accepted that, by not communicating his intentions to his colleagues, he placed them in a situation where they had to react spontaneously.³⁶ Mr Haughton said he had intended to act in the *“best interests of everyone there to sort of bring that to a quick and safe resolution”*.³⁷ He justified his actions to deceive D687, saying:

“The risk was still relatively low. It might not have strangled him. I couldn’t be 100 per cent sure. Hence why when I had the opportunity to secure it and remove that risk, I did. Who is to know what would have happened if he’d dropped. He could have banged his head on the toilet bowl and suffered a severe head injury. I don’t know.”³⁸

³¹ [DPG000021_074](#) para 211c

³² [CJS005652_008](#)

³³ [CJS005652_009](#)

³⁴ [CJS005652_009](#)

³⁵ [Daniel Haughton 16 March 2022 109/4-111/11](#); [SER000543_036](#) para 164

³⁶ [Daniel Haughton 16 March 2022 110/20-23](#)

³⁷ [Daniel Haughton 16 March 2022 110/25-111/3](#)

³⁸ [Daniel Haughton 16 March 2022 111/22-112/3](#)

In his statement, Mr Haughton accepted that he could have taken a more strategic approach to managing the incident with D687. He conceded that, now he is more experienced, *“I would probably deal with a similar situation differently, for example, through a planned intervention.”*³⁹

22. In Mr Martin’s Use of Force report, he wrote that he discovered D687 sitting on the toilet with the ligature and a cigarette, and that he contacted the control room and asked for a manager and more staff to assist. He said that Mr Farrell and Mr Donnelly arrived and tried to reason with D687.⁴⁰

23. Mr Tulley recorded in his Use of Force report that Mr Donnelly had asked him to accompany him to Reception, where D687 had entered the toilet and attached a ligature. He said that Mr Martin and Mr Bulled were monitoring D687, who had the ligature around his neck and attached to a handrail.⁴¹

24. In Mr Farrell’s Use of Force report, he wrote that he had taken control of D687’s right arm because Mr Tulley appeared to be struggling. He also ticked a box to indicate that he had used an inverted wrist hold technique against D687.⁴² In an interview with the PSU, which conducted an investigation into D687’s complaint, Mr Farrell acknowledged that an inverted wrist hold affects people’s pain threshold at different levels but said that he did not apply any pressure. Mr Farrell also stated that D687 had not said that his wrist was hurting at any point.⁴³

25. In his oral evidence to the Inquiry, Mr Donnelly accepted that he should not have said *“we’ll wait for a minute until you pass out and then we’ll cut you down”*. He said that the intention behind his comment had been to point out to D687 the futility of him harming himself. Mr Donnelly added, *“I was trying to persuade him to give up the ligature.”*⁴⁴ In his oral evidence to the Inquiry, Mr Farrell said that he could not recall Mr Donnelly’s comment to D687 but that, if he had heard it, he would have challenged it.⁴⁵

³⁹ [SER000453_037](#) para 166

⁴⁰ [CJS005652_020](#)

⁴¹ [CJS005652_012](#)

⁴² [CJS005652_025](#)

⁴³ [HOM002725_022](#) para 6.4.17

⁴⁴ [Christopher Donnelly 23 February 2022 148/19-149/8](#)

⁴⁵ [Shane Farrell 8 March 2022 105/11-23](#)

Relevant expert evidence

26. The Inquiry's use of force expert, Mr Jonathan Collier, noted that staff engaged with D687 for at least 11 minutes before Mr Haughton intervened. Mr Collier wrote:

*"In order for force to be lawful it has to be when there is an imminent risk of harm and that all other options have been exhausted. The engagement should have continued with an aim for D687 to remove the ligature and be escorted peacefully. It is accepted that escort staff were waiting but negotiation and persuasion must always be the prime resolution option."*⁴⁶

27. In respect of Mr Haughton, Mr Collier said:

*"Using subterfuge as a means to get closer can remove all trust that a detainee has in staff and will make future incidents more difficult to resolve. Additionally as the senior person he should not have become actively involved and should have taken a supervisory role, where he could monitor the staff and detainee."*⁴⁷

28. He considered that the incident should have been managed as a "planned incident". This would have involved a structured response including negotiation, recording of the incident on either a handheld device or a body worn camera, a member of Healthcare in attendance, and management by a DCM. Mr Collier stated that, as D687 was only threatening self-harm, there was ample time for a plan to have been made.⁴⁸

29. Despite his criticisms of the fact that force was used, Mr Collier considered that the techniques employed were proportionate, except for:

- Mr Tulley's restraint of D687's legs once he was on the ground; and
- Mr Farrell's use of an inverted wrist hold.

⁴⁶ [INQ000111_056-057](#) para 220

⁴⁷ [INQ000111_057](#) para 221

⁴⁸ [Jonathan Collier 30 March 2022 91/7-92/8](#)

30. In relation to the leg restraint, Mr Collier wrote:

“A fourth officer to control the legs is only used when necessary and when the control is being compromised by excessive movement or resistance. It appears this was a routine application rather than for exceptional circumstances. The use of a ‘leg officer’ must only be when the situation requires additional control, for instance if staff are struggling to gain control of the upper body and the detainee is using their legs to prevent staff applying restraints. Any use beyond this is not necessary and more force than necessary. There is no evidence within the statements to suggest it was necessary on this occasion and therefore I conclude it was disproportionate to the threat at the time.”⁴⁹

31. Mr Collier said that the use of the inverted wrist hold by Mr Farrell was not justified, as this technique was only to be used in the most extreme circumstances in cases of an immediate risk of harm, and the staff had confirmed to the PSU that D687 was not difficult to restrain.⁵⁰ Moreover, he commented that there was no evidence to suggest that the protocols for applying a pain-inducing technique (PIT) had been followed, or that there was any justification for inflicting pain. He noted that handcuffs can be applied with no pain being caused at all.⁵¹

Conclusions

32. It is clear from the covert footage of the incident that D687’s life was not imminently at risk and he was not posing a threat to the safety of the officers. Although D687 was upset, he was responding calmly to the staff, who were successfully engaging with him. As such, there was no justification for the use of force and the officers should have continued in their efforts to de-escalate the situation.

33. It is incumbent on every officer only to use force when it is necessary. It is clear from the position of the officers in the accessible toilet that they were not anticipating that force would be needed. However, in my opinion, once Mr Haughton had moved towards D687 and taken hold of the ligature, he had effectively instigated a use of force. The other officers did not therefore initially act unreasonably in how they responded.

34. Mr Haughton failed to assess the situation and to consider and exhaust all options available to him before using force against D687. The force was therefore unnecessary. In my opinion, as the senior manager in attendance, Mr Haughton should have ensured that Healthcare staff were present and that

⁴⁹ [INQ000111_057](#) para 223

⁵⁰ [Jonathan Collier 30 March 2022 99/4-99/13](#)

⁵¹ [Jonathan Collier 30 March 2022 100/11-22](#)

either Mr Donnelly or Mr Farrell had activated their body worn cameras, owing to the risk that force would be used. Mr Haughton's use of the lighter to get close to D687 was underhand and deceptive, and I consider that it was likely to have had the effect of eroding trust between D687 and the staff. I agree with Mr Collier's comment on this issue.

35. Mr Donnelly's comment to D687 was completely inappropriate and demonstrated both a lack of professionalism and a disregard for D687's distress. I consider it probable that Mr Farrell did hear what Mr Donnelly said to D687, and therefore he ought to have challenged it. The footage shows that Mr Donnelly made this comment within one minute of arriving at the scene with Mr Farrell and Mr Tulley. Even if Mr Farrell was not in the accessible toilet at the time, the acoustics at the start of the footage demonstrate that what is being said inside the toilet can clearly be heard by those outside.

36. There is no evidence that D687 was using his legs to resist the use of force. I agree with Mr Collier that Mr Tulley's restraint of D687's legs was therefore unnecessary and disproportionate.

37. Mr Farrell's application of an inverted wrist hold was also unnecessary and disproportionate. It is clear from the audio of the covert footage that there was a sudden change in D687's demeanour at the point when he felt pain in his arm. The effect of the wrist hold was to increase D687's distress and prolong the need to restrain him. Before the application of the wrist hold, D687 was talking calmly and reiterating his intention to take his own life. After the wrist hold was applied, he began threatening to spit at and bite staff. Mr Farrell's action therefore appeared to have the effect of escalating rather than de-escalating the situation.

38. With the exception of Mr Donnelly's unacceptable comment to D687, the interactions between the officers and D687 while he was seated on the toilet were appropriate and professional, and appeared to be aimed at de-escalating the situation. I did not hear evidence of abusive language towards D687 before or during his restraint. However, I do not consider that the force used against D687 was necessary as a last resort. The use of the inverted wrist hold was disproportionate and had the effect of causing unnecessary pain to a detained person who was clearly in distress. The failure on the part of any manager to activate their body worn camera was unacceptable.

39. It is not clear from the footage whether force was applied to D687's ribs or torso. D687 clearly alerted staff to the pain in his arm during the restraint but did not voice any complaint about other pain or discomfort at this time. However, in his witness statement D687 said that he was only aware of rib pain some time later, once his transfer to The Verne was under way.⁵² His medical records indicate that he was diagnosed with bruising to his ribs

⁵² [DPG000021_075](#) para 213

following examination at Dorset County Hospital later that day.⁵³ In my view, it is likely that the injury to D687's ribs resulted from the use of force against him at Brook House.

40. D687 disclosed thoughts of self-harm in the days preceding the incident on 13 May 2017. He missed three scheduled appointments with the mental health team between 5 May 2017 and 13 May 2017, and there were no apparent attempts to follow these up with D687, despite him being subject to an ACDT at the time.⁵⁴ In my opinion, he was left more vulnerable as a result. I discuss the issue of missed mental health team appointments in Chapter D.8 in Volume II.

41. I considered D687's likely state of mind at the time of the incident and the impact that these events would therefore have had on him. D687 was subject to an ACDT, was expressing his intention to take his own life and had taken steps to prepare to do so. In my view, he was therefore more vulnerable to mistreatment. I accept that Mr Donnelly's comment added to his feelings of worthlessness and that he was frightened by the restraint. I consider that D687 probably felt humiliated both by his restraint and by the comment made by Mr Donnelly in these circumstances. I also accept D687's evidence to the Inquiry that he experienced intense pain: a PIT was used, he could be heard complaining about pain to his arms and he was later diagnosed with bruised ribs. In my view, there is credible evidence that D687 was treated in a way that is capable of amounting to inhuman and degrading treatment.

⁵³ [DPG000014_062](#)

⁵⁴ [CJS001139_010-012](#); [CJS000993](#)

Chapter C.6:

D1914 on 27 May 2017

1. D1914 is a Romanian national.¹ He told the Inquiry that he had arrived in the UK as a European Union citizen in 2009, and had a long-term partner here. He has two children who live in Romania.² D1914 was detained at Brook House between March and August 2017.³

The underlying facts

2. D1914 suffered from ischaemic heart disease, which was recorded in his medical notes on his admission to Brook House.⁴ D1914 did not report any significant mental health issues prior to 27 May 2017, but he was reported to have a history of self-harm and to have been aggressive towards medical staff on eight occasions.⁵ On 6 May 2017, D1914 complained to Ms Emily Parr, a Registered General Nurse, that he was experiencing regular chest pain, and on 15 May 2017 he reported that his symptoms also included chest tightness.⁶ In his witness statement to the Inquiry, D1914 explained that the exacerbation of these symptoms caused him to fear that he would have a heart attack.⁷ D1914's medical history provides important background to what occurred on 27 May 2017.

3. On 27 May 2017, Dr Husein Oozeerally, lead GP at Brook House during the relevant period and at the time of the Inquiry's public hearings, wrote to G4S and the Home Office:

*"The above detainee [D1914] is fit to fly and fit for detention. He will need a medical escort due to the nature of his medical condition. I am happy for reasonable force to be used (C and R) in order to facilitate the removal."*⁸

4. Detention Custody Manager (DCM) Steven Dix told the Inquiry that he spoke to D1914 on 27 May 2017 regarding his removal directions for a flight

¹ [DL0000229_001](#) para 2

² [DL0000229_001](#) para 4

³ [DL0000229_002](#) para 5; [DL0000229_003](#) para 8

⁴ [CJS0074524_001](#)

⁵ [CJS0074524_001, 003, 005, 006, 008, 014, 015](#)

⁶ [CJS0074524](#)

⁷ [DL0000229_005](#) para 10

⁸ [CJS001160](#)

the following day.⁹ DCM Nick London authorised D1914's move to E Wing under Rule 40 of the Detention Centre Rules 2001 (removal of association). Mr London recorded that the justification for the move was *"to maintain good order and discipline of the centre"* and that D1914 was *"refusing to relocate to Eden Wing"*.¹⁰ However, an IS.91RA Part C form submitted the same day records that D1914 *"stated that he would kill himself rather than return to Romania, because of this threat he has now been placed onto ACDT [Assessment Care in Detention and Teamwork] constant supervision and is now on Rule 40"*.¹¹

5. The Inquiry heard and saw evidence of a number of conversations between staff about the planned use of force on D1914 that day. Footage covertly recorded by Detention Custody Officer (DCO) Callum Tulley shows him talking to DCO David Webb and DCO Ioannis (Yan) Paschali in a staff room with a film playing in the background.¹² Mr Tulley asked Mr Webb to show him how to use the shield. Mr Webb stood up and held a shield at an angle of approximately 45 degrees away from himself. He told Mr Tulley to *"Hit with the edge, anywhere between the knee and the throat"*, and then added, *"just keep fucking going. Keep going until you can't go any further."*

6. A further clip appears to follow on shortly after this conversation, as Mr Tulley, Mr Webb and Mr Paschali were still in the staff room, Mr Tulley was in the same position and the same film was playing in the background.¹³ The footage starts with DCM Stephen Loughton reading the letter from Dr Oozeerally to the Home Office. Mr Loughton informed the officers that D1914 had had a *"bypass. Triple bypass, heart attack, triple bypass booking in for August"* and told them to meet in the staff room in Personal Protective Equipment (PPE) at 19:00. Mr Loughton then left the room and Mr Tulley, Mr Webb and Mr Paschali continued the conversation. The Inquiry obtained a transcript of this conversation:

"Callum Tulley: Now you've got me nervous for slightly different reasons now.

Yan Paschali: Oh, relax man. you will be fine.

Unknown Male Speaker: If he dies, he dies.

Yan Paschali: Yeah, exactly.

Unknown Male Speaker: It's nothing on us.

⁹ [SER000437_006](#) para 22

¹⁰ [CJS001768_002](#)

¹¹ [CJS001768_006](#)

¹² [KENCOV1025 - V2T017052700011](#)

¹³ [KENCOV1025 - V2T017052700011](#)

Dave Webb: At the end of the day [inaudible] rolling his fucking head [inaudible] with the shield, so I wouldn't worry about it.

Yan Paschali: I was here all night [inaudible], mate. Just leave it.

Yan Paschali: I was just here all night. [inaudible].

Dave Webb: Just don't choke him out, without it will be fine.

Unknown Male Speaker: Or punch him in the chest.

Dave Webb: Yeah, yeah.

Yan Paschali: He's stupid like that. Which we've seen.

Unknown Male Speaker: Leaning knee on his chest, I might.

Dave Webb: Walk over his back."¹⁴

7. Later that day Mr Tulley spoke to DCO Daniel Lake in the library; this conversation was also caught on camera.¹⁵ Mr Lake used the computer there to access information about D1914 and read his prior convictions to Mr Tulley. Mr Lake told Mr Tulley that D1914 was a "nutter". The two officers discussed D1914's medical history, including the fact that he was scheduled to undergo heart bypass surgery. Mr Lake referred to the fact that a doctor had said the officers could use force on D1914, despite his medical issues, and speculated that D1914 might fake having a heart attack. The conversation ended with Mr Lake laughing and saying, "If he dies, he dies." Under questioning by Counsel to the Inquiry, Mr Lake stated that he believed people detained in Brook House might fake health problems to postpone their removal.¹⁶ He said that he could not remember saying "If he dies, he dies" but that, if he had said it, it would have been because of "the culture at Brook House".¹⁷

8. A fourth clip of footage, again filmed later that day, shows a conversation between Mr Tulley and Mr Webb regarding the planned use of force against D1914. Mr Tulley asked "What if he dies?" and Mr Webb responded, "No, we've got that disclaimer." He told Mr Tulley that he would get copies of the document so that "You've actually got a fucking copy of the doctor's letter."¹⁸

9. The final clip of footage shows Mr Tulley, Mr Paschali, Mr Webb and DCO Alice Brown in a staff room putting on their PPE.¹⁹ Approximately

¹⁴ [TRN0000087_016-017](#) lines 594-612. On the transcript, the words "If he dies, he dies" and "It's nothing on us" are attributed to Mr Webb. The Inquiry accepts, however, that it was not Mr Webb who made those comments

¹⁵ [KENCOV1025 - V2017052700012](#)

¹⁶ [Daniel Lake 1 March 2022 41/2-12](#)

¹⁷ [Daniel Lake 1 March 2022 42/8-22](#)

¹⁸ [TRN0000087_020](#)

¹⁹ [KENCOV1025 - V2017052700019](#); [TRN0000087_029-030](#)

7 minutes 35 seconds into the footage, Mr Tulley's covert camera was covered as he put on his overalls, but the conversations in the room could still be heard. Approximately 40 seconds later, Mr Webb said that D1914 had obtained "a *shit load of spice*" and was intending to smoke it. Mr Webb said that he thought this was the reason why D1914 would be subjected to a full search.²⁰ In a later conversation, approximately 15 minutes into the footage, Mr Webb joked with the other officers that D1914 might have or pretend to have a heart attack. Mr Webb referred to D1914 as a "cunt".

10. The Inquiry saw a recording of the briefing provided by Mr Dix to the officers who were going to restrain D1914, and a recording of the conversation immediately before the briefing as captured by Mr Tulley.²¹ As can be seen from Mr Tulley's covert footage, the briefing was formally recorded on a handheld camera by DCM Nathan Ring, who had been designated as the officer responsible for recording the use of force.

11. In the conversation prior to the briefing, Mr Dix explained to Mr Tulley that, as soon as the door of the cell was opened, Mr Tulley was to enter and stand right in front of D1914 with the shield in order to stop D1914 "*doing anything* [to himself]". Mr Tulley sought clarification as to whether or not he was expected to use the shield and Mr Dix confirmed, "*Anything you feel or anything Yan feels or anything like that, and I miss it, then you just deal with it as normal.*" Mr Dix then said, "*At the end of the day you lot have got to justify it.*"

12. In the briefing that followed, Mr Dix told the officers that D1914 had removal directions for the following day. Mr Dix added:

"He is refusing to go on this flight and is refusing to relocate to Eden Wing. The estimated pickup time is 09:00 and this is during the core regime time hence why the move needs to be done before."

Mr Dix told the officers, "*Despite negotiations by myself and DCO Sean Sayers it has not been possible to resolve the situation peacefully.*" He informed them that D1914's cell mate had reported that D1914 "*had bought some spice and he was planning to smoke it so he ends up dying or ends up in hospital to stop his removal directions*". This was said to be another reason why the move to E Wing could not wait.²²

13. The Inquiry saw the handheld camera footage of the use of force, which lasted for just over 18 minutes and was recorded by Mr Ring.²³ The footage

²⁰ A 'full search' is a search of an individual that requires the removal and inspection of all clothing and footwear. It must be conducted by two officers of the same sex as the individual, and the individual must not be completely naked at any stage or in the view of others not involved in conducting the search. See [CJS000713_004](#) para 7

²¹ [KENCOV1025 - V201705270019; TRN0000087_031-033](#)

²² [KENCOV1025 - V2017052700020\(a\)](#)

²³ [Disk 50 UOF 134.17 cam 3](#)

begins with the officers standing outside D1914's cell in full PPE. Mr Tulley entered D1914's cell and instructed him not to move. Mr Webb, DCO Sean Sayers, DCO Ryan Bromley, DCO Jonathan Edon, Mr Lake, Mr Dix and another unidentified manager followed closely behind. D1914's cell mate, who was sitting on the bed at the left-hand side of the cell, stood up and walked out of the cell with Mr Bromley, Mr Edon, Mr Lake and Mr Sayers. D1914 was lying on the bed at the right-hand side of the cell and was naked from the waist up. Mr Dix remarked that D1914 was holding his chest and asked that a member of Healthcare staff check him. D1914 was quiet and Mr Paschali asked him to walk to E Wing, which he verbally refused to do. Mr Paschali and Mr Webb helped D1914 to a seated position. Mr Webb held D1914's hand while Mr Paschali held his forearm, and D1914 was bent forwards, audibly breathing heavily. Medical observations were carried out by two members of Healthcare staff, who discussed D1914's oxygen saturation and blood pressure. While the observations were made, D1914 leaned towards Mr Paschali and rested his head on his arm. He then sat up and explained to the staff around him that he did not want to fly back to his country, that he had "*bail next week*" and that his family were in the UK. He also informed the staff that he had suffered three heart attacks and mentioned an operation. Mr Paschali told D1914 that he was just being moved to E Wing and reassured him that he was not being placed on a flight. D1914 said that he did not want to go. The atmosphere appeared calm and neither D1914 nor any staff were speaking in raised voices.

Figure 13: D1914 sitting on his bed being held by Mr Paschali and Mr Webb, and attended to by Healthcare



14. After approximately 5 minutes 15 seconds, Mr Dix asked the Healthcare staff, "*Happy?*", to which Mr Eddie Omoraka (a Registered Mental Health Nurse) replied, "*Yeah.*" Mr Dix then said, "*Okay. So, [D1914], you're going to*

go to E Wing.” D1914 replied that he did not want to go and Mr Dix asked him twice more to walk compliantly, with the warning that the officers would “assist” him if he refused. On both occasions, D1914 responded, “No.” Mr Dix then gave the other officers an instruction to use force. There were 14 seconds between Mr Omoraka saying that he was happy with D1914’s medical observations and Mr Dix authorising the use of force.

15. Mr Webb and Mr Paschali moved D1914 from the bed and he immediately sank to the floor. Multiple officers told him to stand up. Mr Dix continued to ask D1914 to stand and walk, and he appeared to get partially to his feet with the assistance of the officers, but then to sink back to the floor. As he did so, Mr Tulley took control of his head. D1914 shouted “*help me*” and “*I am no criminal, why you do this?*”. He told the officers, “*if I die you are responsible*”. D1914 remained on the floor and Mr Dix told him that if he did not stand up and walk he would be placed in handcuffs and carried, which would cause him pain. D1914 asked to call his wife, which Mr Dix confirmed he could do once he was on E Wing.

16. D1914 tried to stand up a second time, with the support of the officers, but then appeared to sink back to the ground. Mr Dix gave D1914 one last chance to stand up, and said that he would be placed in handcuffs and lifted if he did not. D1914 asked why he was being restrained and said that he had had three heart attacks. He spoke with a raised voice, and was audibly upset. Mr Dix said “*I’m not discussing it with you now*” and asked D1914 twice more if he would stand and walk. D1914 again asked why he was being moved, and so Mr Dix instructed the other officers to “*put his hands behind his back*”.

17. At that time, D1914 was seated on the floor of his cell with his right leg tucked underneath him and his left leg stretched out to the side. In order to move D1914’s hands behind his back, Mr Paschali and Mr Webb pushed D1914 forwards on top of his right leg so that his head and neck were parallel to the ground. Mr Tulley maintained control of D1914’s head. D1914 remained in this position for a total of 1 minute 35 seconds. D1914 cried out in apparent pain, and could be heard breathing deeply and saying, “*Please, I have died. I am tired.*” After one minute in this position D1914 said, “*please I’m good, I finish, sorry*”. He could be heard panting. Neither the officers nor the Healthcare staff raised any concerns regarding D1914 being held in this position.

Figure 14: Officers restraining D1914 on the floor as handcuffs are applied behind his back



18. When the handcuffs had been applied to D1914, he was allowed to sit back up and the head restraint was removed. D1914 could be heard panting heavily, and was still positioned with his chest leaning forwards over his right leg.

Figure 15: Officers restraining D1914 on the floor following the application of handcuffs



19. Mr Dix again asked D1914 if he would stand up and walk, to which D1914 replied, *"It's not possible to walk"*, still panting heavily. Mr Dix responded, *"Well it is. So the officers are going to assist you."* Mr Webb then suggested the possibility of using an evacuation chair. Mr Dix asked D1914 if he would sit in a chair, but D1914 did not respond and remained leaning forwards and panting heavily. Mr Dix therefore instructed the officers to help D1914 onto the bed, which they did.

20. D1914 sat down on the edge of the bed, with his hands handcuffed behind his back. A voice could then be heard saying *"Dixie, Dixie"*, and Mr Dix moved to speak to someone behind Mr Ring (the camera operator), who said, *"he can't sit down, get him up"*. Mr Dix responded *"okay"* and instructed D1914 to stand up and walk with the officers. He said that in order for the handcuffs to be removed and for D1914 to be able to sit in the evacuation chair, D1914 had to become compliant. Mr Webb said *"We gotta get him moving because he's in cuffs"* and the person behind Mr Ring again tried to get Mr Dix's attention. In total, D1914 was sitting on the bed while handcuffed for 30 seconds.

21. D1914 got to his feet with Mr Webb holding his right arm and Mr Paschali holding his left. While this was happening, the person behind Mr Ring told Mr Dix again that D1914 *"has got to stay on his feet the whole time"*, to which Mr Dix responded, *"it's a bit hard [inaudible]"*. D1914 asked for his shoes and told the officers that he was *"not feeling good"*. Mr Dix responded, *"Healthcare are here so the quicker we get going, the quicker we can release you."* Mr Dix then left the cell and D1914 followed, supported by Mr Webb and Mr Paschali.

22. As D1914 walked slowly and without physical resistance along the wing, he stated, *"Big complain. If I die today night, all people is responsible for this."* As D1914 exited C Wing, with Mr Webb and Mr Paschali still holding his arms, he said to Mr Omoraka:

"You are a Black shit man, fuck your mother ... you are responsible for me, you take my blood pressure. Today night, if I die, that's a big problem."

23. D1914 was walked into a cell on E Wing and told by Mr Dix that a full search was going to be carried out. Mr Dix asked D1914 if he would comply and remove his clothes himself. D1914 initially appeared not to understand what was being asked of him, but then said, *"Yeah, no problem."* The cuffs were removed from D1914. Mr Ring then appeared to leave the cell, taking the camera with him. D1914's full search is not shown on the footage.

24. Once the full search had been completed, the camera refocused on D1914. He was sitting on the bed in a cell in a pair of boxer shorts. Mr Ring asked Mr Dix if D1914 wanted to put any more clothes on, but Mr Dix confirmed that he did not. D1914 asked to see Healthcare and Mr Omoraka

entered the cell. D1914 asked Mr Omoraka *“why [inaudible] happen, I had three heart attacks”* and showed him the scars on his arms and on his chest. D1914 said, *“look what they do to people, look, this is good?”*. Mr Dix then asked Mr Omoraka, *“happy?”*, and Mr Omoraka left the cell. The footage ends with Mr Dix agreeing to bring D1914 cigarettes, a phone and a coffee.

25. The Inquiry saw footage of the use of force debrief, led by Mr Dix.²⁴ The debrief took less than two minutes and consisted of Mr Dix briefly describing the incident and stating that D1914 had been made subject to Rule 40 due to *“non-compliance and for not doing his removal directions”*. Mr Dix asked staff to confirm their names, ranks and whether they had any injuries. He additionally asked the Healthcare staff if they had any concerns. Mr Omoraka said that he had no concerns. Before ending the debrief, Mr Dix asked whether anyone had anything to add, and the officers confirmed that they did not.

26. D1914 told the Inquiry in his written statement that this incident was *“One of the most disturbing and distressing events during my time in Brook House”*.²⁵ He wrote that officers did not negotiate extensively with him prior to the planned use of force. Rather, he said, they asked him to go to E Wing and he said that he did not want to.²⁶ D1914 said that the footage showed that officers were *“pumped”* and prepared to hit him with a shield if necessary.²⁷ He said that the comments officers made about him were disgusting and that they saw him as sub-human.²⁸ D1914 told the Inquiry that the officers did not care if they killed him because they had the protection of Dr Oozeerally’s letter.²⁹ D1914 wrote that the letter confirmed that Healthcare staff did not care about him.³⁰ D1914 said that he suffered sharp chest pains when the staff entered the cell to remove him; he was scared that his heart condition would worsen.³¹ D1914 said in his statement that he did not feel safe to stand up and felt unable to do so.³² He said that he could not breathe properly and that, when officers grabbed his arms, he fell to the ground in shock.³³ Regarding the use of force, D1914 wrote that he felt the officers might break his arms with their restraint, and that he had bruises on his wrists as a result of the handcuffs.³⁴ In his account of the full search, D1914 said it was humiliating and that the officers treated him like an animal.³⁵ D1914 said that it was not

²⁴ [Day 8 PM 2 December 2021 00:20:46-00:22:34 \(Disk 50 UOF 134.17 cam 2\)](#)

²⁵ [DL0000229_037](#) para 130

²⁶ [DL0000229_037](#) para 131

²⁷ [DL0000229_005](#) para 11

²⁸ [DL0000229_039](#) para 138

²⁹ [DL0000229_005](#) para 11

³⁰ [DL0000229_040](#) para 141

³¹ [DL0000229_041-042](#) paras 144-149

³² [DL0000229_042](#) para 149

³³ [DL0000229_042](#) paras 149-150

³⁴ [DL0000229_042](#) para 150

³⁵ [DL0000229_043](#) para 155

necessary to isolate him and that this had left him feeling like he had no value.³⁶

27. Mr Webb told the Inquiry in his oral evidence that his ability to hear D1914's heavy breathing might have been affected by the helmet he was wearing. When asked by Counsel to the Inquiry about the heavy breathing heard on the footage, he said, *"I might not necessarily hear all that you're hearing, breathing or not, because you've got a helmet on."*³⁷

28. Under questioning from Counsel to the Inquiry, Mr Webb accepted that his description of how to use a shield was wrong.³⁸

29. Both Mr Webb and Mr Lake suggested in their oral evidence that they relied on Healthcare to tell them whether a detained person was fit to have force used against them. Mr Webb said, *"So medicals, if they say he's okay, he's okay. If not, we stop"*,³⁹ and Mr Lake said, *"if I was told it was okay and the doctors have said it's okay, then it's okay"*.⁴⁰

30. Dr Rachel Bingham, a clinical advisor to Medical Justice (a charity that provides medico-legal reports and advice to detained people), expressed concern that GPs appeared to overstep their remit in the sanctioning of force and, in turn, failed to identify and raise clinical concerns when necessary, with reference to D1914 in particular.⁴¹

31. Under questioning by Counsel to the Inquiry, Dr Oozeerally accepted that it would never be in the interests of a patient to have force used against them, except in the very limited circumstances of acting to save their life, if it was in imminent danger.⁴²

Relevant expert evidence

32. The Inquiry instructed Dr James Hard, the Inquiry's medical expert, to provide an independent opinion regarding the medical and clinical care issues at Brook House during the relevant period. In his oral evidence to the Inquiry, Dr Hard noted that healthcare staff, including GPs, have an important safeguarding and monitoring role in relation to the use of force.⁴³ In respect of D1914, he stated that it was a failure of Dr Oozeerally not to have raised D1914's cardiac history and the serious risks of placing additional stress upon

³⁶ [DL0000229_044](#) para 159

³⁷ [David Webb 3 March 2022 149/21-150/2](#)

³⁸ [David Webb 3 March 2022 137/16-140/19](#)

³⁹ [David Webb 3 March 2022 150/13-20](#)

⁴⁰ [Daniel Lake 1 March 2022 42/1-7](#)

⁴¹ [BHM000033_051](#) para 136; [Dr Rachel Bingham 14 March 45/20-47/9](#)

⁴² [Dr Husein Oozeerally 11 March 2022 134/21-135/11](#)

⁴³ [Dr James Hard 28 March 2022 88/25-89/4](#)

him.⁴⁴ He said that it was not in D1914's best interests to have had force used against him in order to remove him from the country.⁴⁵

33. Mr Jonathan Collier, the Inquiry's use of force expert, also reviewed this incident and raised a number of concerns.

33.1 Mr Webb's demonstration to Mr Tulley of how to use a shield was incorrect and appeared to imply that the bottom edge of the shield was used to deliberately target areas of the body. Mr Collier said that this technique would create a high risk of injury.⁴⁶ The language used throughout the demonstration implied that the shield should be used offensively rather than as a defensive tool.⁴⁷

33.2 The use of PPE was not warranted.⁴⁸

33.3 Force was not used as a last resort and was used in circumstances where D1914 was suffering from ill health and not presenting any risk to the officers.⁴⁹ No meaningful negotiations took place before nine members of staff in full PPE entered the cell.⁵⁰ D1914 was not due to leave Brook House until the following day. There was therefore ample time to speak to D1914 and try to gain his compliance.⁵¹

33.4 It was not necessary to place D1914 in handcuffs. Consideration ought to have been given to the size and health of D1914, and to the potential risks of placing him in handcuffs with his arms behind his back.⁵²

33.5 D1914 ought to have been given a T-shirt before he was removed from his cell as a matter of decency.⁵³

33.6 The debrief conducted by Mr Dix lacked depth.⁵⁴

Conclusions

34. The footage shows force being used against a man who appeared to be in physical distress but who was calm and communicative with staff. The period of time when D1914 was on the floor and pushed forwards from the waist was particularly troubling to watch.

⁴⁴ [Dr James Hard 28 March 2022 92/9-18](#)

⁴⁵ [Dr James Hard 28 March 2022 90/16-24](#)

⁴⁶ [INQ000111_033](#) para 117

⁴⁷ [INQ000158_019](#) para 4.2

⁴⁸ [INQ000111_033](#) para 121

⁴⁹ [INQ000111_032](#) para 116; [INQ000111_033](#) para 120

⁵⁰ [INQ000177_004](#) para 2

⁵¹ [INQ000111_032](#) para 116; [INQ000111_033](#) para 120

⁵² [INQ000111_034](#) para 122; [INQ000177_004](#) para 4

⁵³ [INQ000177_004](#) para 4

⁵⁴ [INQ000158_019-020](#) para 4.4

35. Dr Oozeerally should have raised concerns in advance about force being used against D1914. In my view, not only was it not in D1914’s best interests to be subject to a use of force in these circumstances, but it was also positively harmful to D1914 and put him at further risk. In my opinion, Dr Oozeerally showed a concerning lack of insight into the risks to D1914 during his oral evidence to the Inquiry.⁵⁵ I discuss this issue further in Chapter D.7 in Volume II.

36. The records state that D1914 was made subject to Rule 40 for “*refusing to relocate to E Wing*” and to “*maintain good order and discipline of the centre*”.⁵⁶ However, the IS.91RA Part C form records that D1914 “*stated that he would kill himself rather than return to Romania, because of this threat he has now been placed onto ACDT constant supervision and is now on Rule 40*”.⁵⁷ In addition, while reference is made in the footage by Mr Webb to D1914 intending to take spice, this is not listed as a reason for the authorisation of Rule 40 within the documentation. Accordingly, it is not clear from these records, when read together, precisely why D1914 was made subject to Rule 40. While it may be justifiable in certain circumstances to relocate a detained person to E Wing ahead of their imminent removal, it is not appropriate for that detained person additionally to be made subject to Rule 40 while on E Wing where they do not separately satisfy the criteria for Rule 40.⁵⁸ If there was a genuine concern that it was necessary to make D1914 subject to Rule 40 for his own protection (due to the risk of suicide), that should have been made clear in the records. In my view, the documentation gives the distinct impression that D1914 was inappropriately made subject to Rule 40 as a first response to his suicide threat, and/or for the administrative convenience of staff. The use of Rule 40, including in relation to those who are at risk of suicide or self-harm, is considered in more detail in Chapter D.5 in Volume II.

37. Similarly, the use of force as anything other than a last resort is inappropriate. It is particularly concerning to see that Mr Tulley was instructed to use a shield against D1914 as a tool to prevent him from self-harming, in preference to de-escalation techniques. While the Inquiry heard evidence that D1914 was said to have been in possession of spice, there was no evidence that this was in fact the case. It does not appear that his cell was searched; the officers did not ask D1914 any questions about having spice; it was not mentioned in the Rule 40 documentation; and there is no evidence to suggest that a Security Information Report was completed (this is required for information relevant to the safety and security of the immigration detention estate). In the circumstances, it does not appear to me as though the officers considered the report from D1914’s cell mate to be a serious risk, but they still

⁵⁵ [Dr Husein Oozeerally 11 March 2022 135/21-145/6](#)

⁵⁶ [CJS001768_002](#)

⁵⁷ [CJS001768_006](#)

⁵⁸ [CJS006043_004](#)

referred to it as a basis for a use of force. This use of force incident is discussed further in Chapter D.6 in Volume II.

38. It is clear from the footage and audio recordings of conversations among staff that D1914's medical issues were well known to staff. Mr Lake and another member of staff both (unrelatedly) used the phrase "*If he dies, he dies*" in reference to the risks associated with using force against D1914.⁵⁹ Both officers demonstrated a callous indifference to the wellbeing of a vulnerable detained person in their care. Mr Webb also referred to D1914 as a "*cunt*" when discussing the planned use of force with other officers.⁶⁰

39. Healthcare staff have an important safeguarding role in the context of the use of force against a detained person: for example, in raising any concerns about the use of force and any contraindications (clinical reasons not to use force on a particular detained person). This safeguarding responsibility applies both in advance of a planned use of force and during a use of force, whether that force was planned or spontaneous. D1914 had a serious heart condition that was documented in his medical records.⁶¹ He had undergone two coronary artery bypass surgeries prior to his detention. While at Brook House, D1914 had experienced cardiac symptoms including chest pain and palpitations. He had been taken to hospital by ambulance, including 10 days earlier on 17 May 2017 due to an abnormal blood result. He was awaiting a cardiac catheter procedure due to abnormal heart rhythm. He also had a history of self-harm.

40. The officers appeared to rely entirely upon the Healthcare staff to alert them to the need to stop the restraint. While this is an appropriate role for Healthcare staff to undertake, it is clear from the footage that, once Mr Omoraka had completed his clinical observations of D1914, no further clinical readings were taken for the duration of the restraint.⁶² In addition, Mr Omoraka should also have alerted staff to the dangers of a handcuffing technique that is associated with positional asphyxia (as discussed in Chapter D.7 in Volume II). Given D1914's health vulnerabilities, far greater priority should have been given to the risks to his wellbeing by all the staff present. D1914 asked questions or sought clarification at several points during the incident. There was no apparent consideration of removing the PPE to assist in effective communication with D1914 or to enhance the ability to hear D1914's heavy breathing; nor of de-escalation. No subsequent clinical checks were carried out, despite D1914's heavy breathing and his requests for help.

⁵⁹ [KENCOV1025 - V2017052700011; TRN0000087_016](#)

⁶⁰ [TRN0000087_030](#)

⁶¹ [CJS0074524_001](#)

⁶² [Day 8 AM 2 December 2021 03:11:15-03:17:53 \(Disk 50 UOF 134.17 cam 3\)](#)

41. While force was not used in the manner suggested by Mr Webb, the force that was used against D1914 was neither necessary nor used as a last resort. Mr Dix allowed only 14 seconds after Mr Omoraka had completed his medical observations before instructing officers to use force. Regardless of whether earlier attempts had been made to persuade D1914 to walk to E Wing unassisted, Mr Dix did not allow adequate time to attempt to engage and persuade D1914 immediately prior to the use of force. As noted by Mr Collier, there was no pressing need to move D1914, as his flight was the following day. There was no reason, therefore, not to allow time for this.

42. I am also concerned by the use of handcuffs on D1914. In Mr Collier's opinion, handcuffs were unnecessary in the circumstances, particularly in light of D1914's physical condition.⁶³ I agree. D1914 was unable to support his own weight and was audibly breathless throughout the incident. He did not pose any risk to the officers, and the only resistance he appeared capable of offering was verbal.

43. Moreover, the way in which D1914 was handcuffed was dangerous. While Mr Collier did not comment on this specific point in relation to D1914, he was clear that people under restraint should not be flexed forward and handcuffed behind their back due to the serious medical risks that this technique causes, including positional asphyxia.⁶⁴ Mr Collier stated that this is something officers ought to have known.⁶⁵ I consider that the footage demonstrates that these risks were in fact known by at least Mr Webb, Mr Dix and the unidentified officer behind Mr Ring. Despite this, none of the staff in the cell intervened to ensure that D1914 was not put at risk. This was unacceptable and demonstrated a complete disregard for D1914's welfare.

44. I also agree with Mr Collier's evidence that, as a matter of decency, D1914 should have been given the opportunity to put on a T-shirt.

45. Mr Collier also commented on the debrief held by Mr Dix, which he described as lacking depth.⁶⁶ Again, I agree with Mr Collier's assessment. There was no discussion of Mr Dix's decision-making or reflection about whether any aspects of the restraint could or should have been managed differently. The Healthcare staff made a superficial contribution to the discussion and Mr Dix did not seek any meaningful comment from any of those present.

⁶³ [INQ000111_034](#) para 122; [INQ000177_004](#) para 4

⁶⁴ [Jonathan Collier 30 March 2022, 51/24-25, 52/1-25, 53/1-12](#); *Inquest into the Death of Jimmy Kelenda Mubenga: Report by the Assistant Deputy Coroner, Karon Monaghan QC Under the Coroner's Rules 1984, Rule 43*, p25, para 68

⁶⁵ [Jonathan Collier 30 March 2022, 52/18-25-53/1-12](#)

⁶⁶ [INQ000158_019](#) para 4.4

46. I consider that D1914's treatment was capable of causing intense physical or mental suffering. His physical and mental ill health at the time put him at risk of significant harm while being restrained. I accept D1914's evidence to the Inquiry that he suffered sharp chest pains when the officers entered his cell, and that the restraint caused him pain. Moreover, as noted in paragraph 43, D1914 was placed in a position known to cause positional asphyxia and was plainly out of breath throughout the use of force. In the circumstances, there was a clear disregard for D1914, including whether the restraint caused physical suffering. D1914 had a known history of self-harm which I consider made him more vulnerable to mistreatment. I accept D1914's evidence that he felt he was treated as an "*animal*" during the strip search.⁶⁷ The use of PPE by staff was inappropriate and could have been frightening for D1914. In addition, it is my view that the use of force against D1914 while he was partially dressed was humiliating and showed a lack of respect for his human dignity. Therefore, I find that there is credible evidence that these acts are capable of amounting to inhuman and degrading treatment.

⁶⁷ [DL0000229_043](#) para 155

Chapter C.7:

D149 on 31 May 2017

1. D149 was detained at Brook House between May and June 2017. His medical records state that he was born in Albania.¹ D149 did not give evidence to the Inquiry.

The underlying facts

2. D149 arrived at Brook House on an open Assessment Care in Detention and Teamwork plan following an incident during which he had taken spice, climbed onto the safety netting on level 2 of Colnbrook immigration removal centre and threatened to jump.² He had attempted to self-ligature approximately one month earlier.³ D149 attended an initial health assessment at Brook House on 22 May 2017. During this assessment, he disclosed that he had been abused when he was eight years old and that he had a diagnosis of mixed personality disorder. He was allocated a single occupancy cell until he could be assessed by a GP or Registered Mental Health Nurse.⁴ D149 attended an appointment with Dr Husein Oozeerally on 23 May 2017, following which he was prescribed antidepressant medication. He failed to attend a mental health appointment scheduled for 29 May 2017.⁵

3. The Inquiry saw covertly recorded footage of a conversation that took place on 31 May 2017 between Detention Custody Officer (DCO) Callum Tulley, Detention Custody Manager (DCM) Jason Miller and DCM Carrie Dance-Jones.⁶ Ms Dance-Jones was the assigned Duty Director at the time. Mr Tulley told the DCMs that a detained person had just attempted to remove his keys by pulling on the security chain that attached them to his belt. After Mr Tulley had described the detained person as D149, Mr Miller accessed details about him on his computer and told his colleagues that D149 had been identified as posing a risk of escape. Ms Dance-Jones made a call and can be heard saying:

¹ [CJS000984_001](#)

² [CJS000972_013-019](#)

³ [HOM018812_007](#)

⁴ [CJS000984_002-003](#)

⁵ [CJS000984_002-003](#)

⁶ [KENCOV1027 - V2017053100010](#)

“D149. He just tried to grab an officer’s key, um, oh is he? What you doing today? We need to block him. He’s an escape risk and he’s tried to grab an officer’s keys. So I think we need to, need to stick him down there.”

She finished the call and said to Mr Tulley and Mr Miller, *“Right, he’s going down the block.”*

4. Mr Tulley completed a Security Information Report (used to record matters relevant to the safety and security of the immigration detention estate, and collated by the Security department at Brook House) about D149. In it, he wrote that he believed D149 had been attempting to take his keys. Mr Tulley signed and dated the report, indicating that the time was 13:55.⁷

5. DCM Stephen Loughton wrote in an incident report that Ms Dance-Jones had spoken to him at 14:30 on 31 May 2017 and informed him what had happened. Mr Loughton said that he spoke to D149, who was *“irate”* when Mr Loughton explained that the decision had been taken to move him to the Care and Separation Unit (CSU). D149 refused to go. Mr Loughton explained that he waited until 17:00 to remove D149 to the CSU, as this was when the centre would be in lockdown for roll count. He assembled a team of officers and a nurse at 16:45.⁸

6. There are three clips of footage showing force being used on D149 on 31 May 2017. The first is from a body worn camera showing the incident from the other side of D Wing. It is approximately 20 minutes long.⁹ The second clip is from a handheld camera operated by DCM David Aldis and is approximately 22 minutes long.¹⁰ The third clip is also from the handheld camera and lasts for approximately one minute.¹¹ Taken together, the three clips show the immediate lead-up to the use of force on D149 and the use of force itself. This includes D149 being moved from D Wing and through E Wing, and relocated in a cell in the CSU.

7. The body worn camera footage begins with five officers approaching D149’s cell on D Wing. Mr Loughton was leading the group, and DCO Kirstie Freeburn, DCO Ryan Tait, DCO Jonathan Edon and DCO David Webb followed behind, wearing Personal Protective Equipment (PPE). Ms Freeburn was at the back of the group, and Mr Webb and Mr Edon were supporting Mr Tait, who was holding the shield in a defensive position.

⁷ [CJS004298_002](#)

⁸ [CJS004352_002](#)

⁹ [CJS0073778 \[Disk 52 UOF 135 17 BWC\]](#)

¹⁰ [CJS0074114 \[Disk 53 S2120002\]](#)

¹¹ [CJS0074062 \[Disk 53 S2120003\]](#)

Figure 16: Officers approaching D149's cell



8. The second clip shows Mr Loughton opening the cell door and speaking to D149. D149 was in bed and Mr Loughton asked him to come out of his cell and walk to E Wing. As D149 got up from his bed he appeared to see the officers braced at the door of the cell. D149 asked *"What have you got them for?"* and accused Mr Loughton of *"Setting me up"*.

9. D149 walked out of his cell and, in response to Mr Loughton's instruction, stood with his back to the wall next to the cell door.

Figure 17: D149 leaving his cell



10. D149, who appeared and sounded agitated, asked Mr Loughton repeatedly why he was being moved to E Wing, but Mr Loughton did not directly respond, saying, *"you know the reason"*. D149 told the officers surrounding him not to touch him, and asked Mr Webb why he was standing

with his fists clenched. He refused to walk with the officers and said, *“Do what you got to do”*, so Mr Loughton instructed the officers to use force. There was a gap of around 100 seconds between Mr Loughton entering D149’s cell and his authorisation of the use of force.

11. The four officers in PPE moved forward and restrained D149, with an officer taking hold of each arm. As one officer put D149’s arm behind his back, D149 could be heard shouting out in pain and saying, *“You’re breaking my arm”*.

12. The officer bent D149 forwards and then attempted to hold him in this position so that handcuffs could be applied. D149 strongly resisted the restraint, struggled against the officers, dropped his weight and attempted to hook his legs around theirs and kick them. He shouted at and verbally threatened the officers.

Figure 18: D149 struggling against the restraint



13. D149 was bent forwards for a total of 1 minute 30 seconds before the officers took him to the floor, in part due to the officers’ inability to resist and control his struggles. D149 continued to shout and demand that his arm be released.

14. Officers then held D149 with his chest to the floor and his knees tucked underneath him. He was kept in this position for 1 minute 15 seconds. Mr Loughton instructed Ms Freeburn to straighten D149’s legs out, which she attempted but failed to do. D149 screamed, *“let me go”*. Ms Freeburn then attempted to apply handcuffs to D149, but Mr Loughton took them from her and applied them to D149 with his hands behind his back. D149 swore at the officers, threatened to kill them and screamed out in apparent pain. He was plainly very distressed.

15. D149 was then helped to his feet and began to kick out and attempt to wrap his legs around those of the officers. The officers attempted to escort D149 along the wing but he began to drag his legs and sink back to the ground. It is not possible to tell what he was saying on the footage, but his voice was high in pitch and he appeared to be in pain. As the officers tried to move him forward, the footage clearly shows that he had been handcuffed with one palm facing his back and the other palm facing outwards. Other detained people were banging on the doors of their cells.

Figure 19: The handcuff position on D149



16. Mr Webb and Mr Edon then dragged D149 along the wing, supporting him under his arms. D149 tried to obstruct this by putting one leg against the wall on his right side and his other leg against the railings to his left. The officers were saying, *“walk, walk”* and *“watch his feet ... get in front of him”*. After 20 seconds, the group paused again as D149 tried to drop towards the floor. One officer could be heard saying *“you need to stand him up”*, and the officers brought D149 to his feet. They managed to walk him to the end of the wing, despite D149 continuing to kick out at them and trying to wrap his legs around them.

17. Once they had reached the end of the wing, D149 dropped his weight again. Mr Loughton told the officers that they needed to lift D149. The body worn footage from this time shows that Mr Aldis gestured towards Mr Loughton, beckoning him over to the group. Mr Loughton approached and Mr Aldis pointed towards the handcuffs on D149. Mr Loughton bent over D149 and appeared to attempt to adjust the handcuffs, but when he stood back up D149’s hands were still in the same position.

- 18.** As Mr Loughton moved away, D149 could be heard panting heavily. Mr Loughton called out *"Nurse, you alright?"* and the attending nurse, Ms Donna Batchelor, responded *"yep, yep [inaudible]"*. Mr Webb tried to talk to D149 and persuade him to start walking. D149 refused, so Mr Webb took hold of his left hand and flexed his wrist. D149 screamed out in pain until Mr Webb let him go five seconds later.
- 19.** Following this infliction of pain, D149 continued to shout at and verbally abuse officers, and his resistance to the officers' attempts to persuade him to stand up and walk became even stronger. The officers brought him to his feet, but D149 threatened to bite the officers, and hooked his leg around Mr Edon's leg in such a way that Mr Edon could no longer place it on the floor. Mr Loughton instructed Ms Freeburn to intervene and unhook Mr Edon's leg. As she did this, the officers and D149 went to the ground again. Once Mr Edon's leg was freed, Mr Webb appeared to move D149's left hand a second time, causing him to scream out in pain.
- 20.** D149 called the officers *"cunts"* and appeared to be attempting to bite Mr Tait, the officer controlling his head. Mr Loughton then said, *"Dave, you need to get him up, we can't leave him like this"*, and the officers brought D149 back to his feet. As soon as they had done this, D149 recommenced kicking the officers. They told him to stop, but D149 responded *"I am not giving up lightly, I am pissed off"* and went to the ground a fourth time.
- 21.** In total, it took the officers over 10 minutes to move D149 from D Wing into the adjoining corridor. Once in the corridor, D149 could be heard threatening officers and saying, *"get off you're hurting me"*. At one point he was being dragged on his knees, and Mr Loughton instructed, *"you can't drag him"*. The group then stopped, and the officers held D149 bent forwards over his knees.
- 22.** D149 made threats to torture the officers, and to make their families pay for what they were doing. Ms Batchelor asked D149 to sit up for her, but D149 responded by shouting, *"get the fuck off me, don't touch me, because you don't know whats going through my head right now"*. The nurse told the officers to carry on.
- 23.** Mr Loughton instructed the officers to get D149 up, which they did, and they managed to move D149 to the top of the stairs. Two additional officers, DCO Sean Sayers and DCO Ryan Bromley, were called over to assist and act as 'anchors' while D149 was taken down the stairs. D149 was originally taken down the stairs facing forwards, and screamed, *"you're breaking my arm"*. Halfway down the first set of stairs, the officers repositioned D149 so that his back was facing the wall. D149 continued to scream out, complain about his arm and make threats to the officers. An officer can be heard saying, *"Stop fighting and it will stop hurting. You're the one that's making it hurt."*

24. Once at the bottom of the stairs, D149 became more compliant and walked without shouting. He began shouting and making threats to the officers again as he and the officers approached E Wing.

25. Once in the CSU, D149 began to kick out at the officers' legs as they attempted to search him. He was then taken inside a cell and seen by Ms Batchelor. D149 told Ms Batchelor that he had injuries to his arms; she responded that he probably had some muscle damage from when he had been fighting. She recorded in the Use of Force documentation that D149 had "*sustained redness and marks from handcuffs to wrists*".¹²

26. Mr Webb told the other officers how to release the restraint on D149 and exit the cell. D149 was face down on the floor of the cell with his knees tucked under his chest.

27. Mr Webb instructed D149 to straighten out his legs, which he did compliantly. Mr Tait then let go of D149's head, and Ms Freeburn leaned in to remove D149's handcuffs. However, due to the amount of time it was taking her, Mr Loughton stepped in and removed one of the cuffs. As D149 started to struggle, Mr Tait stepped in to restrain his legs. D149 was screaming in apparent pain and Mr Webb shouted, "*release your arm*". Ms Freeburn attempted to remove the other handcuff but was unable to do so, and Mr Loughton again took over and removed it. Mr Webb then instructed Mr Tait to put D149's legs into a figure of four lock.¹³ As he did so, he appeared to force D149's legs and D149 screamed out in pain. The footage ends with Mr Webb, Mr Tait and Mr Edon still restraining D149. By this time, D149 had been face down on the floor with his hands behind his back for over four minutes. In his oral evidence to the Inquiry, Mr Webb accepted that Mr Tait was not in the correct position to execute the leg restraint; he explained that he was not a use of force instructor at the time of the incident.¹⁴

28. The third and final clip of footage of the use of force appears to follow immediately on from where the second clip ends.¹⁵ It shows D149 in the prone position on the floor of the CSU cell. Mr Webb continued to instruct Mr Tait on how to take control of D149's legs, and Mr Edon and Mr Webb then released D149 and left the cell. Mr Tait was the final officer to release D149; he then ran out of the cell. The cell door was locked behind him. Once released, D149 immediately got to his feet and ran to the cell door, which he started hitting as he shouted abuse at the officers. The footage ends with Ms Batchelor telling D149 through the cell door that she would come and see him in half an hour.

¹² [CJS005650_034](#)

¹³ For teaching points on the application of this technique, see [NOM000001_245](#)

¹⁴ [David Webb 3 March 2022 159/18-160/11](#)

¹⁵ [CJS0074062 \[Disk 53 S2120003\]](#)

29. The Inquiry also saw two clips of footage covertly recorded by Mr Tulley. The first shows a conversation between Mr Tulley, Mr Bromley, Mr Sayers and an unidentified female member of staff prior to the use of force taking place. The officers were discussing D149. Mr Sayers and Mr Bromley both referred to D149 as “a fucker”, and the female officer could be heard referring to D149 as a “little shit”.¹⁶ The second piece of covert footage shows a conversation between Mr Tulley and Mr Webb on the day after the use of force. Mr Webb can be heard referring to the use of force on D149 and saying, “Fucking hurt [inaudible]. Big time. When I put him in a straight hold [inaudible] in the office downstairs heard screaming.” Mr Webb also said, “Nothing personal but if you’re going to be a fucking dick, it’s going to hurt innit?”¹⁷ In his oral evidence to the Inquiry, Mr Webb denied intentionally causing D149 pain. He acknowledged that he had described his comments to G4S investigators as “locker room talk”.¹⁸

30. Mr Loughton wrote in his Use of Force report:

“At approximately half past two on the afternoon of 31st May 2017 I was informed by Duty Director of the day Caz Dance-Jones that she had received a report that a detainee by the name of [D149] ... had attempted to grab an officers [sic] keys in the library and that he has done this before in a previous centre so for the safety and security of the centre he is to be moved to our care and separation unit and be placed onto Rule 40 [of the Detention Centre Rules 2001].”¹⁹

31. Mr Loughton then explained that he had spoken to D149 about the decision to make him subject to Rule 40 on two occasions, once shortly after 14:30 and again between 16:45 and 17:00. During the first conversation, Mr Loughton recorded that D149 said he would not be going to the “block”, and on both occasions he recorded that D149 became “aggressive” or “irate”.

32. It appears that D149 was initially held in the CSU under Rule 42 of the Detention Centre Rules 2001, although the Inquiry did not see evidence of when and by whom this was authorised before DCM Stephen Pearson authorised holding D149 under Rule 40 at 21:52.²⁰ The Rule 40 documentation indicates that the Home Office, Independent Monitoring Board, Healthcare and Religious Affairs were not informed until 23:00.²¹

¹⁶ [KENCOV1027 - V2017053100016](#)

¹⁷ [KENCOV1028 - V2017060100017 clip 1; TRN0000088_002](#)

¹⁸ [David Webb 3 March 2022 163/22-164/20, 165/22-166/24](#)

¹⁹ [CJS005650_008](#)

²⁰ [CJS001820_002](#)

²¹ [CJS001820_001](#)

Relevant expert evidence

33. The Inquiry’s use of force expert, Mr Jonathan Collier, originally considered that force was only used after all reasonable efforts to persuade D149 to walk compliantly to E Wing had failed.²² However, in his oral evidence and having watched the footage afresh, Mr Collier said that he would have expected Mr Loughton to have engaged more with D149 before using force, for example by providing an answer to D149’s question as to why he was being moved.²³

34. Mr Collier’s overall impression of this incident was that the staff were inexperienced and lacked an understanding of how to manage the situation.²⁴ He commented that *“once it became evidence [sic] that this was a complex and difficult removal, consideration could have been given to summoning additional experienced staff”*.²⁵ In his view, this incident involved a number of failings.

34.1 D149 was kept in the prone position for an unnecessary amount of time, which risked interfering with his ability to breathe normally.²⁶

34.2 The handcuffs were applied to D149 while one of his hands was turned in, rather than with his hands ‘back to back’. This, Mr Collier explained, causes pressure through the wrist even without staff taking hold of the detained person’s arms.²⁷ The incorrect application of the handcuffs to D149 meant that the carry technique could not be performed and the application of pain to D149 could not be controlled.²⁸ Mr Collier told the Inquiry that, when it became apparent that the handcuffs had not been applied correctly to D149, they should have been removed and reapplied.²⁹

34.3 Mr Collier initially considered that the use of a wrist flexion – a pain-inducing technique (PIT) – was reasonable.³⁰ He later concluded in his oral evidence that it was unnecessary due to the fact that D149 was already being controlled by handcuffs.³¹ He also considered that the PIT

²² [INQ000111_028](#) para 92

²³ [Jonathan Collier 30 March 2022 34/24-35/14](#)

²⁴ [INQ000111_026](#) para 83

²⁵ [INQ000111_026](#) para 84

²⁶ [Jonathan Collier 30 March 2022 41/21-42/4](#)

²⁷ [Jonathan Collier 30 March 2022 36/4-11](#)

²⁸ [INQ000158_060](#) para 26.9

²⁹ [INQ000111_027](#) para 85

³⁰ [INQ000111_027](#) para 89

³¹ [Jonathan Collier 30 March 2022 39/14-17](#)

was applied to D149 without following the correct procedure: (i) give an instruction; (ii) give a clear warning; and (iii) apply pressure.³²

- 34.4** The officers who restrained D149 did not follow the correct procedure when moving him down the first flight of stairs to E Wing, in that they went down “square on”. Mr Collier described the way the movement was conducted as “particularly risky for staff and D149”, and said that the technique was a potentially dangerous approach when restraining someone who was resisting.³³ In his second report, Mr Collier explained:

“Staff should have set up the stairway negotiation formation prior to moving. This would require additional staff to act as ‘anchors’ at the lower side of the three-officer team.”³⁴

- 34.5** That notwithstanding, Mr Collier noted that, after the first flight of stairs, the staff had corrected their position.³⁵
- 34.6** Staff appeared unsure of how to release the restraint of D149 and exit the cell safely. When attempting to apply the figure of four leg restraint, Mr Tait was incorrectly positioned and tried to compensate by pulling on one of D149’s legs. There was also a misapplication of the technique used to restrain D149’s legs, which caused his feet to be twisted and resulted in pressure being put through his hips and his knee joint.³⁶ This risked physical injury and caused him pain, although this was noticed and corrected.³⁷

Conclusions

35. The footage of this incident shows staff struggling to gain control of and move D149 for a prolonged period. Once force was used, D149 resisted staff and was verbally abusive. The footage demonstrates that he was distressed and, at times, in pain.

36. The decision to move D149 was justifiable based on the intelligence that staff had available to them. Mr Loughton’s attempt to persuade D149 to walk to E Wing at around 14:30 was appropriate. In light of D149’s refusal to comply, Mr Loughton was right to make arrangements for a planned removal in the event that a use of force became necessary.

³² [INQ000111_027](#) para 89; [Jonathan Collier 30 March 2022 38/17-25](#)

³³ [INQ000111_023](#) para 64

³⁴ [INQ000158_098](#) para 2

³⁵ [INQ000111_023](#) para 64

³⁶ [Jonathan Collier 30 March 2022 43/12-44/1](#); [INQ000111_027](#) para 87

³⁷ [Jonathan Collier 30 March 2022 43/12-44/1](#); [INQ000111_027](#) para 87

37. Once the staff attended D149's cell to move him to E Wing, there were a number of failures in how the incident was managed. Mr Loughton allowed only 100 seconds to negotiate with D149 before instructing the other officers to use force. I do not consider this to have been an adequate amount of time. The negotiation was held in circumstances where D149 could see the team of officers in full PPE, extremely close to him and poised to use force on him. Finally, during the negotiation Mr Loughton refused to answer D149's questions as to why he was being moved. It is my impression from the footage that there appeared to be an assumption of the inevitability of a use of force on the part of the officers assembled to move D149, meaning that the attempts to engage with him were superficial. In the circumstances, force was not used as a last resort.

38. As identified by Mr Collier and discussed above, the officers failed to apply the techniques as instructed in the Use of Force Training Manual. As force should only ever be used as a last resort, it ought to be common for the use of force to be met with a degree of resistance. Indeed, it is hard to imagine a scenario where force is legitimately used in circumstances where the subject is not resisting. Officers who are up to date with their training ought to be capable of managing this. However, the movement of D149 was clearly challenging for staff and, in my view, Mr Loughton should have taken decisive action – such as summoning additional or more experienced staff, or pausing the restraint to allow a more meaningful conversation to take place with D149 – once it became apparent that Mr Webb, Mr Tait and Mr Edon were unable to carry out the use of force swiftly and safely.

39. The misapplication of the techniques resulted in D149 being restrained for an extended period of time and experiencing pain. For example, the incorrect application of the handcuffs resulted in pain to D149 that could not be controlled. It is my opinion that the pain was probably applied unintentionally and as a result of the officers' incompetence and inexperience rather than as a PIT. In any event, if they had intended to apply this technique, there are clear guidelines on how to do so, which the officers did not follow.

40. As the group reached the top of the stairs, Mr Bromley and Mr Sayers were instructed to act as anchors. However, this formation was set up as D149 was on the edge of the stairs, and at one point he appeared to start moving, front on, down the stairs before the officers were ready. Indeed, one officer could be heard saying, "*woah, woah, woah*" before D149 was brought back under control and then moved so that his back was facing the wall. I agree with Mr Collier that the formation should have been set up earlier, and away from the stairs, in order to avoid unnecessary risk being caused to D149 and the officers themselves.

41. I agree with Mr Collier's assessment of the attempts to restrain D149's legs. Most concerning, the difficulties encountered in correctly applying the restraint techniques meant that D149 spent an unnecessary amount of time restrained in the prone position, which is associated with a risk of positional asphyxia.³⁸ As a result, the force used was neither proportionate nor justified. Ms Batchelor, as the attending member of Healthcare staff, should have alerted officers to the dangers of restraining D149 in this position.

42. While derogatory language was not used in front of D149, I find that the words used by Mr Webb, Mr Bromley, Mr Sayers and the unidentified female officer both before and after the use of force were highly unprofessional.

43. The incompetence and inexperience of the staff restraining D149 created an avoidable risk to his and their safety during the use of force, and increased the likelihood of injuries being sustained. Force was used against D149 for at least 20 minutes and, for a significant period of that time, the incorrect application of techniques resulted in the officers causing needless pain to D149. It is notable that he screamed at the officers that they were breaking his arm multiple times during the use of force. I consider that – particularly due to the duration of the restraint and the clear distress that D149 suffered throughout – his treatment was likely to cause him intense physical and mental suffering. I also consider that being dragged along the floor, together with the prolonged periods of time during which he was kept in the prone position, risking positional asphyxia, was likely to be a humiliating experience for D149. Consequently, I find that there is credible evidence that these acts are capable of amounting to inhuman and degrading treatment.

³⁸ [INQ000158_006 para 1.3; Jonathan Collier 30 March 2022 44/8-15](#)

Chapter C.8:

D390 and D1851 on 5 June 2017

1. D390 and D1851 are both Nigerian nationals. They shared a cell at Brook House for approximately one and a half months.¹
2. D390 did not provide evidence to the Inquiry. D1851 was detained at Brook House between April and July 2017.² In his witness statement to the Inquiry, D1851 explained that he found Brook House a very stressful environment to live in and that his mental health diminished as a result. He described feeling acute fear, anxiety and stress, and not being able to sleep.³ It is not apparent from D1851's medical records that he ever reported these symptoms to the Healthcare team at Brook House.⁴

The underlying facts

3. The Inquiry saw handheld camera footage of a briefing led by Detention Custody Manager (DCM) Stewart Povey-Meier on 5 June 2017.⁵ The time was approximately 17:10.⁶ Mr Povey-Meier told the assembled officers and Healthcare staff that D390 was due to be transferred to Harmondsworth immigration removal centre and had indicated that he would refuse to go. Mr Povey-Meier explained to the assembled staff that he had contacted the Duty Director, Mr Stephen Skitt. Mr Povey-Meier said that the assembled officers would form two teams, the first of which would focus on escorting D390 to the waiting escort staff. This team was to be composed of Detention Custody Officer (DCO) Ben Shadbolt, DCO Ryan Bromley and DCO Sean Sayers, with DCO Callum Tulley supporting them. Mr Povey-Meier explained that D390 would be asked to walk to the escort staff, and if he did not, the team was to take control of him and take him downstairs. The second team was to escort D390's cell mate, D1851, to a safe area on A Wing. This team was to be composed of DCO Darren Bulled, DCO Neil Timms and DCM Shane Farrell. In addition, DCM Nick London was to operate the handheld camera,

¹ [DL0000095_001](#)

² [DL0000143_001](#) paras 1 and 2

³ [DL0000143_025](#) para 93

⁴ [DL0000088](#)

⁵ [CJS0073856 Recorded Briefing: ACTIVE 33225385_1](#)

⁶ [CJS005624_008](#); [CJS005624_021](#)

and Ms Carole Reed, a Staff Nurse, and Ms Eavan Owens, a healthcare assistant, were also to attend.

4. The Inquiry saw the handheld camera footage of the two teams of officers entering the cell.⁷ The footage, which lasts approximately 12 minutes 30 seconds, begins with Mr Povey-Meier looking through the viewing panel into the cell shared by D390 and D1851. A riot shield, held by someone off camera, is visible at the edge of the frame.

Figure 20: Mr Povey-Meier looking through the viewing panel



5. Mr Povey-Meier then looked downwards and stepped back slightly. The camera did not follow his line of sight to the floor. An officer could be heard asking *"Has he flooded the floor?"* before Mr Povey-Meier looked back into the cell and called D390's name once. No response was audible from D390. After looking into the cell a second time, Mr Povey-Meier told the other officers that a kettle was being boiled inside the cell. Mr London could be heard asking, *"Do you want to turn the electricity off?"* Mr Povey-Meier did not reply but asked D1851 to come to the door and then, talking to him through the crack along the hinged edge of the door, asked him to come out of the cell with the officers so that he could talk to D390.

6. D1851's response is only partially audible on the footage. He can be heard speaking in a calm voice and saying, *"I'm sorry, I don't know what's going on [inaudible] sorry."* The remainder of his response to Mr Povey-Meier is inaudible on the footage. Mr Povey-Meier responded, *"okay"*. Mr London asked

⁷ [CJS0074063 UOF 137.17 \(2\)](#)

Mr Povey-Meier, *“Is he refusing to come out?”* Mr Povey-Meier did not specifically answer this question but nodded slightly and told the officers that D1851 was on the right-hand bed and that D390 was standing towards the back of the cell near the kettle. Mr London warned the officers twice: *“Watch out for that kettle.”* Mr Povey-Meier then unlocked and opened the cell door and moved swiftly out of the way. Six officers immediately entered the cell, which was in darkness. All the officers were in Personal Protective Equipment (PPE) and two of them were carrying riot shields.

7. Within two seconds of the door being opened, Mr Shadbolt, Mr Sayers and Mr Bromley moved rapidly towards D390 and pushed him onto his bed using a shield. None of the officers spoke to D390 before force was used against him. Meanwhile, D390 said, *“I’m here, I’m here, what happened? I’m packing my stuff?”*. Mr Timms, Mr Bulled and Mr Farrell followed behind, at a slightly slower pace, and surrounded D1851’s bed, preventing him from moving from it. D1851 was sitting in the bed, holding his hands up. Mr Timms held his shield close to D1851 but there is not a clear enough view of the position of the shield to establish whether it made direct contact with him. D1851 was sitting up with his back against the far wall of the cell. He was holding his hands up with his palms facing the officers. D1851 is shown on the footage for only a few seconds. D1851 said, *“I am not going anywhere please, I am not going anywhere.”* He repeated this statement several times to the officers standing around his bed.

Figure 21: Mr Bromley, Mr Shadbolt and Mr Sayers pinning D390, and D1851 sitting on his bed with his hands up



8. The cell lights were turned on approximately 25 seconds after the officers entered the cell, by which point D390 had already been restrained. Approximately 15 seconds after that, D390 was led out onto the landing with his arms restrained behind his back by Mr Bromley and Mr Shadbolt. He said, *"I was told to pack though, what's this about?"*, before he was led from A Wing.

9. D1851 is not visible on the footage for the remainder of the incident, but three officers can still be seen inside the cell, standing close to his bed. It is not clear from the footage whether any of these officers were still holding a shield, but their posture suggests that they were not.

10. In D1851's written evidence to the Inquiry, he said that it was not true that D390 had been repeatedly boiling the kettle:

*"Boiling a kettle repeatedly, which is next to my head where I was laying on the bed, is something I would have noticed. There is no ventilation in the room, and so it would have been full of steam if it had been boiled repeatedly."*⁸

11. D1851 said that he spoke to Mr Povey-Meier and explained that he would not stand to the side of the door because this would result in him being hit when it was opened. He said that he told Mr Povey-Meier that he would instead go and sit on his bed and not intervene.⁹ D1851 characterised the force used against D390 as *"unjustified excessive use of violence against a totally defenceless person"*.¹⁰

12. D1851 said that two officers pinned him down using their shields while he was on his back. He said that one shield was pressed onto his chest and the other was holding down his legs.¹¹ However, in his oral evidence to the Inquiry, D1851 suggested that only one of the officers had used a shield against him. He said: *"they initially came in and I think one of the staff got their shield to me and I had to sit up and push it"*.¹²

13. D1851 also said:

*"the way they were dressed in full kind of riot gear with heavy-duty plastic shields was menacing and overwhelming. They were like the army, and it was like some kind of military raid."*¹³

⁸ [DL0000143_010](#) para 37

⁹ [DL0000143_010-011](#) para 39

¹⁰ [DL0000143_011](#) para 41

¹¹ [DL0000143_011](#) para 42

¹² [D1851 3 December 2022 95/11-13](#)

¹³ [DL0000143_009](#) para 35

14. D1851 said that he cried a lot after the incident on 5 June 2017. He described struggling to stay positive in a difficult environment and said:

“However, this took on a completely different aspect in that they had physically touched me, which added an additional fear of the officers.”¹⁴

He added that the incident left him feeling like he was no longer safe in his cell.

15. In D1851’s evidence to the Inquiry, he said that the incident left him feeling *“helpless, and completely vulnerable. There was no guarantee that my health and safety would be safeguarded while I was in detention. It felt like a lawless environment.”¹⁵* D1851 said that he did not make a request to be seen for an assessment under Rule 35 of the Detention Centre Rules 2001 as the understanding among detained people was that this process was only for those who had been a victim of torture.¹⁶ I discuss the issue of accessing Rule 35 assessments in detail in Chapter D.5 in Volume II. D1851 said that he had been diagnosed with *“PTSD [post-traumatic stress disorder], depression and anxiety”* following his release from Brook House.¹⁷

16. D390 did not give evidence to the Inquiry. I considered his account of the events provided in an unsigned witness statement in support of D1851’s claim for unlawful detention, as it relates to the potential mistreatment of D1851. In this statement, D390 said that he had shared a cell with D1851 for a month and a half and that, in that time, he believed that D1851’s physical and mental health deteriorated. D390 described D1851 as having cold sweats in the night, crying on many occasions, and becoming more withdrawn and reclusive.¹⁸

17. D390 said that he had been forcibly removed from Brook House and that D1851 had been in the cell with him when this happened.¹⁹ D390 described D1851 informing the officers that if he stood by the side of the door it would hit him as it was opened, and that he would instead sit on his bed and allow them to enter the cell. D390 said that D1851 offered no threat and that it had not been necessary for him to be pinned down by two large officers.²⁰ D390 described D1851 as screaming and shouting at the officers to leave him alone.²¹ D390 said that he was hit with batons and suffered injuries including persistent migraines and swelling to his knee and ankle.²² He said that the

¹⁴ [DL0000143_013](#) para 46

¹⁵ [DL0000143_013](#) para 47

¹⁶ [DL0000143_026](#) para 97

¹⁷ [DL0000143_001](#) para 3

¹⁸ [DL0000095_001](#) para 2

¹⁹ [DL0000095_001-002](#) para 4; [DL0000095_002](#) para 5

²⁰ [DL0000095_002](#) para 5

²¹ [DL0000095_002](#) para 6

²² [DL0000095_002](#) para 9

trauma of the experience still lived with him.²³ D390 said that he was sure that D1851 would also still be affected.²⁴

18. In his written statement to the Inquiry, Mr Povey-Meier said that he had spoken to D390 earlier in the day about why he was subject to a move order. He said that D390 had informed him that he did not want to go. When the officers later went to D390's cell, Mr Povey-Meier said that D1851 had refused to leave the cell and went to sit on his bed. Mr Povey-Meier said that he noticed that there was water outside the door, and that he could see that the kettle had just been boiled as there was steam coming out of it and the lid was open. Mr Povey-Meier said that, as boiling water had "*historically*" been used as a threat, he deemed it necessary and proportionate to go in and use force.²⁵ In his Use of Force report and his evidence to the Inquiry, Mr Povey-Meier said that no force had been used against D1851.²⁶

19. In his witness statement to the Inquiry, Mr Povey-Meier said that his initial plan had been to give D390 another opportunity to walk out of the cell before force was used. He said that D1851's refusal to leave the cell and the fact that there was a boiling kettle changed his risk assessment.²⁷ In his oral evidence to the Inquiry, Mr Povey-Meier accepted that giving D390 another opportunity to walk out of the cell, while the staff were still outside with the door shut, would possibly have only taken a matter of 10 seconds, and that this would not have put his team at risk.²⁸

20. In his Use of Force report, Mr Bromley wrote that Mr Povey-Meier gave D390 instructions through the door but noticed that he was repeatedly boiling his kettle in his cell. Mr Bromley wrote that D390 continued to ignore instructions from Mr Sayers once that officer entered the cell.²⁹ In his oral evidence to the Inquiry, Mr Bromley maintained that D390 had been repeatedly boiling his kettle and had ignored Mr Povey-Meier's instructions.³⁰ Under questioning by Counsel to the Inquiry, Mr Bromley accepted that the footage showed that there was no attempt to speak with either of the detained people once the officers entered the cell.³¹ Mr Bromley also accepted, upon viewing the footage during his oral evidence, that shields were used immediately after the officers entered the cell.³²

²³ [DL0000095_003](#) para 12

²⁴ [DL0000095_003](#) para 12

²⁵ [SER000456_012](#) para 27a

²⁶ [Stewart Povey-Meier 17 March 2022 13/13-14/4; CJS005624_016](#)

²⁷ [SER000456_012-13](#) para 12d

²⁸ [Stewart Povey-Meier 17 March 2022 14/14-16/2](#)

²⁹ [CJS005624_021](#)

³⁰ [Ryan Bromley 7 March 2022 116/11-14](#)

³¹ [Ryan Bromley 7 March 2022 114/25-115/3](#)

³² [Ryan Bromley 7 March 2022 115/6-9](#)

21. In his Use of Force report, Mr Sayers recorded that he had seen a puddle of water on the floor at the entrance to the cell, and that D390 did not listen to him asking him to sit on the bed.³³ Under questioning by Counsel to the Inquiry, Mr Sayers accepted that he could have given D390 more time to react, but blamed his failure to do so on being warned about boiling water being thrown.³⁴

22. Mr Shadbolt wrote in his Use of Force report that it appeared as if the kettle had been boiled numerous times, as there was a large amount of steam outside the cell.³⁵

23. Mr Timms did not complete a Use of Force report in relation to his use of the shield against D1851.

Relevant expert evidence

24. The Inquiry's use of force expert, Mr Jonathan Collier, was critical of how the incident on 5 June 2017 was managed. In his first report to the Inquiry, he said that Mr Povey-Meier should have attempted to engage with D390 face to face rather than authorising the use of force with no opportunity to comply.³⁶ In the circumstances, Mr Collier did not consider that force was used against D390 as a last resort.³⁷ He also considered that the holds used on D390 once he was outside the cell were disproportionate, given his calm demeanour.³⁸ In respect of D1851, Mr Collier noted:

*"Any force used must be recorded, including the force described. The staff would have to justify their decision against the risk presented by D1851. Without any documents there is no evidence to form an opinion on the general principles being applied and whether the force was justifiable."*³⁹

Conclusions

25. There are inconsistencies between the accounts of D1851 and D390, and the footage. In particular, there is no evidence to support D390's allegation that batons were used, or D1851's allegation that two shields were used against him. D1851 said in his response to questions asked by the Inquiry pursuant to Rule 9 of the Inquiry Rules 2006 that he was screaming for the

³³ [CJS005624_026](#)

³⁴ [Sean Sayers 10 March 2022 141/6-142/6, 144/8-20](#)

³⁵ [CJS005624_008](#)

³⁶ [INQ000111_063](#) para 249

³⁷ [INQ000111_065](#) para 260

³⁸ [INQ000111_063](#) para 249

³⁹ [INQ000158_045](#) para 18.2

officers to release the pressure on him, but this cannot be heard on the footage.⁴⁰

26. However, there are also inconsistencies between the footage of the incident and the Use of Force reports completed by Mr Povey-Meier, Mr Bromley, Mr Sayers and Mr Shadbolt, which give an inaccurate impression of the circumstances in which force was used.

26.1 Mr Bromley and Mr Sayers made reference to D390 not complying with instructions given by Mr Sayers, when the footage is clear that no such instructions were given.

26.2 Mr Shadbolt stated that there was an excessive amount of steam outside the cell, and that Mr Povey-Meier spoke to D390 through the viewing panel. However, the footage demonstrates that there was no steam outside the cell, and that Mr Povey-Meier said D390's name only once before he started addressing D1851.

26.3 Mr Povey-Meier did not acknowledge that a shield was used against D1851.

27. As a result of the inconsistencies that I identified, I relied heavily on the footage to determine the facts of what happened during this incident.

28. During the relevant period, there was an assumption that full PPE would always be used, with no apparent consideration of the fear or distress that might be caused to detained people by its routine use.⁴¹ The Use of Force reports did not reference any historical aggressive or refractory behaviour by D390 or D1851, and there was no other evidence to suggest that PPE was necessary in this situation. I discuss the inappropriate use of PPE further in Chapter D.7 in Volume II.

D390

29. The Inquiry saw no evidence from the footage to support the assertion that D390 was "*repeatedly*" boiling the kettle. I am sure that he was not. Mr Povey-Meier looked through the viewing panel twice, for a total of less than 15 seconds, before telling his colleagues that a kettle was being boiled. He did not say anything about excessive steam in the cell and there was no evidence of steam in the air when the cell door was opened. In the circumstances, and given the time of day, the most plausible explanation for the kettle being boiled is that D390 was either making a hot drink or some food. Moreover, force was used approximately one minute after Mr Povey-Meier stated that a kettle was being boiled in the cell. None of the officers asked D390 why he was boiling the kettle or asked him to stop doing so; in addition, there was no attempt to turn

⁴⁰ [DL0000143_012](#) para 43; [CJS0074063 UOF 137.17 \(2\)](#)

⁴¹ [Steven Dix 9 March 2022 79/16-81/15](#); [David Webb 3 March 2022 151/5-154/3](#); [Nathan Ring 25 February 2022 106/18-107/15](#); [Stewart Povey-Meier 17 March 2022 14/19-25](#)

off the electricity to the cell, nor any suggestion that the officers should come back once the water had cooled down sufficiently. The officers did not discuss the appropriate approach to the situation among themselves, and it is not clear what risk D390 was said to pose that necessitated the officers entering the cell immediately. In the circumstances, I find it implausible that Mr Povey-Meier actually believed the kettle posed a risk of harm to the officers.

30. In my view, the incident on 5 June 2017 is an example of officers and managers resorting to force too quickly. They did not appear to view force as a coercive tool that was only to be used when all other alternatives had been exhausted. Rather, there was an assumption on the part of the officers that force was necessary and inevitable, and the reference to the risk of the boiling water appeared to serve as justification for not attempting to de-escalate the situation and negotiate with D390. Indeed, in line with other evidence seen by the Inquiry, there was a casual approach to the use of force, with no apparent consideration of the impact that it could have on those subjected to it.

31. I agree with Mr Collier’s assessment that the use of force on D390 was not justified. Regardless of what conversations had taken place in advance, there should have been meaningful attempts to engage with him and persuade him immediately prior to any use of force. It is clear from the footage that Mr Povey-Meier made no attempt to talk to D390 before or after the cell door was opened. Although Mr Sayers told the Inquiry that it was his normal practice to give a detained person the opportunity to walk compliantly, there is no evidence to suggest that he did so on this occasion.⁴² The speed with which the shield was applied to D390 indicates that there was no final attempt to persuade him to walk with the officers.

32. In my opinion, the force used against D390, particularly considering the use of PPE, was likely to have caused him humiliation. I consider that there is credible evidence that these facts are capable of amounting to treatment that was degrading.

D1851

33. D1851 was one of the few former detained people who were able to give live evidence regarding their experience, and I found him to be an honest and reliable witness. He was candid about what he could see, and readily accepted that he could not see a baton being used. Moreover, he voluntarily clarified that he had to sit up and push a shield away, rather than being pinned as he originally described.

34. It is not clear whether Mr Povey-Meier and D1851 could hear each other through the crack of the cell door, or whether there was a misunderstanding. In any event, Mr Povey-Meier did not communicate effectively with the other officers to explain what he understood D1851 to have said. Nor did he tell the

⁴² Sean Sayers 10 March 2022 138/2-13

officers how they should interact with D1851 once it was clear that he was remaining in the cell.

35. I cannot be sure that the shield made direct physical contact with D1851 but, from the evidence in the footage, I think it is likely that it did. This was disproportionate, unnecessary and inappropriate. The force used was not used as a last resort and was therefore unjustified.

36. Mr Timms, the officer who used the shield against D1851, did not write a Use of Force report. He should have done so. A shield is a form of PPE, and Mr Timms used it to block and control D1851's movements during this incident.

37. D1851 gave a compelling account to the Inquiry regarding the impact of this incident on him. D1851 told the Inquiry in his written statement:

*"They did not care what I had to say and did not respond to me at all. The way they were dressed made the whole experience even more menacing and distressing."*⁴³

38. The Inquiry heard evidence of fundamental deficiencies in the operation of the safeguards contained in Rule 35 during the relevant period; these are discussed extensively in Chapter D.5 in Volume II. The failures in the system of safeguards for vulnerable people in detention left them exposed to a risk of harm, and to deterioration in their mental state and mental health. In my view, D1851's account of mental deterioration during his period of detention in Brook House suggested that he should have been referred for a Rule 35 report at this time, regardless of the fact that he did not specifically request one.⁴⁴

39. In my view, force was not used against D1851 as a last resort when all other alternatives had been exhausted, and it was therefore not justified. I accept D1851's account that he had confirmed to the officers that he would sit on his bed and not intervene in their efforts to remove D390. I consider that, particularly in light of the fact that the officers were in PPE, the use of force was a frightening experience for D1851, which was likely to exacerbate the anxiety, fear and distress with which he was already suffering. Indeed, D1851 said that this incident left him feeling *"helpless and completely vulnerable"*. Therefore, in my view, there is credible evidence that this incident was capable of amounting to degrading treatment.

⁴³ [DL0000143_012](#) para 44

⁴⁴ [DL0000143_025](#) para 93

Chapter C.9:

D1538 in June 2017, and D1538 and D865 on 4 July 2017

1. D1538 was born in Morocco.¹ He said that he had been subjected to severe physical abuse from his father as a child, and sexual and physical assaults by strangers.² He said that he travelled to the UK in 2014 to escape this treatment.³ D1538 was detained in Brook House between June and July 2017.⁴ He told the Inquiry that he did not feel safe in detention as a gay man.⁵

2. D865 was D1538's cell mate for a period while they were both detained in Brook House. D865 is an Algerian national. He was detained at Brook House between December 2016 and January 2018. D865 did not disclose any physical or mental disabilities when he arrived at Brook House.⁶ He did not give evidence to the Inquiry.

3. I assessed four incidents involving D1538 in June and July 2017, the last of which also concerns D865 because the evidence concerning their treatment is linked.

3 June 2017

The underlying facts

4. The Inquiry saw closed-circuit television (CCTV) footage of the IT suite recorded at approximately 10:00 on 3 June 2017.⁷ The CCTV footage does not include audio, but it is of high quality visually. The footage, which lasts 10 minutes 31 seconds, shows a small room with a desk with four computer terminals against the wall facing the CCTV camera. Further computer terminals

¹ [DL0000231_001](#) para 2

² [DL0000231_001](#) para 3

³ [DL0000231_001](#) para 5

⁴ [DL0000231_002](#) para 6

⁵ [DL0000231_029](#) para 106

⁶ [CJS000949_001-002](#)

⁷ [Disk 4 UOF 136.17 3 June 2017](#)

are visible against two other walls of the room, although these are only partially visible at the edges of the frame.

- 5.** The footage begins with three detained people sitting at the computer screens facing the CCTV camera. Three other detained people are partially visible at the edges of the frame, one of whom is sitting in front of a computer terminal. Only the heads of the two other detained people are visible but they too appear to be seated. One of these men was D1538.
- 6.** Approximately 12 seconds after the footage begins, DCO Edmund Fiddy opened the door and walked into the room. Mr Fiddy walked to the corner of the room furthest from the door. D1538 approached Mr Fiddy. The angle of the CCTV camera meant that only their legs could be seen. D1538 stood close to Mr Fiddy for approximately 15 seconds, during which time the other detained people in the room looked over in their direction. Another detained person joined them and guided D1538 away from the officer. D1538 appeared agitated and, after some hesitation, returned to his seat.
- 7.** The other detained people continued to look in D1538's direction, and after approximately 20 seconds he stood up and again approached Mr Fiddy. Mr Fiddy held his hand up towards D1538 as an apparent gesture to keep a distance between them. D1538 moved towards Mr Fiddy with his left arm extended and indicating towards DCO Luke Instone-Brewer (who the footage later shows was behind Mr Fiddy at the time). Mr Fiddy then used his hand to make contact with D1538's upper body and push him away. Mr Fiddy pointed at D1538, who moved back towards him. The pair grappled briefly, and Mr Fiddy put his hands onto D1538's neck and pushed him away. Mr Fiddy's hands made contact with D1538's neck for approximately two seconds.

Figure 22: Mr Fiddy and D1538 grappling in the IT suite



8. Mr Instone-Brewer then entered the frame next to Mr Fiddy. D1538 continued to walk towards the officers, who moved backwards in an attempt to maintain distance between themselves and D1538.

9. The detained person who had earlier guided D1538 away stepped in between D1538 and the officers and again guided him backwards. Mr Instone-Brewer appeared to step towards both detained men, and Mr Fiddy can be seen guiding Mr Instone-Brewer away, using his hands in a de-escalatory manner.

10. D1538 remained agitated, and appeared to be trying to get around the detained person, who was now standing between him and the officers. The detained person maintained one hand on D1538's right shoulder and his other hand on D1538's left side, and appeared to be talking to D1538 in an attempt to calm him down. A third detained person also attempted to guide D1538 away from the staff.

11. D1538 pointed at the officers but then returned to his seat. He remained turned towards the officers and gesticulated towards them, and the third detained person walked back over to D1538 in an apparent attempt to

de-escalate the situation. He placed his hands on D1538's shoulder, and blocked his path when D1538 stood back up. After approximately 30 seconds the third detained person returned to his seat, and D1538 appeared to go back to what he had originally been doing. For the next two minutes the room appeared to be calm.

12. Approximately 4 minutes 50 seconds into the footage, a manager opened the door to the room and stood in the doorway. Mr Instone-Brewer walked towards the manager and addressed him while pointing to D1538, who turned around in his chair. After 10 seconds, Mr Instone-Brewer left the room with the manager and the two officers could be seen talking through the glass panel in the door. Mr Fiddy remained in the room with the detained people. D1538 approached Mr Fiddy approximately 30 seconds after Mr Instone-Brewer left the room. He then briefly returned to his seat before approaching Mr Fiddy again. As D1538 was walking away from Mr Fiddy, Mr Instone-Brewer opened the door and addressed D1538, who turned back and pointed towards Mr Fiddy before joining the officer outside the room. Mr Fiddy left the room shortly afterwards but returned after approximately one minute.

13. In his Use of Force report, Mr Fiddy recorded that D1538 had called Mr Instone-Brewer a "*racist motherfucker*" and had threatened to hit him. Mr Fiddy described D1538 approaching Mr Instone-Brewer in an "*extremely aggressive manner*" and wrote that he was worried for his colleague. Mr Fiddy recorded that D1538 entered his personal space and did not retreat when he told him to. Mr Fiddy recorded that he feared being assaulted, and so adopted a defensive stance and "*made a defensive push*" towards D1538 while telling him to keep back. He wrote that D1538 approached him from the left and that he believed D1538 may have been attempting to assault him and Mr Instone-Brewer. Mr Fiddy wrote:

*"this is when I pushed the detainee backwards as he was once again in my personal space with his head tilted towards mine. When [I] pushed him out of my personal space he simultaneously grabbed the back of my neck and pulled me closer and this is when I pushed him harder for him to stop assaulting me."*⁸

14. Mr Instone-Brewer recorded his account of the event on an incident report form.⁹ He described being asked for access to a computer by D1538 and politely replying that D1538 was welcome to use any computer, but that there were problems with the internet speed. Mr Instone-Brewer wrote that D1538 said "*fuck you*" in response and went on to call him a racist. He said that several other detained people attempted to calm D1538 down, and one of them disputed that Mr Instone-Brewer had been racist. Mr Instone-Brewer recorded that D1538 became more animated and began to threaten to assault

⁸ [CJS001619_003-004](#)

⁹ [CJS001619_027](#)

him. At this point, Mr Fiddy entered the room and, seeing D1538's aggression towards Mr Instone-Brewer, stood between the two men to create a barrier. Mr Instone-Brewer recorded that D1538 approached Mr Fiddy, who commanded him to get back a number of times. Mr Fiddy then pushed D1538 back. D1538 launched himself at Mr Fiddy and grabbed him by the throat, but Mr Fiddy was able to push D1538 back after a short struggle. Mr Instone-Brewer wrote that D1538 then moved away but continued to make threats until he was removed by a manager.

15. Documentation under Rule 40 of the Detention Centre Rules 2001 (removal from association) was completed by DCM Andy Lyden, who recorded the reason for removal from association as the invasion of an officer's personal space. Mr Lyden recorded that the Duty Director, Mr Julian Williams, had been consulted and that Rule 40 was required. Mr Lyden's signature was added at 14:00, four hours after the incident in the IT suite.¹⁰ Mr Williams subsequently recorded that he considered the correct action had been taken. He stated that he had authorised the barring of D1538 from the IT suite for one week.¹¹

16. D1538 made a complaint through his solicitors on 21 August 2017, after he had been transferred to Harmondsworth immigration removal centre.¹² His complaint related to the incident in the IT suite on 3 June 2017 and another incident on 28 June 2017 (which I consider later in this chapter). The complaint in relation to the incident in the IT suite reads:

*"The first allegation is that, on 3 June 2017, there was an incident involving the use of the computer room. Our client states that he was denied use of a computer by a detention officer and that he was not provided a reason for this. Our client then alleges that the detention officer called over other detention officers who then pushed and tried to slap him. Our client was calm until this point but then looked to defend himself. As a result of this incident, the manager was called over and our client was sent to isolation for 24 hours and banned from the computer room for 7 days."*¹³

17. As discussed in Chapter D.10 in Volume II, D1538's complaint was eventually referred to the Home Office Professional Standards Unit (PSU) for investigation in November 2017 (three months after the complaint, as it was at first wrongly allocated by the Home Office to G4S). D1538 was not interviewed about the incident until 15 December 2017, approximately four months after his complaint, and was not given an interpreter.¹⁴ The PSU's investigating officer was Mr John Adamson, who prepared a summary of the interview with

¹⁰ [CJS001619_018](#); [CJS001619_026](#)

¹¹ [CJS001619_015-026](#)

¹² [DL0000067_001-002](#)

¹³ [CJS001360_001](#)

¹⁴ [HOM002627](#)

D1538. This account was not prepared in consultation with D1538 and it has not been adopted by him. The summary records that D1538 told Mr Adamson that he had not approached the officers in the IT suite and that he had simply asked several times to use a computer and had been ignored, and then shouted at, by the officers. D1538 told Mr Adamson that he did not “*get on a computer*” and that he had not sat down at a computer or anywhere. D1538 said that he had not approached the officers, and that he had been pushed by both officers.¹⁵ The PSU investigation report concluded that Mr Instone-Brewer and Mr Fiddy had acted in accordance with their training.¹⁶

18. In his witness statement to the Inquiry, D1538 stated that he was denied use of a computer by a staff member and that he was pushed by another officer following a verbal altercation. This resulted in D1538 feeling that it was necessary to defend himself.¹⁷

19. In his oral evidence to the Inquiry, Mr Fiddy accepted that the CCTV appeared to show him making contact with D1538’s neck, and that he did not use a technique that had been taught to him in training. However, he maintained that he pushed D1538 away in order to protect himself and that he did not use any more force than was necessary in the circumstances.¹⁸

Relevant expert evidence

20. The Inquiry’s use of force expert, Mr Jonathan Collier, noted that the use of force training highlights that the neck is an extremely vulnerable area. However, on the whole he considered that the grab was a “*reactive motion*” that was momentary and then followed by a push away.¹⁹ In the circumstances, Mr Collier took the view that the force used was reasonable, proportionate and applied as there was no other option available to Mr Fiddy.²⁰

Conclusions

21. The CCTV camera did not cover the IT suite in its entirety, and it is not always possible to see D1538 or Mr Instone-Brewer. The absence of audio presents a particular challenge in corroborating the accounts given by D1538 and the officers about the nature of the conversations between them. However, despite those limitations, it is my view that the CCTV footage provides enough detail for me to determine the facts of the physical altercation between D1538, Mr Fiddy and Mr Instone-Brewer. The quality of the images is high, and enabled me to review the body language of each individual involved. D1538 did

¹⁵ [HOM002627_002](#)

¹⁶ [CJS003348_025](#) para 8.25

¹⁷ [DL0000231_024](#) para 90

¹⁸ [Edmund Fiddy 7 March 2022 171/18-172/11](#)

¹⁹ [INQ000111_113](#) para 474

²⁰ [INQ000111_114](#) para 485

not give oral evidence to the Inquiry. However, he did give a very detailed witness statement setting out his account of this incident, and his response to a summary of the CCTV footage, which I have taken into account.²¹

22. Irrespective of what the conversation was about, the footage clearly shows that D1538 approached the officers repeatedly and twice got very close to Mr Fiddy. His body language was at times aggressive. The use of force was brief and appeared to be in direct response to D1538's physical aggression. Given the manner in which D1538 was approaching Mr Fiddy, it was reasonable for Mr Fiddy to believe that he may have been under imminent threat of an assault, and his use of force was therefore justified and proportionate.

23. Although I find Mr Fiddy's actions to have been reasonable in the circumstances, he should have clearly documented in his Use of Force report that he had grabbed D1538's neck during the restraint. Mr Lyden, the manager who reviewed the footage, should also have identified that this happened and ensured that the Use of Force report accurately reflected the incident. In addition, he should have arranged for D1538 to be assessed by Healthcare to ensure there were no injuries to his neck.

24. There was a period of approximately four hours between the incident in the IT suite and D1538 being made subject to Rule 40. It appears likely to the Inquiry that D1538 was made subject to Rule 40 in response to his behaviour earlier in the day and not in order to maintain the safety and security of Brook House, given the passage of time between the incident and the authorisation of Rule 40. The paperwork suggests that Mr Lyden, not the Home Office, authorised the use of Rule 40 in this case.

25. I do not think that there is credible evidence that the use of force against D1538 on 3 June 2017 was capable of amounting to mistreatment. It does not reach the threshold of attaining a "*minimum level of severity*".²² The application of Mr Fiddy's hand to D1538's neck lasted for a matter of seconds and, in my opinion, was not likely to have caused intense physical or mental suffering so as to be considered inhuman treatment. Nor did it appear to cause fear, anguish or inferiority capable of humiliating or debasing, so as to be considered degrading treatment. Despite my conclusion, I have included the facts of this incident in this chapter by way of contextual background, and due to its similarity and close proximity in time to the other incidents involving D1538.

²¹ [DL0000231_024-028](#) paras 89-101

²² [Ireland v United Kingdom \(Application no. 5310/71\) \(1978\) 2 EHRR 25](#); [Soering v United Kingdom \(Application no. 14038/88\) \(1989\) 11 EHRR 439 para 100](#); [Vilvarajah v UK \(Application no. 13163/87\) \(1992\) 14 EHRR 248 para 107](#); [Keenan v United Kingdom \(Application no. 27229/95\) \(2001\) 33 EHRR 38 para 109](#)

6 June 2017

The underlying facts

26. The Inquiry saw four pieces of footage relating to the use of force on D1538 on 6 June 2017.

27. The first was covertly recorded by DCO Callum Tulley on 6 June.²³ The footage, which is 12 minutes 49 seconds long, begins with Mr Tulley responding to an incident in the arts and crafts room. As he entered the room, raised voices could be heard and several detained people could be seen standing around a large table. Mr Tulley asked them to move aside and, as they did so, the camera focused on D1538, who had an officer on either side of him restraining his arms. These officers were DCM Nick London and DCO Ryan Bromley. D1538 was struggling against the officers' restraint and Mr Bromley was urging him to calm down.

28. A manager, DCM Shane Farrell, moved suddenly towards D1538 and took hold of his head, pushing it downwards.

Figure 23: Mr Farrell's first restraint of D1538's head



29. Mr Farrell kept D1538 in this position for approximately four seconds, during which time other detained people in the room called out in protest and moved towards the restraint. The view of D1538 is partially obstructed by

²³ [KENCOV1031 - V2017060600011](#)

Mr London, but D1538 appeared to move backwards before Mr Farrell released his head. It is unclear whether this was a result of him pulling away voluntarily or whether he lost his balance.

30. D1538 became more resistant to the officers restraining his arms. An officer behind Mr Farrell pushed him back towards D1538 and Mr Farrell took control of D1538's head a second time. The other detained people were told to leave the room.

31. After approximately 30 seconds, Mr Farrell released D1538's head. D1538 began to shout at Mr Farrell, who appeared to be arguing back. Mr Farrell gesticulated forcefully at D1538 and DCM Steven Dix came between the two to speak to D1538.

32. At this point, it appears from the footage that there were seven officers in the room, five of whom were in close proximity around D1538. In addition, there were two members of Healthcare staff and the teacher, Ms Sarah Walpole.

33. The staff asked D1538 what had happened and the officers released his arms. D1538 was agitated and swearing, but the details of what he was saying are not clear from the audio. D1538 tried to leave the room but was blocked by staff and told to take a seat. D1538 attempted to explain and demonstrate to the staff what had happened. He was agitated and pacing, and a number of staff gave him instructions to sit down, which he then did, allowing a member of Healthcare to check him for injuries. Ms Walpole explained to Mr Tulley that another detained person had started a fight with D1538 and that this had been unprovoked. Ms Walpole then repeated this information to the other managers and officers. She later recorded the same information in an incident report.²⁴ Mr Dix told D1538 that he would be moved to E Wing while the CCTV cameras were checked to establish what had happened. D1538 walked compliantly out of the room with the officers.

34. The second piece of footage seen by the Inquiry is from the CCTV camera in the arts and crafts room.²⁵ The footage shows D197 entering the room with a bag in his hand. He walked around the large table until he reached D1538, who was sitting at the table drawing, and began to physically attack him. Other detained people around the table separated D1538 and D197, but D197 attacked D1538 a second time. The other detained people again separated the men and D197 then walked out of the room. Mr Bromley, Mr London and Mr Farrell then entered the room and restrained D1538.

35. The third piece of footage seen by the Inquiry was covertly recorded by Mr Tulley after the use of force.²⁶ The footage is 34 seconds long and captures

²⁴ [HOM004133_005](#)

²⁵ [Disk 55 6 June 2017 1526](#)

²⁶ [KENCOV1033 - V2017061000007](#)

a conversation between Mr Tulley and Mr Bromley. Mr Tulley asked, “*Did you see Shane?*”, and Mr Bromley smiled, slightly shook his head and said, “*He took his head clean off. I know.*” Mr Bromley added “*I hate being the head officer*” and “*pulled his neck right down. That’s why even [D149]’s mates were [inaudible] and they’re the ones that fight him.*”

36. The fourth piece of footage seen by the Inquiry was recorded by Mr Tulley after he finished his shift on 6 June 2017. Mr Tulley recorded a piece to camera about some of the day’s events and described the incident in the arts and crafts room.²⁷ He described Mr Farrell pulling D1538’s head down and escalating the situation. Mr Tulley said that Mr Farrell’s approach was a complete overreaction and was unnecessary. Mr Tulley said that this caused the other detained people to react in protest and resulted in more resistance from D1538: “*The behaviour of the manager was ridiculous, it put everyone at risk because you do not know how the other detainees are going to react. It set a shocking example.*”

37. Mr London recorded in his incident report that D1538 was taken to E Wing “*to calm down*”.²⁸ It does not appear that any restrictions were placed on his movement.

38. In his statement to the Inquiry, D1538 said that he felt he was in serious danger when D197 attacked him on 6 June 2017.²⁹ D1538 described being restrained by Mr Bromley and Mr London, and gave his view that this was “*really unfair, I had not done anything wrong – they should have been focusing on [D197] not me*”.³⁰ D1538 added:

“The restraint made me much more angry and frustrated as I felt it was really unfair that they were using force against me just after I had experienced such a frightening attack.”³¹

His statement detailed his recollection of Mr Farrell’s restraint of his head:

“Then from nowhere an officer grabbed my head. This meant I could barely breathe. I was being strangled. It felt like the officer was fighting with my head. They held me very tight, it was painful. This made the situation a lot worse and it made me feel even more frustrated and upset.”³²

39. All three officers wrote that Mr Farrell’s restraint had been prompted by D1538 moving his head around in a way that exposed him to injury.³³

²⁷ [TRN0000064_007-010](#)

²⁸ [CJS005615_002](#)

²⁹ [DL0000231_010](#) para 45

³⁰ [DL0000231_010](#) para 48

³¹ [DL0000231_010](#) para 48

³² [DL0000231_011](#) para 50

³³ [CJS005615_008](#); [CJS005615_012](#); [CJS005615_015](#)

Mr London and Mr Farrell referred to a cabinet or cupboard being in close proximity to D1538's head.³⁴

40. D1538 said that he considered the Use of Force reports submitted by Mr London, Mr Bromley and Mr Farrell to be inaccurate.³⁵ D1538 wrote that it was clear from Mr Tulley's undercover footage that his head had not been near a cabinet when Mr Farrell restrained it. D1538 said that Mr Farrell's actions had caused him to fall and had actually put him in greater danger rather than protecting him.³⁶ D1538 wrote that he could not recall whether he was taken to E Wing or to the Care and Separation Unit (CSU). He noted that the Use of Force reports indicated the former, but that a log provided by G4S recorded that he was taken to the CSU.³⁷ D1538 wrote that being isolated after he was the victim of an unprovoked attack felt like a punishment.³⁸ He told the Inquiry that he had attempted to tell the PSU about the 6 June 2017 incident on 15 December 2017, when he attended a meeting to discuss his complaint dated 21 August 2017, but was told that the PSU was only there to discuss the complaints set out in that letter.³⁹ If this is correct, it is concerning.

41. During his oral evidence to the Inquiry, Mr Farrell was asked by Counsel to the Inquiry about the justification for restraining D1538's head. After watching Mr Tulley's covertly recorded footage, Mr Farrell accepted that D1538 was not at risk of hitting his head on a cupboard when he first took control of his head, but maintained that there was a risk of this at the point when he restrained D1538's head a second time.⁴⁰ Mr Farrell told the Inquiry that none of the other staff present during the incident expressed a view that the force used was excessive.⁴¹

42. In his oral evidence to the Inquiry, Mr Bromley told the Inquiry that he maintained the view that Mr Farrell took hold of D1538's head for D1538's own safety, as there was a risk of him hitting his head on a cabinet.⁴² Counsel to the Inquiry asked Mr Bromley about the covertly recorded conversation that took place between himself and Mr Tulley after the incident. Mr Bromley accepted that the evidence demonstrated that the conversation had taken place but said that he had no memory of it. Mr Bromley said that he was unable to explain why he said to Mr Tulley "*He took his head clean off*" and that he was of the view at the time that Mr Farrell's restraint of D1538's head

³⁴ [CJS005615_008](#); [CJS005615_012](#)

³⁵ [DL0000231_011](#) para 52

³⁶ [DL0000231_011](#) para 54

³⁷ [CJS000896](#) tab 2, row 201, column headed 'Details'

³⁸ [DL0000231_018](#) para 68

³⁹ [DL0000231_018](#) para 73

⁴⁰ [Shane Farrell 8 March 2022 97/16-98/4](#)

⁴¹ [Shane Farrell 8 March 2022 101/4-102/2](#)

⁴² [Ryan Bromley 7 March 2022 123/10-123/24](#)

was “textbook”.⁴³ Mr Bromley said during his evidence that he was still of that opinion in light of the footage.⁴⁴

43. During his oral evidence to the Inquiry, DCM Stephen Loughton said that he had been ‘Oscar 1’ (the operational manager on duty) at the time of the incident in the arts and crafts room.⁴⁵ Mr Loughton told the Inquiry that he was aware from his review of the incident that no body worn cameras had been activated. He suggested, under questioning by Counsel to the Inquiry, that *“Sometimes, when there’s an incident and it happens that quick, you don’t have a chance to put your body-worn camera on.”* It is not clear from Mr Loughton’s evidence whether he spoke to any of the officers who had not turned on their cameras.⁴⁶ When asked by Counsel to the Inquiry why no report of injury form had been completed for D1538, Mr Loughton said that he did not know.⁴⁷

Relevant expert evidence

44. Mr Collier considered that the force used on D1538 was necessary, proportionate and used for no longer than necessary.⁴⁸ In his opinion, the technique used by Mr Farrell was consistent with the use of force training, and he had not seen any evidence that the force used against D1538 was excessive.⁴⁹ He commented:

*“Once the head support was no longer required it was removed, and then re-applied when the situation escalated. I am content that constant evaluation took place and that staff responded appropriately withy [sic] the level of force used.”*⁵⁰

Conclusions

45. I agree with Mr Collier that it was reasonable for Mr Bromley and Mr London to restrain D1538 by his arms, as he was agitated. While the technique used by Mr Farrell to restrain D1538 may have been technically correct, having reviewed the evidence as a whole I do not agree with Mr Collier that it was necessary to apply it at the point at which Mr Farrell did, or that he used only necessary force when he did so.

⁴³ [Ryan Bromley 7 March 2022 125/24-126/10](#)

⁴⁴ [Ryan Bromley 7 March 2022 128/22-129/9](#)

⁴⁵ [Stephen Loughton 1 March 2022 121/14-15](#)

⁴⁶ [Stephen Loughton 1 March 2022 122/15-123/7](#)

⁴⁷ [Stephen Loughton 1 March 2022 123/18-20](#)

⁴⁸ [INQ000111_101](#) paras 417 and 418

⁴⁹ [INQ000158_095](#)

⁵⁰ [INQ000111_101](#) para 418

- 46.** In my opinion, Mr Farrell made an error of judgement.
- 46.1** There was no immediate need to use more force against D1538. While D1538 was struggling, he was being held securely by Mr Bromley and Mr London, and he was not in any danger of hitting his head. As stated above, this was accepted by Mr Farrell.
- 46.2** It is my view that Mr Farrell used more force than was necessary in applying the head support technique. His initial restraint appeared to exert real force, and his quick release of D1538, some four seconds after he first restrained him, suggests that he realised this. It is notable that when he restrained D1538's head the second time, he did so with more control and to a lesser angle.
- 46.3** This is corroborated by the immediate reactions and accounts of other people physically present in the room at the time, who had a clear view of what happened and an ability to gauge the atmosphere following the use of force in a way that is not possible from a simple review of the footage. For example:
- Mr Bromley commented to Mr Tulley shortly after the incident that Mr Farrell took D1538's "*head clean off*" and "*pulled his neck right down*".⁵¹
 - The other detained people in the room shouted, moved towards the restraint and raised their arms immediately after Mr Farrell applied the head support, rather than leaving as requested.
 - At the end of his shift, Mr Tulley recorded his view of how the incident had unfolded. He explained that Mr Farrell grabbed D1538's head and pulled it down, and that the reaction of the other detained people was due to the actions of Mr Farrell. It is not audible on the footage of the incident itself, but in this clip Mr Tulley says that the other detained people were shouting, "*Get off him!*", "*Get off him!*", "*What are you doing to him?*", "*What are you doing to him?*", as a result of Mr Farrell grabbing D1538's head.⁵² Given the reaction of the detained people on the footage, which is described in paragraph 29, I think this is highly likely to be accurate.
- 47.** Mr Bromley's assertion in his oral evidence that, at the time, he thought Mr Farrell's actions in restraining D1538 were "*textbook*" is not credible. I found his evidence to be evasive and self-serving. The informal conversation with Mr Tulley, during which Mr Bromley was unaware that he was being filmed, indicates that Mr Bromley was concerned by what he had witnessed and did not in fact view Mr Farrell's actions to be in line with restraint training. I cannot be sure why he did not report any of his concerns, but note that this

⁵¹ [KENCOV1033 - V2017061000007](#)

⁵² [TRN0000064_008](#)

Inquiry found evidence of a culture that did not encourage or support constructive challenge of colleagues and, in fact, characterised this as 'grassing'. The staff culture in relation to reporting concerns at Brook House is examined in more detail in Chapter D.9 in Volume II.

48. The effect of Mr Farrell using excessive force was that he escalated the situation. I accept that D1538 felt "*a lot more frustrated, stressed and scared*" as a result of Mr Farrell's actions, and I also accept that he felt the use of force was unfair in circumstances where he had been the victim of a physical attack by another detained person, rather than the aggressor.⁵³ Taking these things together, I consider it likely that he also experienced the use of force as humiliating.

49. After D1538 was released from the restraint, action was not taken swiftly enough to establish what had happened and to offer D1538 support. Ms Walpole, who had witnessed the attack on D1538, immediately informed the officers and managers in the room that D1538 had not instigated the violence.⁵⁴ It was reasonable to allow D1538 time to calm down before returning him to a wing. While it is understandable that he perceived being moved to E Wing as a punishment rather than a measure intended to support him in the aftermath of a physical attack, E Wing was also used to accommodate detained people subject to Rule 40 during the relevant period and I have found that Rule 40 was inappropriately used as punishment. (The multi-purpose nature of E Wing during the relevant period is discussed further in Chapter D.7 in Volume II.)

50. As a result of the *Panorama* programme, in December 2017 the PSU was carrying out investigations into multiple incidents that occurred during the relevant period, including several that related to the use of force. These investigations did not include D1538's complaint about events on 6 June 2017. However, as discussed above, they did include investigations into allegations made by him regarding events on 3 June 2017 and 28 June 2017.

51. I considered D1538's state of mental health at the time of the restraint on 6 June 2017 and whether he was more vulnerable to mistreatment as a result. D1538 had been physically attacked by another detained person and was agitated and upset. I accept D1538's evidence that the head restraint had the effect of making him feel more frustrated, stressed and scared, and that the sudden pushing down of his head caused him pain. I find that this was likely to cause him intense mental suffering. Therefore, there is credible evidence that this incident alone was capable of amounting to inhuman and degrading treatment.

⁵³ [DL0000231_018](#) para 72

⁵⁴ [TRN0000089_010](#)

28 June 2017

The underlying facts

52. In D1538’s statement to the Inquiry he wrote that, on 28 June 2017, he was attempting to go to C Wing to meet another detained person who had agreed to provide him with clothes. D1538 wrote that DCO Darren Tomsett told him he was not allowed to go to C Wing and that he needed to change his clothes “because [he] looked gay”.⁵⁵ D1538 said that Mr Tomsett made the comment in front of other detained people, which caused him to fear how they would react, and that he himself reacted angrily.⁵⁶ He said that he was mocked by other detained people for days afterwards as a result of what Mr Tomsett said.⁵⁷ D1538 wrote that he did not feel comfortable in detention and that he believed that staff were hostile towards gay people.⁵⁸

53. D1538 told a PSU investigating officer that Mr Tomsett pushed him and put his head down.⁵⁹ He said that he was told to go to the staff office if he wanted to complain and that, once there, a conversation took place with Mr Tomsett and a manager. He said that Mr Tomsett complained about him to the manager, who did not give D1538 a chance and only listened to Mr Tomsett.⁶⁰

54. In his witness statement to the Inquiry, Mr Tomsett said that he did not specifically remember the incident but stated that he would not have told any detained person that they looked gay.⁶¹ Mr Tomsett said that he was aware from reviewing documentation that he had given D1538 a verbal warning. He said that D1538 had been verbally abusive and had been attempting to get onto C Wing without authorisation.⁶² Mr Tomsett denied pushing D1538’s head down.⁶³ He told the Inquiry that he believed D1538 may have fabricated his account because he was angry that Mr Tomsett had not allowed him onto C Wing.⁶⁴

55. D1538 complained to the Home Office about Mr Tomsett in October 2017, after having initially issued a complaint in August 2017. Owing to a misallocation of his complaint, the matter was initially investigated by G4S and

⁵⁵ [DL0000231_028](#) para 102

⁵⁶ [DL0000231_028](#) para 102

⁵⁷ [DL0000231_029](#) para 104

⁵⁸ [DL0000231_029](#) para 105

⁵⁹ [HOM002627_004](#)

⁶⁰ [HOM002627_002](#)

⁶¹ [INN000024_054-055](#) paras 178-179

⁶² [INN000024_054](#) para 178

⁶³ [INN000024_055](#) para 179

⁶⁴ [Darren Tomsett 7 March 2022 59/24-60/8](#)

there was a significant delay in the PSU investigating D1538's allegations.⁶⁵ The PSU investigating officer did not interview Mr Tomsett, relying instead on an earlier interview carried out by G4S.⁶⁶ The PSU reasoned that D1538's explanation as to why he wanted to access C Wing was doubtful because documentation showed that D1538 had been in possession of clothing on 3 June 2017.⁶⁷ The investigation concluded that there was no definitive evidence that Mr Tomsett had made homophobic comments.⁶⁸ It also concluded that, if D1538's head had been pushed down, this would have constituted a use of force and there was no documentation to record that this had happened.⁶⁹ A summary of the investigation report was sent to D1538 via Home Office Detention and Escorting Services, rather than directly from the PSU.⁷⁰

Conclusions

56. The Inquiry heard evidence that D1538 was, at times, confrontational (see, for example, the conclusions above regarding the incident on 3 June 2017).

57. The Inquiry also heard evidence that Mr Tomsett found "*controlling the door*" between wings to be challenging, due to the amount of abuse he received from detained people who were not allowed to move freely between wings.⁷¹

58. There were also examples of Mr Tomsett's poor behaviour towards detained people, particularly when he believed that his authority was being challenged.

58.1 In a recording from 5 June 2017, Mr Tomsett told a detained person asking for new underwear that he was "*whining like a girl*" and to "*man up*", saying that he would not "*listen to your fucking bollocks*". He also referred to a detained person as a "*cunt*".⁷²

58.2 In covert audio of a conversation between Mr Tomsett and Mr Tulley on 6 June 2017 about the misuse of drugs in Brook House, Mr Tomsett referred to detained people as "*wanker*" and "*fucking idiot*". He also described all the detained people in single occupancy rooms as "*nonces*".⁷³

⁶⁵ [CJS001360](#); [CJS003348_006](#) paras 5.1-5.11

⁶⁶ [CJS003348_022](#) para 7.3.14

⁶⁷ [CJS003348_022](#) para 7.3.13

⁶⁸ [CJS003348_022](#) para 7.3.17

⁶⁹ [CJS003348_022](#) para 7.3.15

⁷⁰ [DL0000060](#)

⁷¹ [Darren Tomsett 7 March 2022 10/15-11/25](#)

⁷² [TRN0000080_002](#); [TRN0000080_004](#)

⁷³ [TRN0000081_006-007](#)

58.3 In a recording from 19 June 2017, Mr Tomsett stated that he had told a detained person he would “*fucking put you out of your misery*”.⁷⁴

58.4 There were multiple allegations of racism against Mr Tomsett from at least five detained people over a number of years.⁷⁵

58.5 There was also a log of complaints of verbal aggression made against Mr Tomsett relating to D1985, D4277, D4049, D381 and D1399.⁷⁶

59. I find D1538’s account credible in light of the other evidence heard about Mr Tomsett’s conduct. The recordings obtained by the Inquiry in particular show that Mr Tomsett was willing to direct particularly insulting and hostile language at detained people in his care, and that he could also be threatening. While Mr Tomsett denied the allegations of racism made against him, and the complaints of verbal aggression made against him were recorded as unsubstantiated,⁷⁷ I consider it highly unlikely that the only times Mr Tomsett used inappropriate language either towards or about detained people were when he was filmed by Mr Tulley.

60. Irrespective of D1538’s stated reasons for wishing to enter C Wing, Mr Tomsett was probably irritated by D1538 during their exchange on 28 June 2017 and is likely to have then used abusive and homophobic language towards him. Homophobic insults are unacceptable in any environment, but in a detained environment they can put individuals at risk of harm. D1538 told the Inquiry that he did not feel detention was an environment where it was safe to be open about his sexuality.⁷⁸ I consider it likely that he was therefore frightened of the consequences of other detained people hearing Mr Tomsett’s comments.

61. It is inherently difficult for a detained person to prove that they were verbally abused by a member of staff. In Chapter D.10 in Volume II, I discuss the barriers detained people faced when complaining about their treatment in the relevant period. D1538 overcame these barriers and made a complaint about Mr Tomsett at the same time as he complained about the force used against him on 3 June 2017. There were serious failings in how D1538’s complaints were investigated. These included confusion between G4S and the PSU on jurisdiction for the complaint and, relatedly, delays in carrying out the investigation.⁷⁹ The PSU investigating officer did not interview Mr Tomsett and no attempt was made to interview other staff on duty at the time or, crucially,

⁷⁴ [TRN0000083_002](#)

⁷⁵ [D180, D4277, D381 \(CJS001443_001-005\)](#); [INN000024_051-052](#) para 171; [HOM002190_001](#) row 5; [D668 6 December 2021 88/24-92/16](#); [TRN0000080_002](#)

⁷⁶ [HOM002190](#)

⁷⁷ [Darren Tomsett 7 March 2022 44/19-20, 49/5-50/17, 62/24-63/23](#); [HOM002547](#); [INN000024_056-057](#) paras 183-186; [HOM002190](#)

⁷⁸ [DL0000231_029](#) para 105

⁷⁹ [CJS003348_006](#) paras 5.1-5.11

other detained people who may have witnessed the exchange between D1538 and Mr Tomsett.⁸⁰ The investigating officer did not identify that there had been multiple other complaints against Mr Tomsett for verbal abuse. In drawing conclusions about whether the verbal abuse took place, the investigating officer appeared to believe that it was simply unlikely that an officer would make such comments to a detained person.⁸¹ This showed a lack of investigative rigour and an apparent naivety about the reality of how some staff did speak to detained people in the relevant period.

62. There is a conflict of evidence between D1538's witness statement and what Mr Tomsett told the Inquiry about whether he pushed D1538's head down. In the circumstances of this aspect of the incident, I am unable to reach any conclusions.

63. I find that Mr Tomsett's comment to D1538, that he needed to change his clothes because he looked gay, implied that Mr Tomsett considered there was something wrong with the way that D1538 was dressed. The comment was therefore probably made with the express intention of humiliating D1538, and I think it is likely that he was humiliated. By the time of this incident Mr Tomsett had been working at Brook House for two years and six months.⁸² He was therefore likely to have been aware that there were some detained people in Brook House who did not approve of homosexuality. In the circumstances, I consider that Mr Tomsett is likely to have appreciated that his specific choice of words could have placed D1538 at risk of harm. As such, I find that there is credible evidence that D1538's treatment during this incident alone is capable of amounting to degrading treatment.

D1538 and D865 on 4 July 2017

The underlying facts

64. D865 arrived at Brook House on 4 December 2016. He was first brought to the attention of the mental health team on 18 May 2017, when DCM David Aldis, who was acting as Oscar 1, reported that D865 was tearful and requested a Registered Mental Health Nurse (RMN) appointment for him. Mr Aldis said that D865 was tearful because he had been in detention for a long time and he wanted to be released.⁸³ D865 was given talking therapy on 22 May 2017 by Mr James Newlands (an RMN). In that appointment, D865 denied suffering with mental health issues but described himself as being

⁸⁰ [CJS003348_007-016](#)

⁸¹ [CJS003348_022](#) para 7.3.17

⁸² [INN000024_0001](#) para 2

⁸³ [CJS000949_005](#)

anxious and unhappy with his present situation. A follow-up appointment was not arranged, because *“he does not think this will help him”*.⁸⁴

65. On 4 July 2017, D865 attempted to hang himself. The Inquiry saw an incident report completed by DCO Ben Opoku on 4 July 2017. Mr Opoku recorded that he had unlocked the door of D865’s cell at around 12:20 so that D865 could attend his job as a wing cleaner. Mr Opoku wrote that D1538, who shared a cell with D865, shouted that D865 was on the floor and had tried to harm himself. Mr Opoku then used his radio to request assistance, and Healthcare staff and other officers arrived at the cell.⁸⁵

66. The Inquiry saw footage covertly recorded by Mr Tulley on 4 July 2017.⁸⁶ The footage, which is just under 19 minutes long, begins with Mr Tulley running along A Wing to respond to the incident. As Mr Tulley approached the end of the wing, several people were standing outside looking into one of the cells. D1538 (one of those outside the cell) told officers that he had been in the toilet, had heard a crash, and had then found D865 lying on the floor with something around his neck.

67. D865 was face down on the floor inside the cell. Mr Tulley indicated that he thought he could still see something tied around D865’s neck. DCM Christopher Donnelly, who was standing close to D865, initially disagreed that there was a ligature but then took a fish knife from his belt and cut what appeared to be a dark cable or shoestring from D865’s neck. D865 was unresponsive.

⁸⁴ [CJS000949_006](#)

⁸⁵ [CJS004312_004](#)

⁸⁶ [KENCOV1043 - V2017070400007 clip 1](#)

Figure 24: D865 unresponsive on the floor of the cell as Mr Donnelly removes the ligature from his neck



68. Members of Healthcare attended to D865, who did not move or respond for approximately three minutes after the ligature had been removed. While D865 was unresponsive, an officer said that he did not think D865 had suspended himself, but that the bracket had broken.

69. Approximately four minutes into the footage, D865 lifted his head and the Healthcare staff explained to him that they were checking his blood pressure. D865 appeared disorientated and could be seen wiping tears from his face. Radio messages can be heard asking that a cell be prepared for constant observations of D865. D865 slowly sat himself up and quietly asked, *“what’s happening?”*. The Healthcare staff explained that they were there to help him, and he allowed them to take his blood pressure. D865 began to cry.

70. D1538 can be heard outside the cell attempting to explain to the officers what he had witnessed.

71. D865 got up and walked to sit on the bed. Mr Donnelly told D865 that he was going to be moved to E Wing *“to keep him safe”*. Mr Donnelly asked D865 what he had been thinking, to which D865 quietly responded, *“don’t know”*. Mr Donnelly asked D865 if he was trying to kill himself, and again D865 responded, *“don’t know”*. He was still crying and a red mark could be seen on his neck. A nurse knelt down beside D865 and gently tried to ascertain what had happened, but D865 started to sob harder and he appeared unable to respond to her.

72. The officers started to gather D865's belongings so that he could be moved. D1538 can be heard saying that he wanted to see a doctor, adding, *"I'm shaking, I'm not alright."* Mr Donnelly responded, *"that's what I asked you"*, but without turning towards D1538 or stopping what he was doing. Mr Tulley and another officer continued to pack up D865's belongings while he sat on the bed and smoked a cigarette. Interaction between the staff and D865 was minimal and related only to identifying his possessions.

73. As D865 left the cell to walk to E Wing, Mr Tulley asked him why he had self-harmed and whether this was caused by him receiving bad news. D865 responded, *"Bad news is I'm here. I've been here two years, it is no good news."* He then added, *"I came back, I want to kill myself. I have no – I lose everything. I don't care about life anymore."*

74. On his arrival at E Wing, an Assessment Care in Detention and Teamwork (ACDT) plan was opened for D865 and he was placed on constant observation.⁸⁷ Ms Christine Williams, the Clinical Lead, completed section 3 of the F213 form (this is used to record Healthcare staff's observations of a use of force incident from a clinical perspective, as well as any injuries to the detained person, and is usually attached to the Use of Force report). She recorded that D865 had red marks around his neck following an attempt to hang himself. D865 said that he wanted an appointment with an RMN.⁸⁸ Entries in D865's medical records indicate that he was seen by Ms Karen Churcher, an RMN, the following day. D865 remained on an ACDT plan until 2 August 2017.⁸⁹

75. Following the *Panorama* programme, G4S investigating officers interviewed Mr Opoku regarding his actions on 4 July 2017.⁹⁰ Mr Opoku initially told the officers that he had seen D865 lying on the floor with a ligature around his neck, and that a TV bracket had come away from the wall. He said that he had waited at the cell door for a first response team to arrive. Later in his interview, after consulting with a workplace colleague, Mr Opoku said that he had not in fact seen a ligature. He said that he had been in a state of shock upon seeing D865 and that this had been the reason why he had not acted.⁹¹ Mr Opoku was issued with a written warning by G4S and was required to attend refresher training in first aid.⁹²

76. The Inquiry saw a second piece of footage covertly recorded by Mr Tulley.⁹³ The footage is approximately 30 seconds long and begins with Mr Tulley asking D1538 what happened to D865. D1538 explained that he

⁸⁷ [CJS001034](#)

⁸⁸ [CJS004312_006](#)

⁸⁹ [CJS000949_007](#)

⁹⁰ [HOM001004_001-006](#)

⁹¹ [HOM001004_003-004](#)

⁹² [CJS0073449](#)

⁹³ [KENCOV1043 - V2017070400007 clip 2](#)

heard the TV fall to the ground while he was in the toilet area of the cell and that he saw D865 *"shaking on the floor"*. He added, *"I swear I'm so scared man."* D1538 told Mr Tulley that he could not watch, which is why he pressed the alarm bell and ran to fetch the officers.

77. Ms Churcher made an entry in D1538's medical records dated 5 July 2017. She recorded that she had seen D1538 on the wing at the request of Mr Donnelly. She wrote:

"He shares a room with fellow detainee who attempted to hang himself yesterday. States he is shaken and has recurrent thoughts and dreams about. Is also stressed about being detained and has been placed on a raised concern."

Ms Churcher added that D1538 had said he wanted to see the mental health team. She recorded that an appointment was scheduled for 10:00 on 10 July 2017.⁹⁴

78. There were two entries made in D1538's medical records on 10 July 2017.

78.1 In the first, which was made at 09:59, Ms Churcher wrote:

"Did not attend the mental health appointment given. This was one off appointment in response to an incident. Therefore no further appointment will be made."

78.2 Ms Churcher also noted that D1538 could self-refer if required.⁹⁵

78.3 The second entry on 10 July 2017 was attributed to Ms Churcher but, in fact, it appears to have been made by Ms Debbie Alred, a consultant occupational therapist. Ms Alred wrote:

"Emotional Health Group: attended the group for the first time. Said had not been able to sleep for six nights, that he woke up in the morning and after breakfast was able to sleep for an hour. Said that he had witnessed someone try and commit suicide."⁹⁶

79. The Inquiry did not receive a statement from D865.

⁹⁴ [CJS007239_008-009](#)

⁹⁵ [CJS007239_009](#)

⁹⁶ [CJS007239_009](#)

80. In his statement to Sussex Police, Mr Tulley said:

“I could not really understand why no one else could see the ligature around his neck. I was still stood outside the room, and yet I could see it clearly. I said ‘no, what’s that tied around his neck’. At this point Chris Donnelly took his fish knife from his belt and cut the ligature off ... Chris Donnelly demonstrated hatred towards the detainees. Am sure he was intent on letting the detainee suffer. I would say it was at least 2 minutes between the first response being called and Chris Donnelly removing the ligature from the detainee’s neck.”⁹⁷

81. In his statement to the Inquiry, D1538 wrote that, on 4 July 2017, he had been in the bathroom area of the cell he shared with D865 when he heard a crash. When D1538 came into the main cell area he saw his cell mate lying on the floor, shaking, with something around his neck. D1538 wrote that it looked like D865 had tied something around the TV bracket.⁹⁸ D1528 tried to call for help and it took staff several minutes to arrive.⁹⁹ D1538 wrote that he asked to see the doctor immediately, as he was feeling scared and disturbed by what he had witnessed.¹⁰⁰ He said that he did not recall being offered a mental health appointment, but was unsure whether this was because he had forgotten or because one was not offered.¹⁰¹ D1538 wrote that he did not receive any additional support as a result of his ‘raised concern’ status, and noted that he was not placed on an ACDT plan.¹⁰² D1538 said that he had previously seen his cell mate attempt to self-harm multiple times: with blades, by banging his head and by putting bags over his head.¹⁰³ D1538 said that the incident on 4 July 2017 had a significant impact on him. He told the Inquiry that he suffered nightmares and disturbed sleep following the incident, and still felt tormented by the images of what he had witnessed.¹⁰⁴

82. In his second statement to the Inquiry, Mr Donnelly wrote that he would have expected the first member of staff on the scene to check for the presence of a ligature around D865’s neck. He did, however, accept that as a manager he should also have checked for one.¹⁰⁵ Mr Donnelly denied Mr Tulley’s allegation that he was intent on allowing detained people to suffer,¹⁰⁶ and that he had demonstrated hatred towards them.¹⁰⁷

⁹⁷ [SXP000120_008](#)

⁹⁸ [DL0000231_019](#) para 76

⁹⁹ [DL0000231_019](#) para 77

¹⁰⁰ [DL0000231_021](#) para 79

¹⁰¹ [DL0000231_022](#) para 80

¹⁰² [DL0000231_022](#) para 82

¹⁰³ [DL0000231_023](#) para 88

¹⁰⁴ [DL0000231_022-023](#) paras 83-85

¹⁰⁵ [SER000442_005](#) para 6b

¹⁰⁶ [Christopher Donnelly 23 February 2022 105/3-17](#)

¹⁰⁷ [SER000442_008](#) para 11b

83. In his oral evidence to the Inquiry, Mr Donnelly accepted that he did not remove the ligature until it was pointed out to him by Mr Tulley.¹⁰⁸ Under questioning by Counsel to the Inquiry, he denied that he had become desensitised to self-harm or suicide attempts.¹⁰⁹ He explained his failure to see the ligature as his *“wrong assumption”* that someone else had already checked D865 did not have anything around his neck.¹¹⁰ Mr Donnelly also accepted that his incident report did not mention Mr Tulley drawing his attention to the fact that D865 had a ligature around his neck, and that there was therefore a delay in removing it. Mr Donnelly accepted that his reason for the omission was *“Probably because I did not want to make myself look bad.”*¹¹¹ Mr Donnelly told the Inquiry that, at the time, he did not know what measures were in place to support detained people who had witnessed self-harm and suicide.¹¹²

Conclusions in relation to D865

84. The footage of this incident is difficult to watch. D865’s subdued distress following his self-harm is very evident. D1538 is also clearly disturbed by the incident.

85. It is not clear from the footage how tightly the ligature was secured around D865’s neck. Regardless, it is extremely concerning that neither Mr Opoku nor Mr Donnelly immediately checked whether the ligature was still in place. It is clear from Mr Tulley’s covertly recorded footage that he was in a position that afforded him a less direct view than Mr Donnelly’s, yet he saw the ligature within seconds of arriving at the cell door.

86. It is hard to understand how Mr Donnelly missed the ligature around D865’s neck. His explanation that he assumed another more junior officer had already checked is concerning in itself. As the manager carrying out the role of Oscar 1, he was in charge of the incident and had a duty to assure himself that there was no ligature. I cannot be sure why Mr Donnelly failed to see the ligature, but I consider it likely that he had become desensitised to self-harm to such an extent that he did not pay sufficient attention. Staff desensitisation is discussed a number of times in this Report (see, for example, Chapters C.5 and C.14, and Chapters D.7 and D.9 in Volume II).

87. I considered D865’s mental and physical health at the time he was found on 4 July 2017. He had just attempted to self-harm by hanging himself from a ligature, and remained unresponsive on the floor for a period of around three minutes. Prior to Mr Tulley’s intervention, the officers were simply standing looking at D865 without examining him or trying to help him. This is

¹⁰⁸ [Christopher Donnelly 23 February 2022 115/6-9](#)

¹⁰⁹ [Christopher Donnelly 23 February 2022 134/21-135/1](#)

¹¹⁰ [Christopher Donnelly 23 February 2022 135/6-11](#)

¹¹¹ [Christopher Donnelly 23 February 2022 123/8-127/3](#)

¹¹² [Christopher Donnelly 23 February 2022 134/2-6](#)

despite them having been called to an incident of self-harm, and it being clear from the conversation among the officers prior to the ligature eventually being removed that D865 had attached himself to the TV in some way. There was a prominent red mark around D865's neck after the ligature had been removed. Had the ligature been secured more tightly, it is possible that this inaction could have resulted in life-threatening harm being caused to D865. In my view, the inadequacy of the response to D865's self-harm demonstrated a disregard for his wellbeing and a lack of respect for his human dignity. As a result, I find that there is credible evidence that this incident was capable of amounting to degrading treatment.

Conclusions in relation to the impact on D1538

88. I also considered the impact of the incident on D1538, who remained in the vicinity of the cell that he shared with D865 for over 10 minutes while staff attended to D865. Self-harm can be acutely distressing both for the person who is injured and for those who witness the act or its aftermath. D1538 found his cell mate unresponsive on the floor of their shared cell. Mr Tulley's covert recording captured two separate instances where D1538 stated that he needed to see a doctor and that he did not feel right. Although D1538 was unable to recall it, his medical records suggest that he did interact with mental health professionals following the incident on 4 July 2017, and his distress at what he had witnessed was recorded in entries on 5 and 10 July 2017. However, the care he was offered was fragmented at best. I note that an entry was made in D1538's medical records to indicate – prior to the time for which it was actually scheduled – that he had not attended his mental health appointment. There was no explanation for this, and it is not clear from his medical records what support he was actually offered, or what his treatment plan was. By his own admission, Mr Donnelly did not know what measures were in place to support D1538 or other detained people who witnessed acts of self-harm, which is concerning in and of itself given the prevalence of self-harming among detained people at Brook House during the relevant period.¹¹³

89. In my opinion, D1538 was not provided with adequate support after he witnessed D865's self-harm. This – combined with his vulnerabilities resulting from his experiences prior to his arrival at Brook House, the impact on him of the use of force on 6 June 2017 and the homophobic abuse he likely suffered on 28 June 2017 – left him exposed to psychological harm. In my view, D1538's treatment on 4 July 2017 resulted in intense mental suffering capable of amounting to inhuman treatment.

¹¹³ A total of 248 ACDT plans for individuals identified as at risk of suicide or self-harm were open at Brook House during the relevant period (Sandra Calver 1 March 2022 224/15-22). Figures originally derived from the following Brook House Independent Monitoring Board reports: IMB000021; IMB000050; IMB000011; IMB000047; IMB000019

Chapter C.10:

D2953 on 10, 11 and 16 June 2017

1. The Inquiry understands that D2953 was born in Bulgaria and was detained in Brook House between June and July 2017.
2. This chapter considers three allegations of assault made by D2953. I have assessed the credibility of these allegations and whether D2953's treatment during these incidents met the necessary threshold for consideration in this Report when considered cumulatively. I have considered them cumulatively given the similar nature of the incidents, the proximity of time within which the incidents occurred, and the overlapping evidence that the Inquiry heard about them.

The underlying facts

3. The Inquiry became aware of D2953's allegations through disclosure by G4S and Home Office Professional Standards Unit (PSU) investigations into assaults that he alleged had taken place.¹ The Inquiry was not provided with any recorded footage of the incidents.
4. D2953 arrived at Brook House at approximately 06:00 on 9 June 2017. His initial assessment records that he displayed unusual behaviour, but no physical or mental health concerns were raised, despite D2953 stating that he was taking 15mg of mirtazapine per day "*for sleeping*".² D2953 was given an appointment with the Brook House GP later that day, but he failed to attend.³ D2953's medical records, which were not available to Brook House staff at the time, noted that he was taking mirtazapine to treat depression.⁴
5. On 9 June 2017, D2953 was made subject to Rule 40 of the Detention Centre Rules 2001 for "*smashing his room up ... spitting at staff*" and flooding his room.⁵ He was assessed on E Wing by Mr Christopher Paynter, a Staff Nurse, to whom D2953 disclosed that he had mental health issues and was taking medication. On 11 June 2017, Ms Lyn O'Doherty, another Staff Nurse,

¹ [CJS001506](#)

² [CJS002196_010-011](#)

³ [CJS002196_010-011](#)

⁴ [CJS002196_010](#)

⁵ [CJS001506_030](#)

received a phone call from a paramedic at NHS 111 who informed her that D2953 had called four times that day stating that he needed medication.⁶ On 12 June 2017, D2953 was seen by Dr Husein Oozeerally, the lead GP at Brook House, who recorded that D2953 was taking three “lots of medication”, but that he was unclear which medication. D2953 was then seen by Ms Karen Churcher, a Registered Mental Health Nurse (RMN), on 14 June 2017. However, D2953 refused to engage with her, saying that he was “not mentally ill” but that he wanted his medication in order to sleep.⁷ Ms Churcher discharged D2953 from the RMN service, but later that day Dr Saeed Chaudhary, another GP at Brook House, noted on D2953’s records “MENTAL HEALTH TEAM TO KEEP TRYING WITH PATIENT” and commented that D2953’s signature had been obtained in order to procure his GP records. D2953 was prescribed mirtazapine by Dr Chaudhary on 16 June 2017 when his medical notes arrived.⁸

6. D2953 called the Equality Advisory and Support Service (EASS) helpline 40 times between 10 June and 17 July 2017.⁹ Some of these calls were short and there was usually no interpreter on the line. D2953 did not speak English as his first language. In a call on 16 June 2017, through an interpreter, D2953 was noted as having told the call handler, “Guards hit me 3 times.”¹⁰ The note continued:

“Haven’t been given my anti-depressant tablets, I can’t sleep at night ... That man was aggressive to me, he apologised after. After third time he hit me he sat on the bed next to me and was explaining something ... That guard hit me 3 times.”¹¹

D2953 told the call handler that, although he was concerned that it might make things worse, he was content for her to call Brook House about the incidents.¹² The call handler did not do so (as discussed in Chapter D.10 in Volume II).

7. On 20 June 2017, D2953 told a member of the library staff at Brook House that he had been “bitten” three times by a member of staff.¹³ The member of staff completed a Security Information Report (SIR), a report that records matters relevant to the safety and security of the immigration detention estate, collated by the Security Department at Brook House.¹⁴

⁶ [CJS002196_013](#)

⁷ [CJS002196_013](#)

⁸ [CJS002196_013-014](#)

⁹ [HOM032609_002](#)

¹⁰ [HOM032609_003](#)

¹¹ [HOM032609_003](#)

¹² [HOM032609_003](#)

¹³ [CJS0073642_0002](#)

¹⁴ [CJS0073642](#)

The Security Manager, Detention Custody Manager (DCM) Carrie Dance-Jones, asked DCM Steven Dix to investigate D2953's allegations.

8. On 24 June 2017, G4S received a written complaint from D2953 about his healthcare and alleging that he had been assaulted three times by an officer.¹⁵

9. Five days later, on 29 June 2017, D2953 spoke to the EASS helpline three times. In the first call, the call handler noted that D2953 again reported that he had been "*bit*" or "*hit*" three times, and that D2953 sounded agitated and as though he was banging on a hard surface and shouting. In the second call, the call handler noted that D2953 said that he had been bitten three times. In the final call, the call handler told him to call the police if he had been abused.¹⁶

10. That same day, 29 June 2017, force was used on D2953 to move him to E Wing because he was wearing boxer shorts when collecting his lunch and refused to get dressed. During this use of force, D2953 told one of the officers involved (DCM Philip Page) that he had previously been assaulted on 16 June 2017. Mr Page recorded the information in his Use of Force report and also in an incident report (used for 'reportable incidents' including assaults, escapes, suicides and full searches).¹⁷ Mr Page did not complete an SIR or a separate incident report about D2953's disclosure to him, and instead simply included it within a large body of text about the different incident on 29 June 2017, without ticking the box for 'Assault on Detainee'.¹⁸ A member of Healthcare staff assessed D2953, as was required after a use of force. She found no current injuries but noted multiple scars from surgeries and possible previous injuries.¹⁹ She also recorded in D2953's medical notes that "*he states he has been punched and hit by officers, states hit around side of head, no bruising or red marks noted*", but did not flag these allegations to her manager or to the Home Office.²⁰

11. On 3 July 2017, an incident report recorded D2953's allegation that he had been bitten by staff three times.²¹ On 8 July 2017, D2953 dialled NHS 111 and asked for help because he felt as though he was not being treated fairly at Brook House.²²

12. On 24 September 2017, more than three months after D2953 had reported the assaults, Mr Dix wrote in an email to Ms Dance-Jones:

¹⁵ [CJS001616](#)

¹⁶ [HOM032609_004](#)

¹⁷ [CJS0073644_008-009](#); [CJS0073644_015](#); [CJS0073643](#)

¹⁸ [CJS0073643_001](#)

¹⁹ [CJS0073644_014-015](#)

²⁰ [HOM032247_009](#)

²¹ [CJS001506_030-031](#) para 6.7.4

²² [HOM004886_013](#)

“I am pretty sure that I did speak to him in his room, from what I recall he did not seem bothered.”²³

The Inquiry saw no evidence to suggest that an investigation was in fact carried out by Mr Dix or anyone else at Brook House until September 2017, when G4S became aware of the allegations against Detention Custody Officer (DCO) Derek Murphy in relation to other detained people.²⁴

13. Following the *Panorama* programme, the PSU conducted an investigation into D2953’s allegations. In summary, these allegations were:

- On 10 June 2017, Mr Murphy hit D2953 on his left thigh in E Wing because he was shouting, hitting and kicking the cell door.
- On 11 June 2017, Mr Murphy hit D2953 on his left side (in his kidney area) because he was shouting, punching and kicking.
- On 16 June 2017, Mr Murphy hit D2953 on the left side of his head because he was shouting.²⁵

14. Mr Murphy denied to the PSU that he assaulted D2953. In his view, the allegations might have been made because the officers sometimes had to say ‘no’ to D2953.²⁶ The PSU investigation concluded that, on the balance of probabilities, there was substance to D2953’s allegations and therefore his complaints were substantiated.²⁷ Investigating officers were unable to locate closed-circuit television (CCTV) footage to verify the details of D2953’s account, including whether any other officers had witnessed the incidents. They did confirm that Mr Murphy was on duty on the days that D2953 alleged that Mr Murphy hit him.²⁸

15. The PSU investigation found that, based upon evidence of Mr Murphy’s abusive conduct in other situations captured in footage recorded covertly by DCO Callum Tulley, it was credible that Mr Murphy had assaulted D2953 on the three occasions that D2953 alleged.²⁹ In addition, the PSU concluded that there were failings in how D2953’s complaints were responded to following the assaults.³⁰

16. In his evidence to the Inquiry, Mr Murphy denied any knowledge of these incidents or the resulting PSU investigation.³¹ He maintained that he did not punch D2953.³²

²³ [CJS0073657_001](#)

²⁴ [HOM032609_002](#)

²⁵ [CJS0073658](#)

²⁶ [CJS001506_028](#) para 6.2.2

²⁷ [CJS001506_035-036](#) paras 7.2.1-7.2.4

²⁸ [CJS0073655_001](#)

²⁹ [CJS001506_035-036](#) para 7.2.1

³⁰ [CJS001506_035-036](#) para 7.2.2

³¹ [INQ000121_010-011](#) paras 34-36; [Derek Murphy 2 March 2022 106/6-112/6](#)

³² [INQ000121_010](#) para 34

Conclusions

17. In making my findings, I took account of the evidence received by the Inquiry of Mr Murphy's verbal abuse of other detained people, including the evidence of him talking about using violence against detained people and the multiple allegations of him physically abusing detained people.

17.1 In March 2017, Mr Murphy had "*recently*" bragged that he had kned a detained person in the face during a restraint, and had 'choke slammed' a detained person who had attacked DCO Daniel Small.³³

17.2 On 14 June 2017, Mr Murphy said to a detained person, "*You look like a fucking mong. Get in your room*", and then "*He looks like a right cunt doesn't he.*"³⁴

17.3 In August 2017, Mr Murphy threatened to "*smash the fucking shit*" out of a detained person.³⁵

I note, however, that Mr Murphy denied using a chokehold against a detained person.³⁶ There is no video evidence of him having done so. However, a lack of video footage is not determinative as to whether or not allegations of abuse are true. As I explain in Chapter D.7 in Volume II, body worn cameras were not always available, and were often not switched on during the relevant period. Moreover, Mr Tulley was only able to record incidents at which he was physically present.

18. The Inquiry did not receive a witness statement from D2953 and so I relied upon the accounts he provided shortly after the incident and then, some months later, to the PSU investigating officers. D2953's accounts are consistent, detailed and believable. He does not seek to hide his own challenging behaviour. Indeed, his descriptions of how he was behaving are consistent with the records made by officers at the time.³⁷

19. It is my view that D2953's account is credible. I find that Mr Murphy probably did hit him on the following occasions:

- on 10 June 2017 on his left thigh;
- on 11 June 2017 on his left side; and
- on 16 June 2017 on the left side of his head.

³³ [CPS000024_005](#)

³⁴ [TRN0000092_028](#)

³⁵ [TRN0000024_003](#)

³⁶ [Derek Murphy 2 March 2022 23/19-26/4](#)

³⁷ [CJS001755](#)

20. I considered D2953's state of mental and physical health and whether it made him more vulnerable to mistreatment. In interviews with PSU investigating officers on 6 and 18 October 2017, D2953 said that past operations on his chest and stomach meant that he knew he could not physically resist being restrained.³⁸ I consider that D2953 probably would have felt unable to defend himself against a physically imposing officer; and that this, especially in the event of repeated attacks, would have left him feeling helpless.

21. In addition, D2953 made repeated attempts to obtain the medication for depression (mirtazapine) he told staff he had been taking when he arrived at Brook House, but this was not prescribed until a week after he was detained. I make no criticism of this delay as medical staff were awaiting D2953's medical records from his community GP before prescribing him medication. D2953 reported during one of his calls to the EASS helpline that he was having problems sleeping.³⁹ In view of this, I consider that his mental ill health would also have left him feeling vulnerable. D2953 told PSU investigating officers that other staff witnessed the assaults on him on 10 June and 16 June 2017. D2953 said that, on the latter occasion, a member of staff told Mr Murphy to apologise to him after the assault.⁴⁰ It is possible that other staff did witness what happened to D2953. Throughout the Inquiry, I heard and saw evidence of staff failing to report the wrongdoing of their colleagues.⁴¹ If other staff did indeed witness these attacks, this is likely to have made D2953 feel especially vulnerable, as he had seen that officers could assault detained people without their colleagues intervening or reporting them.

22. D2953 reported what had happened to him multiple times. He told the EASS helpline call handler on 16 June 2017 that he feared repercussions if she contacted Brook House but that he still wanted her to do so.⁴² D2953 also reported the attacks verbally to multiple staff at Brook House on different occasions, and in writing to the Home Office using a complaints form. English was not his first language but he endeavoured to alert others to what had happened despite this.

23. I cannot be sure of the exact duration and severity of the incidents involving D2953. However, they were likely to have caused him significant pain, suffering and humiliation. I have taken account of D2953's physical vulnerabilities following previous surgery, his mental ill health and his difficulties in obtaining medication previously prescribed to him. In my view, D2953's suffering was compounded by the number of times he was attacked and by the difficulties he

³⁸ [CJS001506_026-027](#) para 6.1.3

³⁹ [HOM032609_003](#)

⁴⁰ [CJS001506_027](#) para 6.1.7

⁴¹ For example, DCO Daniel Lake failed to report DCO Sean Sayers striking D313 on 15 June 2017; see Chapter C.12

⁴² [HOM032609_003](#)

faced when trying to alert staff to what had been happening to him. Therefore, I find that there is credible evidence that the cumulative effect of the three occasions when Mr Murphy hit D2953 was capable of causing intense physical and mental suffering, such that it amounted to inhuman and degrading treatment.

Chapter C.11:

D1275 on 14 June 2017

1. D1275 is an Iranian national. His solicitor provided evidence to the Inquiry on his behalf, as D1275 found it too difficult and distressing to do so directly.¹ D1275 was detained at Brook House for 422 days between May 2017 and June 2018.²

The underlying facts

2. D1275 arrived at Brook House on 1 May 2017. He was immediately referred to a Registered Mental Health Nurse (RMN) following an initial assessment, as he:

“Claims mental health issues. States he hears voices. Repeated ‘they will find me’ on admission. Would not elaborate on who he was referring to or what would happen if ‘they’ found him. Preoccupied and inappropriate in manner. Vague and misleading with answers to questions on admission.”³

In his medical notes, D1275 was recorded as *“Intruding on other detainees’ admissions whilst in the waiting area”*. The assessor noted that it was *“unclear”* whether D1275 had been a victim of torture. D1275 did not attend his arrivals clinic appointment with the Brook House GP on 2 May 2017, or his appointments with an RMN on 9 and 17 May 2017. He was discharged from the RMN service as a result.⁴

3. On 14 June 2017, Detention Custody Officer (DCO) Callum Tulley covertly recorded D1275 being attended to in the courtyard after he had taken the new psychoactive substance known as ‘spice’.⁵ D1275 lay face down and motionless on the ground, grimacing and groaning in apparent pain and violently retching. He was being attended to by a DCO identified to the Inquiry only as ‘Mark’. Detention Custody Manager (DCM) Stephen Loughton, DCM Nick London, DCM Steven Dix and DCO Aaron Stokes were also present, and a crowd of detained people had gathered, who Mr Tulley attempted to

¹ [BHM000042_001](#) para 2

² [BHM000042_007](#) para 21; [BHM000042_026](#) para 84; [CJS000941](#)

³ [CJS001120](#)

⁴ [CJS001121_065-067](#)

⁵ [Day 8 PM 2 December 2021 00:33:00-00:49:02 \(KENCOV1035 - V2017061400015\)](#) and [00:49:20-00:53:53 \(V2017061400016\)](#)

disperse. After approximately four minutes a nurse arrived and Mr Tulley was asked to find an evacuation chair.

Figure 25: D1275 on the ground of the courtyard being attended to by 'Mark'



4. Mr Tulley returned to the courtyard approximately four and a half minutes later, having been unable to find an evacuation chair. The courtyard was still full of detained people crowding around D1275, who appeared to be conscious and distressed, crying out, "mama".

5. D1275 got to his feet unsteadily and was taken to E Wing by several officers. Mr Stokes and another officer supported him as he walked.

6. D1275 was met at the door to E Wing by DCO Derek Murphy. The footage shows that Mr Murphy held the door open for D1275 and said:

"I've no fucking sym[pathy], look at the state of that. Look, imagine bringing that home to your Mother. Alright, how are you doing? There you go young man."

7. After a quick search, D1275 was taken into a cell where Mr Murphy put him into the recovery position on the bed. Over the course of at least 15 minutes, D1275 fluctuated between appearing intoxicated and incoherent, and appearing to understand what was being said to him. Healthcare staff took medical observations as various officers came and went from D1275's cell. One officer (it is not clear who) suggested that the officers ought to film detained people who had taken spice and show them the footage later so that they

could see *“how stupid they’ve been”*. DCM Nathan Ring shouted to D1275, *“Does your face taste nice mate, because you’re chewing it off.”*

8. While the officers were making these comments, Healthcare staff were monitoring D1275’s blood pressure. One of the nurses said that D1275 was tachycardic (ie his heart was beating too fast), and attempts were made to put a pulse oximeter onto D1275’s finger to measure the oxygen levels in his blood.

9. Mr Tulley briefly left D1275’s cell. When he returned, Mr Murphy, who was then also in the cell, said in a loud voice, *“I have absolutely no sympathy for them, absolutely no sympathy for them at all. If he dies, he dies.”* He then appeared to leave the cell.

10. Mr Tulley sat across from D1275 and talked to a nurse about D1275’s heart rate. The nurse explained that D1275’s heart rate was currently 128 beats per minute, but that it had reached 178 beats per minute when D1275 was in the courtyard. She explained that the worst thing that can happen when someone takes spice is that their heart rate drops too low and the person stops breathing. Mr Tulley asked the nurse whether she thought that someone in Brook House was likely to die soon, and she replied *“yeah”*.

11. The nurse then noticed that D1275 appeared to be sleeping, woke him up and placed an oximeter on his finger. D1275 appeared drowsy and the nurse gently encouraged him to stay awake.

12. As she did so, she, Mr Tulley and Mr Stokes continued to talk about the prevalence and seriousness of spice in Brook House, and the ability of Healthcare staff to respond. This issue is discussed further in Chapter D.8 in Volume II.

13. After approximately six and a half minutes, Mr Tulley turned his covert camera back to D1275, who was smiling. D1275 then started to sing loudly in a foreign language and play with the oximeter. He was singing intermittently for approximately 15 minutes.

14. One of the nurses asked D1275’s name and Mr Ring appeared to be unable to pronounce it, saying, *“How do you pronounce that?”*. His tone was mocking and he answered his own question, saying, *“Knob”* and *“We’ll stick with div”*. The nurse appeared to respond *“no”* to this, and D1275 then briefly stopped singing.

15. The nurse checked D1275’s heart rate again, and expressed concern that he was still tachycardic. Mr Ring shouted over D1275, *“stay still you div”* and called him a *“scrotum”*. In relation to D1275’s elevated heart rate, Mr Ring said, *“I’ll get him cold water. That will sort his heart out. That will do it the world of good.”* Mr Tulley then left the wing.

16. When Mr Tulley returned, approximately seven minutes later, D1275 could still be heard singing. Shortly afterwards, Mr Tulley asked Mr Ring what

D1275 was doing. Mr Ring commented, *“Probably gurning. Checking out the inside of his skull. Eyes are rolling around.”*

17. In line with what he told G4S investigating officers in the course of his disciplinary interview on 7 September 2017, Mr Murphy told the Inquiry that he did not dispute that he said the words attributed to him.⁶ However, he told the Inquiry that he believed the secretly recorded footage had been edited to mislead the viewer about the context and timing of his comments, which he said was indicated by a change to the light.⁷

18. Mr Murphy told the Inquiry that he recognised that his comments were inappropriate.⁸ He also said that they were born of frustration at the fact that D1275 had taken spice after they had previously discussed the dangers of doing so.⁹

19. Mr Ring also accepted that he had made the statements heard on the footage during his G4S disciplinary interview on 7 September 2017.¹⁰ In his oral evidence to the Inquiry, Mr Ring said that the intention behind his comments had been misinterpreted, stating:

“I’d had a previous conversation talking about how cold water can stop you passing out and that and how it affects your heart rate. That was just another joke, silly comment really.”¹¹

20. Mr Ring told the Inquiry in his witness statement that his actions were a result of feeling frustrated with D1275 for taking spice.¹² He likened the incident to being out with a friend who drinks too much alcohol.¹³ Mr Ring accepted in his oral evidence that he and Mr Murphy were not setting a good example to other staff during the incident. He maintained that the comments needed to be seen in the context of the *“rapport”* he had with D1275 and that they were a result of his frustration with the situation.

Conclusions

21. I do not find Mr Murphy’s explanation that the footage is misleading credible; he was not able to offer any evidence to support this allegation. I note that there are occasional inaudible comments within the covertly recorded footage but, in my view, the overall quality of the footage is sufficiently clear to see who is speaking and to hear what they are saying. There are no

⁶ [CJS005928_004-005](#); [INQ000121_006](#) paras 18a-18b; [Derek Murphy 2 March 2022 77/1-77/24](#)

⁷ [Derek Murphy 2 March 2022 79/1-82/6](#)

⁸ [Derek Murphy 2 March 2022 77/22-24, 78/13-14](#)

⁹ [INQ000121_005-006](#) para 18

¹⁰ [HOM001503](#)

¹¹ [Nathan Ring 25 February 2022 123/11-18](#)

¹² [Nathan Ring 25 February 2022 118/24 120/24-7](#)

¹³ [Nathan Ring 25 February 2022 120/19-121/7](#)

inconsistencies in the time stamp on the footage to suggest that it has been edited, and derogatory statements by Mr Murphy and Mr Ring can clearly be heard. The footage itself is disturbing to watch.

22. I considered D1275’s state of mental and physical health and whether it made him more vulnerable to mistreatment. Concerns had been raised about D1275’s mental health in May 2017.¹⁴ Mr Murphy told the Inquiry that he was not aware of this at the time of the incident because it was not routine to be given information about a detained person’s mental health unless it related to self-harming.¹⁵

23. In terms of his vulnerability during the incident, D1275 was intoxicated and incoherent on the covertly recorded footage.¹⁶ He was unable to communicate clearly with the officers or medical staff, and appeared to be unaware of what was happening around him for large portions of the incident. Indeed, neither D1275 nor his solicitor was aware that he appeared in the footage until his solicitor viewed the unpixellated footage in relation to another formerly detained person and recognised D1275 as being present.¹⁷ That notwithstanding, the comments made by Mr Murphy and Mr Ring were dismissive, unprofessional and callous. In particular, I found Mr Ring’s mocking of D1275’s name and the disdainful manner in which he retorted, “*We’ll stick with div*”, to suggest a disrespectful attitude towards D1275.

24. As discussed further in Chapter D.9 in Volume II, there is a clear power imbalance between a member of staff and a detained person. Such an imbalance of power is particularly pronounced when a detained person is in a situation of additional vulnerability, such as being highly intoxicated. Whether Mr Ring actively chose to exert his authority inappropriately or was simply unaware of the imbalance between himself and D1275, he was an experienced officer who should have appreciated the heightened sense of vulnerability felt by an individual intoxicated with spice. He could also reasonably have been expected to appreciate that D1275 was not able to communicate his feelings of fear or anguish. I consider that this makes the incident all the more concerning.

25. Mr Murphy and Mr Ring could not have known with any certainty whether D1275 could understand the disparaging comments they made about him. D1275’s physical state at the time rendered him unable to advocate for himself in any meaningful way, and it is clear from the footage that Mr Murphy and Mr Ring had little regard for his wellbeing or the impact that their words may have had.

¹⁴ [CJS001120](#)

¹⁵ [Derek Murphy 2 March 2022 70/17-71/1](#)

¹⁶ [Day 8 PM 2 December 2021 00:33:00-00:49:02 \(KENCOV1035 - V2017061400015\) and 00:49:20-00:53:53 \(V2017061400016\)](#)

¹⁷ [BHM000042_032 para 110](#)

26. In my view, D1275's mental ill health made him profoundly vulnerable to mistreatment. During this incident, D1275 was repeatedly referred to in humiliating and debasing terms, which shows a lack of respect for his human dignity. It is unclear whether he was able to hear what was being said, although had he been able to do so this is likely to have compounded any anguish or fear he felt as a result of his intoxication. In any event, the nature of the mistreatment of D1275 on 14 June 2017 leads me to conclude that there is credible evidence that it was capable of amounting to degrading treatment.

Chapter C.12:

D313 on 15 June 2017

1. D313 is a Moroccan national who came to the UK with his family when he was approximately two years old.¹ He was detained in Brook House between May and June 2017.² He struggled with a drug addiction until 2019.³

The underlying facts

2. D313 is not recorded as having disclosed any mental or physical health conditions on his arrival at Brook House on 31 May 2017. However, he did test positive for opiates. D313 was seen later that day by Dr Husein Oozeerally, the lead GP at Brook House, who prescribed him methadone and required him to be kept under review. On 3 June 2017, D313 was noted to be under the influence of a new psychoactive substance known as ‘spice’.⁴

3. On 15 June 2017, D313 was moved to E Wing after taking spice.⁵ As the effects of the drug were wearing off, there was an interaction between D313 and Detention Custody Officer (DCO) Sean Sayers outside D313’s cell.

4. In his witness statement to the Inquiry, D313 said that Mr Sayers assaulted him without provocation and that Mr Sayers appeared to be angry and not to like him. D313 said:

“He gave me a full punch to the face (I am aware that the disclosure refers to it as a slap but that is not what happened). It was extremely painful and I was completely knocked over. Officer Sayers then picked me up by my face and threw me back on the bed. There was nothing I could do to stop him hurting me. He was so much bigger and more powerful than me.”⁶

5. Mr Sayers told the Inquiry that D313 was verbally aggressive and had “motioned to headbutt” him, an account that he also gave to G4S investigators in 2017.⁷ According to Mr Sayers, he used force against D313 to put him into

¹ [HOM030801_005](#) para 1

² [DL0000233_001](#) para 2

³ [DL0000233_001](#) para 5

⁴ [CJS001048_002-004](#)

⁵ [CJS001201_008](#)

⁶ [DL0000233_015](#) paras 67-68

⁷ [Sean Sayers 10 March 2022 150/24-151/1, 160/25-161/5; CJS005933_002](#)

his cell in order to protect himself. In his witness statement to the Inquiry, Mr Sayers said that he did not strike D313.⁸ In his oral evidence, he added:

*"I tripped onto the bed. I didn't throw him onto the bed. And obviously, when I got up, I've put my hand down to get up off of a kneeling position and his face was there."*⁹

6. D313 did not complain about Mr Sayers' actions at the time. He explained this to the Inquiry as follows:

*"I have a serious learning disability, so, even if there were materials available to me [on] how to complain, I wouldn't have been able to read them. There was no-one there that I felt I was able to confide in who may have been able to help me with any complaints. In any event, I was too frightened to say anything anyway ... I knew exactly what could happen when you got on the wrong side of one of the officers and I was too scared. I retreated into myself after I was assaulted and I did not want to raise too much of a fuss. I would have been too scared to speak out. I also did not think that I would be taken seriously if I complained. The investigation into the assault on me by Officer Sayers on 15 June 2017, which failed to get an account from me, only confirms my feelings about the complaints process."*¹⁰

7. The Inquiry reviewed a transcript of a covertly recorded conversation between DCO Callum Tulley and D313 on E Wing shortly after the incident. During that conversation, D313 said, "I'm telling you what, he's not getting away with it. I don't care, he's not getting away, he's going to get his fucking head smashed up outside." Mr Tulley asked D313 who and what he was talking about. D313 then referred to Mr Sayers as a "Fat cunt" and said, "No nothing, nothing. Biggest mistake of his life."¹¹

8. Five minutes after the incident, Mr Tulley was recorded asking DCO Daniel Lake why D313 was making threats against Mr Sayers. Mr Lake replied that D313:

*"called Sean a fat cunt. Sean was like 'do something about it then' and then he come over like he was going to hit Sean, Sean grabbed him and threw him in his room, went into his room and then went bang at it."*¹²

Mr Tulley asked, "Did he give him a proper smack?", to which Mr Lake replied, "Yeah, backhander right on his face." When Mr Tulley asked what had caused Mr Sayers' actions, Mr Lake replied:

⁸ Sean Sayers 10 March 2022 62/16-68/18; BDP00004_016

⁹ Sean Sayers 10 March 2022 152/20-25

¹⁰ DL0000233_018-019 paras 84-86

¹¹ TRN0000093_026 lines 932-957

¹² TRN0000093_027 lines 970-975

“Angry. Called him a fat cunt ... he’s just had beef throughout the day. [inaudible] He was like ‘I want to go back to B wing’ and Sean went ‘stop smoking that fucking spice then’ and he just went ‘shut up you fat cunt’. Sean just lost it.”¹³

9. Mr Lake went on to say that Mr Sayers:

“Threw him in his room, backhanded him in his room. But it did look like, to be fair on Sean [inaudible], it looked like he was going to hit Sean, like the way he approached Sean with his hands back like that.”¹⁴

Mr Tulley asked if that had happened on camera, and Mr Lake told him that Mr Sayers had picked up D313 and carried him into his cell in view of the camera but that the ‘back-handing’ happened in D313’s cell.¹⁵ This means that the back-handing would not have been captured on camera.

10. D313 told the Inquiry that at least one other officer was present at the time of the incident and therefore witnessed Mr Sayers punch him.¹⁶ In his disciplinary interview with G4S investigators on 8 September 2017, Mr Sayers said that there were no other officers in the vicinity when he lifted D313 into his cell. The G4S investigators reviewed closed-circuit television (CCTV) footage (which was not available to this Inquiry) and saw Mr Sayers lifting D313 in what they described as a “bear hug type hold” and carrying him into his cell, accompanied by DCO Gary Croucher and Mr Lake. All three DCOs then remained in D313’s cell with him for 13 seconds.¹⁷ Mr Sayers told the Inquiry that he accepted that the other two officers were there, but that he still felt he had had to deal with the situation alone.¹⁸

11. The Inquiry viewed covertly recorded footage of a conversation between Mr Sayers, DCO Ryan Bromley and Mr Tulley in a staff office.¹⁹ The conversation took place about an hour after the incident on E Wing. Mr Bromley asked, “You got a good team down there?” Mr Sayers replied, “No, that’s why I did it on my own.” Mr Sayers leaned back with his hands behind his head in a relaxed position, which he maintained as he described what had happened. He said:

“I literally picked him up off his feet, took him to his room and threw him on the bed. I slipped, accidentally landed on him and then accidentally helped myself up off his face.”

At this point, Mr Sayers extended his arm to demonstrate a pushing movement.

¹³ [TRN0000093_027](#) lines 994-998

¹⁴ [TRN0000093_028](#) lines 1015-1017

¹⁵ [TRN0000093_027-028](#) lines 1010-1015

¹⁶ [DL0000233_015](#) para 69

¹⁷ [CJS005937_004-005](#)

¹⁸ [Sean Sayers 10 March 2022 154/2-154/23](#)

¹⁹ [Day 25 PM 7 March 2022 00:29:20-00:31:03 \(KENCOV1036 - V2 017061500019\)](#)

12. When interviewed by G4S investigators, Mr Croucher accepted that he was shown on CCTV to have been present when Mr Sayers lifted D313 into his cell, and that he was then in the cell for 13 seconds.

13. Mr Lake told investigators that he could not remember the incident, and maintained this position in his evidence to the Inquiry.²⁰ A disciplinary investigation by G4S into the conduct of Mr Sayers regarded Mr Lake's inability to recall the incident as suspicious, and described him as evasive and unhelpful.²¹ Mr Lake told the Inquiry that he had no reason to protect other staff, either now or at the time of the G4S investigation in September 2017, but did acknowledge that there was a collective feeling of staff being under attack in the aftermath of the *Panorama* programme.²²

14. Mr Sayers acknowledged at various times that there was a significant difference in physical stature between himself and D313, who he described as "*tiny*" and "*a small guy*".²³

15. D313 told the Inquiry that his cheek was red and bruised following the incident, and that he still had marks when his family came to visit him. D313 explained that he did not tell them what had happened to him because he was worried about the impact it might have on them.²⁴ Mr Sayers said that he did not request a nurse, as he did not think he needed to if no injury had occurred as a result of the use of force.²⁵ That notwithstanding, D313 was monitored by the Healthcare team while he was on E Wing as he recovered from the effects of taking spice. The injuries mentioned by D313 were not recorded in his notes.²⁶

16. Mr Sayers did not record the use of force against D313. He told the Inquiry that this was because the units were busy and understaffed, and by the time it got to the end of his shift he had forgotten about it.²⁷

17. The G4S disciplinary investigation found that Mr Sayers used an unauthorised method of restraint against D313, but found there to be insufficient evidence to substantiate the allegation that D313 was assaulted by Mr Sayers.²⁸ I note that the G4S investigators appear to have made no attempt to interview D313 about his account of the events.²⁹

²⁰ [CJS005935](#); [CJS005937_007](#); [Daniel Lake 1 March 2022 59/10-14](#)

²¹ [CJS005937_011](#)

²² [Daniel Lake 1 March 2022 65/14-65/21](#)

²³ [Sean Sayers 10 March 2022 149/01-171/11 20/3-11](#); [CJS005933_0002](#)

²⁴ [DL0000233_015](#) para 71

²⁵ [CJS005933_002](#); [BDP00004_017-018](#) para 65; [Sean Sayers 10 March 2022 166/2-8](#)

²⁶ [CJS001048_006-007](#)

²⁷ [Sean Sayers 10 March 2022 168/24-169/8](#); [BDP00004_017](#) para 62

²⁸ [CJS005937_011](#)

²⁹ [CJS005937_002-003](#); [DL0000233_018](#) para 78

Conclusions

18. D313's evidence to the Inquiry was detailed, and it was consistent with the accounts given by Mr Lake to Mr Tulley and by Mr Sayers himself later the same day. The Inquiry saw and heard evidence that force was used inappropriately in other situations during the relevant period (between 1 April and 31 August 2017), and that staff routinely did not report this.³⁰ The Inquiry also heard evidence of assaults on detained people taking place in cells to avoid CCTV; indeed, it was Mr Tulley's evidence that this is where much of the abuse took place.³¹ I took account of this evidence when considering the credibility of the account D313 provided. D313 did not give oral evidence to the Inquiry and therefore his account was not tested under questioning. No criticism is made of D313 by my recording this fact here. However, it is a factor that I bore in mind when considering the credibility of his account.

19. The covertly recorded conversations are themselves compelling. Mr Tulley's account of the incident in a BBC incident log is consistent with those evidence sources, and further supports what the Inquiry saw and heard about this incident.

20. In the circumstances, I am sure that on 15 June 2017 Mr Sayers picked up D313 in a 'bear hug' and threw him onto the bed in his cell on E Wing. Mr Sayers then struck D313 in the form of a slap, punch or 'back-handing' to his face, and pushed himself up on D313's face. Mr Sayers' explanation that he felt unable to rely on his colleagues to assist him in managing D313's aggression does not excuse his actions. I consider it more likely that Mr Sayers was seeking to punish D313 for calling him a "*fat cunt*".

21. I am also sure that Mr Sayers caused the injuries to D313 that he described. Given the findings that I have made in respect of Mr Sayers' actions, it is beyond question that some injury was caused to D313, and I have no reason to doubt his account of the injuries that he sustained. I do not consider that the absence of any reference to those injuries in D313's medical records is determinative of what happened. From the evidence available, it is not possible to determine whether the incident took place before or after the final set of medical notes for the day were made by the Healthcare team, who were observing D313 for the purpose of monitoring the effects of spice. D313 did not report this incident to the Healthcare team, which I accept was due to fear. I do not find it credible that Mr Sayers was unaware that D313 had been injured by him, a much larger man, falling onto him and putting his weight

³⁰ For example, see my discussions regarding the use of force in Chapter C.4 (in relation to an incident on 24 April 2017), Chapter C.10 and Chapter D.7 (in Volume II) (under the heading 'Inaccurate, undetailed and missing reports')

³¹ [DPG000021_0067-0069](#) paras 186-194; [BHM000029_0010](#) para 37; [Callum Tulley 29 November 2021 113/14-16](#)

onto D313's face. In my view, it is likely that Mr Sayers failed to call for a nurse because he was attempting to avoid scrutiny.

22. I am sure that Mr Lake witnessed what happened to D313 inside his cell. I do not find it credible that Mr Lake remembered the events clearly enough to describe them to Mr Tulley five minutes later on 15 June 2017, but then had no subsequent recollection of what had happened. However, if Mr Lake was genuinely unable to recollect an incident where a colleague picked up and then struck a detained person only three months after it occurred, this indicates a concerning picture about the insignificance of it to him and his desensitisation to such an incident.

23. I find it likely that Mr Croucher was also a witness, although the Inquiry did not hear any evidence to suggest that he relayed what he had seen to others in the way that Mr Lake did.³²

24. The casual way in which the incident was discussed among some DCOs indicates to me that there was an acceptance within that group that this kind of behaviour would not be reported by other staff. I have found this to be a recurring theme throughout the evidence heard by the Inquiry.³³ I am sure that some former and current Brook House staff have 'closed ranks' with those accused of wrongdoing in order to protect them.

25. As discussed in Chapter D.7 in Volume II, the Inquiry heard evidence from multiple sources that failure to comply with the requirements of Prison Service Order 1600 – which requires that anyone "*involved*" in the use of force completes a Use of Force report – was widespread at Brook House in the relevant period.³⁴ The absence of any Use of Force reports may indicate that some staff were deliberately concealing what took place on 15 June 2017, but I cannot be sure of this. I heard evidence from numerous other staff about the pressures they faced on the wings, and that there was not enough time to complete the necessary reports.³⁵ It is also possible that Mr Sayers chose not to complete a Use of Force report in order to avoid scrutiny.

26. I considered D313's physical and mental health at the time of the incident and whether he was particularly vulnerable to mistreatment. D313 was recovering from the effects of spice when he was forcibly carried to his cell in an unauthorised and inappropriate manner. More concerning, he was hit in the face by an officer who was responsible for his care and safety. This blow appears to have been the result of a desire to retaliate against or punish D313 for his perceived challenging behaviour. I accept that D313 was fearful as a

³² [CJS005937_004-005](#)

³³ See, for example, [Reverend Nathan Ward 7 December 2021 189/15-191/2](#); [Daniel Lake 1 March 2022 53/21-54/16](#); [Daniel Small 28 February 2022 163/24-164/10](#)

³⁴ [Prison Service Order 1600: Use of Force \(INQ000185\)](#), HM Prisons Service, August 2005

³⁵ [Ioannis \(Yan\) Paschali 24 February 2022 47/23-25](#); [Clayton Fraser 28 February 2022 86/10-19](#); [Derek Murphy 2 March 2022 120/18-121/9](#); [Sean Sayers 10 March 2022 168/24-169/20](#)

result of this experience, and that this prevented him from reporting what had happened to any of the Brook House staff. In my opinion, there is credible evidence that this incident was capable of amounting to degrading treatment.

Chapter C.13:

D2054 on 28 June 2017

1. The Inquiry understands that D2054 was born in Nigeria and came to the UK around 2002. He was detained in Tinsley House immigration removal centre in May 2016 and was released in June 2016. D2054 was then re-detained at Brook House in June 2017.

The underlying facts

2. On 21 June 2017, D2054 was made aware that directions had been issued for his removal on a charter flight. Later that day, Detention Custody Manager (DCM) David Aldis opened an Assessment Care in Detention and Teamwork (ACDT) plan for D2054. The plan recorded that D2054 had stated that he *"CANNOT go back to Nigeria due to his previous torture he suffered there"*.¹

3. On 26 June 2017, Ms Christine Williams (Clinical Lead) made an urgent mental health referral for D2054 as he had disclosed low mood and thoughts of self-harm.²

4. Two days later, on 28 June 2017, D2054 was informed that he would be removed from the UK later that day.

5. At around 13:45, D2054 was found by Detention Custody Officer (DCO) Luke Odey with cuts to his upper left arm. He told Mr Odey: *"I do not want to live this life anymore."*³ Mr Aldis, who was performing the role of 'Oscar 1' (the operational manager on duty) that day, increased D2054's required observations under the ACDT to constant supervision.⁴ D2054 was attended to by four members of Healthcare, who checked him and dressed his wounds. He was then walked to a constant supervision cell on E Wing.⁵ On arrival at E Wing, a full search was authorised by Ms Michelle Brown (a member of the Senior Management Team acting as Duty Director) and carried

¹ [HOM002388_004](#)

² [HOM002389_014](#)

³ [HOM002397_003](#)

⁴ [HOM002397_007](#)

⁵ [HOM002397_003](#)

out by DCO Derek Murphy and Mr Odey.⁶ A razor blade was found during this search.⁷

6. Mr Aldis briefed a team of officers to carry out a planned removal of D2054 to Reception where a Tascor escort team would meet him to transfer him to his removal flight. The officers assigned to remove D2054 were Mr Murphy, DCO Jonathan Martin, DCO Ben Shadbolt and DCO Daniella Di-Tella, all of whom were wearing full Personal Protective Equipment (PPE). They were joined by Ms Williams and DCM Christopher Donnelly. The latter was to operate the handheld camera.⁸

7. The Inquiry saw the footage from the body worn camera worn by Mr Aldis during the use of force.⁹ The handheld camera footage of the use of force recorded by Mr Donnelly is 9 minutes 19 seconds long.¹⁰ In combination, the footage provides a clear and unambiguous account of what took place during the removal.

8. The body worn camera footage shows that at 22:23 Mr Aldis opened the door to D2054's cell, which was in darkness. Mr Aldis turned the lights on and a substance which appeared to be blood could be seen on the floor at the foot of D2054's bed. He informed D2054 that escort officers had arrived to take him to his removal flight.

9. D2054, who was sitting in bed with a cover over him to the waist, responded, "*I'm not okay, my blood pressure is high.*" Mr Aldis said that he understood but asked D2054 to walk to Reception with the officers. D2054 responded that he was "*not okay*". From the audio on the footage, it appears that he had started to cry. Mr Aldis repeated that he understood, and referenced that he had a member of Healthcare staff with him (Ms Williams). He did not ask Ms Williams to examine D2054.

10. Mr Aldis asked D2054 to accompany him compliantly a further five times. Mr Aldis told D2054 twice that officers would be sent into his cell to remove him by force if he did not do so. D2054 indicated that he would not come willingly, saying, "*I'm not okay, boss.*" Mr Aldis then said, "*okay, force*" and gestured with his hand to the officers to enter. Mr Aldis attempted to persuade D2054 to comply for approximately 60 seconds before instructing the officers to use force. In his incident report, Mr Aldis recorded that D2054

⁶ [CJS005991_009](#) para 6.2.3. A 'full search' is a search of an individual that requires the removal and inspection of all clothing and footwear. The search must be conducted by two officers of the same sex as the individual, and the individual must not be completely naked at any stage or in the view of others not involved in conducting the search (see [CJS000713_004](#) para 7)

⁷ [HOM002397_003](#)

⁸ [CJS0073734](#) [Disk 26 20170628221925 E2047N_0006]

⁹ [CJS0073736](#) [Disk 27 28 June 2017 2221BWVC DCM Aldis]

¹⁰ [CJS0074053](#) [Disk 26 20170628222251 E2047N_0007]

started to cry when he was told that he needed to walk to Reception for his flight.¹¹

11. Mr Murphy entered the cell holding a shield, supported by Mr Shadbolt and Mr Martin. The footage does not show the officers' movements or D2054 for approximately five seconds but a loud crash is heard, directly followed by screams from D2054. When the camera was redirected into the cell, two officers were seen at the side of D2054's bed, leaning over and taking control of him, while another officer was kneeling on the bed. D2054 continued to scream loudly.

12. Mr Murphy handed the shield to Mr Aldis, who passed it out of the cell to Ms Di-Tella. As Mr Aldis turned, Ms Williams was outside the cell holding a green medical bag.

13. A hand was placed over the lens briefly. D2054 is then shown lying naked on the floor of the cell, on top of the bedcovers and with his feet facing the cell door. An item of clothing, which appeared to be boxer shorts, was next to him on the floor. D2054 was screaming, repeatedly wailing, "*Jesus, Jesus, where are you Jesus*" and kicking out with his legs in a cycling motion. Mr Shadbolt held D2054's head and Mr Murphy and Mr Martin restrained D2054's arms. Mr Aldis instructed Ms Di-Tella to take control of D2054's legs and assisted her in applying the correct technique.

14. Approximately 1 minute 19 seconds after the officers were first instructed to use force, DCO Andrew Simmonds placed a towel over D2054's genitals. Until this point, D2054 was entirely naked.

15. Once Ms Di-Tella had controlled D2054's legs, Mr Aldis instructed the officers to move D2054 into a seated position. D2054 continued to cry out for Jesus. His face was distorted and he appeared to be in significant distress. As D2054 sat upright, a dressing on his arm can be clearly seen. This was covering the injuries to D2054's upper arm caused by his attempts to self-harm earlier that day. Blood at the edge of the dressing can also be seen. The officers pushed D2054's upper body forwards and moved his hands around to his back to enable Mr Simmonds to apply handcuffs. While in this position, D2054's verbal protests became more strained and he appeared to be breathing more deeply. In total, D2054 remained in this position for approximately 45 seconds.

¹¹ [HOM002384_002](#)

Figure 26: D2054 being restrained by three officers while another applies handcuffs behind his back



16. Once handcuffed, the officers allowed D2054 to sit upright and he repeatedly asked, *“why am I being treated like this”*. The officers did not respond and brought D2054 to his feet. D2054 continued to cry out for Jesus, and the towel that had been covering his genitals fell away. It was picked up quickly by Mr Simmonds, who held it around D2054’s waist for the remainder of the use of force.

17. Mr Shadbolt took control of D2054’s head, and at 22:25 the officers walked D2054 out of the cell, through E Wing and into Reception. As Mr Aldis walked ahead of the officers and D2054, much of this part of the use of force is not visible on the body worn footage. However, as Mr Simmons walked behind D2054, it was captured on handheld footage.¹² This shows that the restraint of D2054’s head and arms was maintained throughout his relocation to Reception, and he remained handcuffed behind his back. D2054 continued to call out for Jesus.

18. After one minute, Mr Aldis asked the officers whether D2054 was still resisting and told them to give D2054 a chance to stand up straight. Mr Shadbolt asked D2054 whether he would walk compliantly if the head restraint was removed. D2054 did not specifically respond, but continued to call out for Jesus and appeared breathless. Mr Aldis instructed the officers to continue.

19. Shortly afterwards, Mr Aldis turned around and said, *“do we still have Healthcare”*. The group then appeared to wait while Ms Williams caught up with

¹² [CJS0074053 \[Disk 26 20170628222251 E2047N 0007\]](#)

the officers and D2054. When Ms Williams arrived, Mr Aldis asked her if she had any concerns about the restraint and she replied that she did not.

20. D2054 continued to cry out for Jesus, saying, “*why am I being treated like this?*”, “*what have I done?*” and “*this is the end of my life*” as he was taken into Reception. He also stated that he had been tortured in Nigeria. The officers did not respond but told him to relax.

Figure 27: D2054 being taken to Reception under restraint



21. Once in Reception, D2054 was handed over to Tascor escorts and provided with clothes. The incident lasted approximately 10 minutes in total and this was the only opportunity D2054 was given to get dressed.

22. D2054 made a complaint on 3 July 2017 about the force used on him. In his complaint, D2054 said that he was trying to explain his condition to the officers but they rushed him. He stated that he hit his head on the floor during the restraint and became unconscious, before regaining consciousness and shouting, “*Jesus*”. He also said that the use of force caused the cuts on his arm from his earlier self-harm to bleed.¹³ D2054 did not provide a statement to the Inquiry. Although a ‘Report of Injury to Detainee’ (section 3 of the F213 form) from earlier on 3 July 2017 referred to D2054 bleeding from cuts on his arm as a result of his self-harm, a further such report from after the use of force stated, “*no injuries noted at this time*”.¹⁴

¹³ [CJS001627_003-004](#)

¹⁴ [HOM002389_010-013](#)

23. In response to D2054’s complaint, the Home Office Professional Standards Unit (PSU) carried out an investigation, led by investigating officer Ms Helen Wilkinson. It concluded that the force used was reasonable and proportionate.¹⁵ This conclusion was upheld by the Prisons and Probation Ombudsman.¹⁶

24. In her evidence to the Inquiry, Ms Wilkinson accepted that she might have reached a different conclusion had she been aware that the practice of applying handcuffs to a person when they were seated was no longer included in the training syllabus.¹⁷ This was due to the risks of compressing the chest and breathing difficulties associated with being bent forward for prolonged periods of time. Ms Wilkinson was asked by Counsel to the Inquiry whether she considered staff should have removed some of their PPE to de-escalate the situation. She said that she had not, *“because I’d never come across where they’d – where officers had removed PPE while the use of force was still going on”*.¹⁸

25. At the time of the use of force on D2054, Ms Williams said that she had no concerns about his wellbeing other than noting his high blood pressure.¹⁹ During her oral evidence to the Inquiry, Ms Williams was asked by Counsel to the Inquiry, *“Did you consider the treatment, particularly that he was naked, to be degrading?”* Ms Williams replied that she did and said that she could not explain why she did not raise this at the time.²⁰

26. Having considered the report from the Inquiry’s use of force expert, Mr Jonathan Collier, Mr Aldis accepted that the helmets, gloves and head support could have been removed during the restraint. Mr Aldis also accepted that the practice of handcuffing in the seated position had been withdrawn.²¹

27. It appears that D2054 also complained to Sussex Police about this incident. His report was filed with no further criminal investigation to be taken following receipt of an email from Ms Wilkinson explaining the outcome of the PSU investigation.²²

28. The Inquiry did not hear oral evidence from any of the officers involved about this incident.

¹⁵ [CJS005991_024](#) paras 7.5.9-7.5.12

¹⁶ [PPO000029](#)

¹⁷ [Helen Wilkinson 24 March 2022 59/9-24](#)

¹⁸ [Helen Wilkinson 24 March 2022 59/25-60/14](#)

¹⁹ [CJS0073734 \[Disk 26 20170628221925 E2047N 0006\]](#)

²⁰ [Christine Williams 10 March 2022 114/17-21](#)

²¹ [INQ000181_019](#) para 90c

²² [SXP000018](#)

Relevant expert evidence

29. Mr Collier considered that force was used against D2054 only after all attempts made by the officers to persuade D2054 to comply with instructions had failed.²³ However, he took the view that the continued use of force on D2054, as he was walked from his cell to Reception, could be classed as excessive. This was due to D2054 no longer presenting a risk to the officers, despite his continued shouting.²⁴

30. Mr Collier was critical of the head restraint not being released once the officers had gained control. He also told the Inquiry that, at this stage, the officers could have removed their helmets and gloves.²⁵ Mr Collier said that thought should have been given to removing the PPE and the head support technique to promote de-escalation and communication with D2054.²⁶

31. As with other incidents, Mr Collier identified that the staff had placed a detained person in handcuffs behind his back while seated. This technique had been withdrawn from the Use of Force training syllabus at the time. This was due to the serious medical risks caused by being bent forwards for prolonged periods, including compression of the chest, interference with normal breathing and potentially death.²⁷ I discuss this further in Chapter D.7 in Volume II.

32. Mr Collier was asked by Counsel to the Inquiry about the effect of restraining a detained person while they were naked. He agreed that, for those who experience mental illness and related vulnerabilities, nakedness during restraint may be an aggravating factor in feeling humiliated or degraded.²⁸

Conclusions

33. D2054's level of distress was very clear from the footage. Force was used on him for a minimum of 9 minutes 19 seconds, and he wailed and cried out throughout. The footage was difficult to watch and to listen to.

34. In my view, the footage provides a clear and detailed account of what happened during the use of force against D2054. In the circumstances, I have not found it necessary to rely on the report by the PSU in order to draw my conclusions and I have not done so.

35. It is concerning that D2054 was not offered any opportunity to get dressed prior to or during the use of force against him. The issue of the use

²³ [INQ000111_079](#) para 317

²⁴ [INQ000158_008-009](#) paras 1.3-1.4; [INQ000111_076](#) para 301

²⁵ [INQ000111_078](#) paras 310-311

²⁶ [INQ000111_076](#) para 301

²⁷ [INQ000111_075](#) para 300

²⁸ [Jonathan Collier 30 March 2022 69/8-70/7](#)

of force against naked detained people is discussed further in Chapter D.7 in Volume II.

36. Given the late hour, Mr Aldis should have anticipated that D2054 was likely to be asleep and potentially undressed. It is not acceptable that there was no foresight or planning for such a situation. For example, the officers should have taken a clothing pack (a pack of clothing provided to detained people who arrive at Brook House without any clothing of their own) to D2054's cell in case it was needed. There is no evidence that they did. Mr Aldis should have given D2054 an opportunity to get dressed before force was authorised. It is unacceptable that he did not. I note that there was a pair of boxer shorts on the floor of the cell which D2054 could have put on within a matter of seconds. If D2054 did not have any other clothes, these could then have been supplemented by a clothing pack had one been made available. In my view, it is not acceptable to restrain naked detained people except in the most exceptional circumstances and as a last resort, due to the inevitable humiliation that it entails. This was not the case here. I note that when D2054 was eventually offered the chance to get dressed, he did so willingly.

37. In my view, the use of force against D2054 was not justified. I do not agree with Mr Collier that force was used as a last resort. Although Mr Aldis asked multiple times if D2054 would walk with him, these requests were in quick succession and no time was allowed for D2054 to orientate himself. Mr Aldis remained at the door of the cell, far away from D2054, and with officers in full PPE standing behind him. He did not enter the cell to speak to D2054 one-to-one. D2054 repeatedly said that he was "*not okay*", but Mr Aldis failed to enquire what was wrong with him and simply referenced the fact that he had Healthcare available. He did not ask Healthcare to examine D2054. Within approximately one minute of opening the door, Mr Aldis authorised the use of force. Moreover, and as stated above, D2054 was not given any opportunity to get dressed prior to the use of force. As such, insufficient efforts were made to engage with D2054 and to persuade him to accompany the officers, and force was not used as a last resort when all other options had been exhausted.

38. Too little consideration was given to D2054's vulnerabilities (in particular, his account of torture, his low mood, the urgent referral to mental health services and the earlier incident of self-harming that day), which were known to the staff ahead of the use of force. This is specifically true of Mr Aldis, to whom D2054 had disclosed a history of torture, and who had responded to D2054 self-harming shortly after he had been told that he was due to leave the UK that day.²⁹

39. Once force had been instigated, handcuffs were inappropriately applied to D2054 behind his back and while he was seated. This was unacceptable,

²⁹ [HOM002384_003-004](#)

given that the reason for rescinding this method of restraint from the Use of Force Training Manual was that a detained person had died (as discussed in Chapter D.7 in Volume II). It is my impression from the footage that this had an impact on D2054, as his vocal protests became strained and he appeared to start breathing more deeply. It is deeply concerning that this was not noticed by any of the officers. They should have been aware of the risks and should have responded appropriately to the condition of D2054 during the use of force.

40. Ms Williams did not raise any concerns throughout the entirety of the use of force and restraint on D2054. As the attending member of Healthcare staff, she should have challenged the actions of the other staff, in particular in handcuffing him inappropriately behind his back while seated. She should have reported the incident immediately afterwards. If she could not observe the incident adequately, she should have moved so as to be able to monitor D2054's safety, raised a concern with the officers that she could not adequately monitor his safety or intervened immediately to stop the restraint. I am concerned that Ms Williams did not take her safeguarding responsibilities more seriously. She only appeared to reflect upon issues such as the propriety of restraining detained people while they were naked when under scrutiny by this Inquiry, suggesting a desensitisation to the distress of vulnerable detained people in her care. Such matters are discussed further in Chapter D.8 in Volume II.

41. Ms Wilkinson told the Inquiry that she might have reached a different conclusion had she been aware that the potentially dangerous technique of handcuffing behind the back while seated had been removed from the Use of Force Training Manual. In circumstances in which it was her role, and that of the PSU, to reach conclusions on the appropriateness of the use of force, it is concerning that the PSU did not ensure that its investigating officers had sufficient and up-to-date knowledge regarding use of force techniques.

42. Insufficient consideration was given to de-escalation as D2054 was moved from his cell to Reception. I agree with Mr Collier's analysis that the PPE and head support technique ought to have been removed at this point. While D2054 was verbally challenging, there is no evidence to suggest that he was physically resisting the officers. Further, there were no other attempts made to de-escalate the situation, such as by answering D2054's questions and explaining to him why force was being used. Both factors resulted in D2054 being restrained excessively and unnecessarily.

43. The Inquiry did not see evidence to support D2054's account that the cuts on his arms bled during the restraint on 28 June 2017. Nor did the Inquiry see evidence to support the account that he lost consciousness during the use of force.

44. In my view, given that D2054 was clearly highly distressed about the prospect of his removal – and had self-harmed that day – the force used

against him was likely to have caused him intense mental suffering. Indeed, his serious anguish is plain from his reaction to the use of force and the distress that he demonstrated throughout. In my view, force was not used as a last resort when all other alternatives had been exhausted, and it was therefore not justified. In addition, the fact that D2054 was naked or near-naked for the duration of the use of force was likely to have resulted in this incident being a humiliating experience for him. Therefore, there is credible evidence that D2054's treatment was capable of amounting to inhuman and degrading treatment.

Chapter C.14:

D728 on 6 July 2017

1. D728 was born in Somalia. He was detained in Brook House between June 2017 and November 2017. He did not give evidence to the Inquiry, so little is known by the Inquiry about his background.

The underlying facts

2. D728's medical records stated that he had disclosed a history of misuse of drugs, and that he heard voices in his head, had difficulty sleeping, and had been taking methadone and an antidepressant.¹ He was referred to a Registered Mental Health Nurse (RMN) on 5 June 2017 because he had disclosed that he was hearing voices and wanted to kill himself, and he had been verbally abusive to officers.² An RMN visited D728 twice that day but he declined mental health support.³ The Inquiry has not seen any evidence of a mental health assessment, although D728 was subject to an Assessment Care in Detention and Teamwork (ACDT) plan.⁴

3. On 6 July 2017, D728 climbed onto the safety netting on A Wing and placed a ligature around his neck.⁵ Officers removed him from A Wing to the Care and Separation Unit (CSU) within E Wing under the provisions of Rule 40 of the Detention Centre Rules 2001.⁶ It appears that D728 was placed on constant supervision under the ACDT suicide prevention measures.⁷ On that day there were six detained people (including D728) on constant supervision. However, Brook House only had two cells with large viewing windows designed to allow officers to maintain constant observation of those inside. As such, four detained people were in cells with only a narrow slit through which officers could maintain constant supervision. D728 was one of those four.⁸

4. Detention Custody Officer (DCO) Callum Tulley was working on the CSU on 6 July 2017 and covertly recorded events there. In the footage, Mr Tulley

¹ [CJS000970_015](#)

² [CJS001023](#)

³ [CJS000970_018-019](#)

⁴ [CJS000970_018-019](#)

⁵ [CJS001870_002](#)

⁶ Rule 40 of the [Detention Centre Rules 2001](#) allows the removal of a detained person from association where "*it appears necessary in the interests of security or safety*"; see Chapter D.6 in Volume II

⁷ [CJS001870_002](#)

⁸ [CPS000025_037](#)

attempted to carry out constant observations of D728 but was unable to do so because D728 was using toilet tissue to block the observation panel from the inside of the cell.⁹ Mr Tulley asked D728 to remove the toilet paper but D728 refused and told Mr Tulley to stop staring at him and to “*Shut the fuck up.*” He also told Mr Tulley that he wanted to take a shower.¹⁰ Mr Tulley recorded in a BBC Incident Log that D728 had blocked the observation panel 15 times over a 3-hour period.¹¹

Figure 28: Toilet tissue blocking the constant observation panel



5. After 1 hour 40 minutes, Mr Tulley called for a manager to assist. DCO Charles Francis and Detention Custody Manager (DCM) Stephen Webb arrived shortly afterwards.¹²

6. Mr Francis entered D728’s cell first and immediately said, “*Right. If I have to come back here again. You won’t be going anywhere today. You’ll be staying down here permanently. You understand?*”. Mr Tulley and Mr Webb then entered the cell, and D728 can be seen in his bed, under the duvet. Mr Webb and Mr Francis stood next to D728’s bed and over D728.

7. D728 complained in a raised voice that he was not being given his medication. Mr Francis started to argue with D728, commenting that D728 had agreed with the doctor that he would wait until the morning. Mr Francis spoke over D728 in a raised voice and pointed down at him. D728 said that he was not feeling well and that he did not want to be in Brook House. Mr Webb said,

⁹ [KENCOV1044 - V2017070600006](#); [KENCOV1044 - V2017070600007](#)

¹⁰ [KENCOV1044 - V2017070600006](#)

¹¹ [CPS000025_037](#)

¹² [Day 2 PM 24 November 2021 00:38:58-00:53:30 \(KENCOV1044 - V2017070600007\)](#)

also in a raised voice, *"it's not unlawful"* and *"no-one wants to fucking be here, I don't want to fucking be here"*.

8. D728 replied, *"I'm not allowed to smoke, I'm not allowed to fucking shower."* Mr Webb told D728 that he could have a shower once enough staff were available but *"it depends on your behaviour"*. Mr Francis shouted, *"Right [D728] when did I say you could have a shower ... I said it would be about an hour"* and moved to leave the cell. D728 explained, *"I'm a Muslim, I need to clean myself, I need to pray, I got nothing in this room, none of my property is here"*, to which Mr Francis retorted, *"You should have thought of that before you got lippy."* D728 started to talk about his suicide attempt the night before, but both Mr Webb and Mr Francis groaned, one of the officers said, *"yeah, yeah, yeah"* and both officers left the cell.

9. Mr Tulley closed the door to D728's cell behind him, but within five seconds D728 had covered the viewing panel again. Mr Francis reopened the cell door and removed the toilet tissue from the viewing panel. D728 stood behind Mr Francis and said that he needed to smoke. Mr Francis stood at the door of the cell and began to argue with D728 about what time the shop opened. D728 made it clear that he thought it opened at 8:30 but Mr Francis shouted, *"the shop opens at nine ... Okay. You're so fucking clever ... give it a rest, give it a fucking rest."* Mr Francis's body language was aggressive throughout the argument. For example, he leaned towards D728 and used his arms to gesture at him.

10. Mr Webb joined in the argument and said, *"Listen, listen"* before shouting:

"right shut up a minute! ... your fucking attitude, depends on how this is gonna go for you, this is how this is gonna go for you. Piss us off, you won't have a shower, you won't have nothing!"

Mr Francis shouted, *"Listen the doctor said you have enough medication in your body to last you four weeks ... he thinks you don't need it."* Both officers then left the cell, with D728 still shouting at them.

11. Mr Francis told Mr Tulley that he would have to keep going into the cell to remove items from the viewing panel. Mr Webb then said, in a quieter voice, *"I'll fucking punch the cunt. I tell ya"*, to which Mr Francis replied, *"If you don't, I will."*

12. After another couple of seconds, the officers went back into D728's cell. Mr Webb said:

"Depending on how you behave here is depending on how this is going to go for you. Be a grown up. Help us, and we'll help you ... Dick us about and we'll make your life a living fucking misery."

D728 said, *“I want a shower and I want to fucking pray ... please, please forgive me”* but the officers left the cell. As Mr Tulley closed the cell door, Mr Webb remarked, *“Fucking twat, he is.”*

13. Approximately seven minutes later, Mr Webb noticed that D728 was continuing to cover his observation panel. He opened D728’s cell and D728 and Mr Webb spoke to each other in raised voices. Mr Webb said:

“Stop being a fucking idiot ... be a fucking man yeah, not a child be a fucking man yeah ... I’m not in the fucking mood for you today.”

D728 said, *“I’ve tried to take my life and you try to bully me.”* Mr Webb responded, *“Do you think I care? I ain’t fucking in the mood for you, alright.”*¹³ The door was then closed and D728 continued to cover the viewing panel with toilet paper. DCO Aaron Stokes was standing outside D728’s cell, and Mr Tulley asked him, *“How do you deal with someone like that?”* Mr Stokes responded, *“Chin him.”*

14. Approximately six minutes later, Mr Webb returned and Mr Tulley told him that D728 kept covering the viewing panel. Mr Webb responded, *“I was gonna let him have a shower but he’s fucking blown that.”* Another manager, DCM Stephen Pearson, later spoke to D728, provided him with a cigarette and told him that he could have a shower if he behaved himself.

15. Mr Tulley and Mr Stokes discussed D728 again later that day in a staff office. Mr Stokes relayed to Mr Tulley that D728 had said to him, *“I’m gonna hang myself if I don’t get off here.”* Mr Stokes described his response as follows:

*“I just literally went – crossed my arms, you can see it on the camera, just literally went in the room: ‘Do it. Just take yourself. I’ll cut you down, fucking crack on with it’. So what? I’m bloody bored of these empty threats. Honestly, would I give a shit if you hang yourself? I can’t physically stop you from hanging yourself. I can cut you down Can try and stop you from doing it but I ain’t gonna get in trouble for it, so you crack on mate, you get done with it. He didn’t like it when I said, stop playing your silly games and get on with it. He’s like, they’re not silly, they’re genuine personal reasons. Like, no, you’re playing silly games, mate. Don’t start.”*¹⁴

16. Under questioning by Counsel to the Inquiry, Mr Webb, Mr Francis and Mr Stokes recognised that their comments were inappropriate. However, they sought to explain them as a reaction to frustration and stress, or as just *“blowing off steam”*.¹⁵ Mr Webb was reluctant to accept that there was any

¹³ Day 2 PM 24 November 2021 00:38:58-00:53:30 (KENCOV1044 - V2017070600007)

¹⁴ TRN0000094_056

¹⁵ MIL000003_018; Stephen Webb 8 March 2022 195/19-196/16; Charles Francis 3 March 2022 79/18-82/5; INQ000132_005-006 para 11

difference between detained people swearing at staff and staff swearing at detained people. In his oral evidence to the Inquiry, Mr Webb said that, on occasion, he adopted what he termed a “*mirroring technique*” that he had discussed with others at an HM Prison Service National Tactical Response Group event. Mr Webb said:

“You would go into a situation, if someone was aggressive and shouting, you would match their aggressiveness and their volume.”¹⁶

Relevant expert evidence

17. In her first report, the Inquiry’s cultural expert, Professor Mary Bosworth, referred to the conversation between Mr Stokes and Mr Tulley.¹⁷ She commented that the words Mr Stokes used suggested that he had become desensitised to the distress of the men in his care.

18. The Inquiry’s use of force expert, Mr Jonathan Collier, said that he was not aware of the ‘mirroring technique’ described by Mr Webb and that it was not something that was covered in training. He added that, in situations where staff are attempting to de-escalate a situation, they should be demonstrating that they are:

“Someone who is in control of the situation, that’s willing to engage, that doesn’t resort to swearing, bad language.”¹⁸

Conclusions

19. The footage of events on 6 July 2017 shows tense and aggressive interactions between D728 and Mr Francis and Mr Webb. There was frequent swearing and raised voices and the interactions appeared fraught with frustration.

20. I have considered D728’s state of mental and physical health and whether it made him more vulnerable to mistreatment. D728 had recently climbed onto the safety netting on A Wing and placed a ligature around his neck. He had been moved into the CSU under Rule 40 and placed on constant supervision because his risk of self-harm was considered to be very high. Both Mr Webb and Mr Francis directly threatened to make D728’s life difficult for him while inside his cell.¹⁹ Mr Francis suggested that he would prolong D728’s time on E Wing if he had to return to the cell again, and Mr Webb stated that if D728 did anything to annoy him he would not be permitted to shower. Separately, Mr Stokes talked about hitting D728 and referred to him as

¹⁶ [Stephen Webb 8 March 2022 201/1-4](#)

¹⁷ [INQ000064_009-010 paras 2.17-2.18](#)

¹⁸ [Jonathan Collier 30 March 2022 185/22-186/25](#)

¹⁹ [Day 2 PM 24 November 2021 00:38:58-00:53:30 \(KENCOV1044 - V2017070600007\)](#)

“an absolute cunt”.²⁰ I agree with Professor Bosworth that the words Mr Stokes used in his conversation with Mr Tulley suggested that he had become desensitised to the distress of the men in his care.²¹ The speed at which Mr Webb and Mr Francis resorted to making threats, and the casual and uninhibited manner in which all the officers used aggressive, threatening and derogatory language, suggests to me that such language had been normalised by all three officers. They appeared to lose sight of their responsibilities towards the detained person in their care. In relation to their treatment of D728, Mr Webb and Mr Francis appeared to view D728 as manipulative, obstructive and not worthy of compassion. I do not accept that Mr Webb was using a mirroring technique when he swore at detained people.

21. D728 was asking the officers for a shower specifically because he is a Muslim and he needed to pray. Ablution before prayer is a fundamental part of ritual purity in Islam. As such, denying him the means to wash is likely to have had a particularly negative impact on him. Mr Webb told the Inquiry that he did not believe that his actions as a manager would have influenced other officers, although he acknowledged his regret that Mr Francis “got tied up” in what he said to D728.²² Although Mr Francis began to argue with D728 before Mr Webb became involved, his evidence indicated that he felt influenced by the more senior member of staff. Mr Francis told the Inquiry in his written statement:

*“Effectively, I was joining in with what Steve Webb had said. On reflection, I should not have done so. I can see that my support for his comment might have encouraged further abuse of this detained person, which I regret.”*²³

22. In my view, Mr Webb’s conduct showed a lack of appreciation of the power imbalance between him and a detained person, or of the influence he exerted on more junior staff. It is particularly striking that Mr Webb did not appear to have had regard to this power imbalance, despite D728 being held subject to Rule 40 and being on constant supervision following an attempt to self-harm. I consider such issues further in Chapter D.9 in Volume II of this Report.

23. I acknowledge that staff on the CSU on 6 July 2017 described being faced with a highly charged and challenging environment that day. Mr Tulley noted that there were six detained people on constant supervision.²⁴ Mr Webb described multiple urgent incidents to which he needed to respond, and stated that there was no other manager available to step in and talk to D728 – an

²⁰ [TRN0000094_047](#)

²¹ [INQ000064_009-010](#) paras 2.17-2.18

²² [Stephen Webb 8 March 2022 198/14-199/21](#)

²³ [HOW000001_017](#) para cii

²⁴ [CPS000025_037](#)

approach that Mr Webb thought might have de-escalated the situation.²⁵ Mr Francis told the Inquiry that he was following the lead of Mr Webb in how he spoke to D728. Mr Francis also said that he was still “*a little annoyed*” with D728 because D728 had thrown something over him earlier that day.²⁶ Both Mr Webb and Mr Francis asserted that their interactions with D728 were ultimately aimed at getting him to comply with the rules.²⁷

24. The covert footage shows that D728 swore at staff and repeatedly covered the observation panel in his cell door. However, it is also clear from the footage that both Mr Webb and Mr Francis were aggressive and confrontational towards D728, and did not deal with the situation calmly or professionally. They did not attempt to de-escalate, and instead allowed their frustration to affect their conduct. While the covertly recorded footage shows that the threats to hit D728 were made when he was on the other side of the cell door, I do not accept that the officers knew for certain that D728 could not hear them.

25. It is clear from the officers’ evidence and the footage that there were a small number of officers dealing with detained people with particularly demanding needs and challenging behaviours.²⁸ The staff working on the CSU did not seek advice or guidance from senior managers, even though they felt unable to deal calmly with the demands they faced that day. A BBC Incident Log recorded Mr Tulley’s account that staff were “*losing their cool*” and that the centre “*was not coping with the amount of difficulty*”.²⁹ It is plain, therefore, that there were insufficient staff to meet the needs of the detention centre that day.

26. The officers were ill equipped to deal with the complex needs of the detained people in the CSU. There is no excuse for the language that was used towards and about D728. However, in my view, the treatment of D728 did not occur in a vacuum. The low number of staff – inadequately trained to deal with the challenges on the CSU – coupled with a lack of senior manager oversight, contributed to an environment where such treatment took place (discussed in Chapter D.9 in Volume II). Regardless of the reasons, the treatment of D728 was unacceptable.

27. I have considered D728’s mental and physical health at the time of the incident. He had earlier expressed his intention to self-harm and had been placed on constant observations as a result. This means that D728 was considered to be in need of the most intense level of support because of his

²⁵ [Stephen Webb 8 March 2022 202/16-203/17](#)

²⁶ [Charles Francis 3 March 2022 86/7-87/7](#)

²⁷ [Stephen Webb 8 March 2022 200/17-201/18](#); [HOW000001_017-018](#) para 14di

²⁸ [IPA000001_005](#) para 34; [IPA000001_008](#) paras 60-66; [SER000449_007-009](#); [BFA000002_004](#); [DL0000141_043](#) paras 127-129; [SER000456_009](#) para 21; [INQ000122_002](#) para 10; [SER000433_006](#) para 38; [MAR000001_002](#) paras 14-15; [HOW000001_010](#) paras ei-eiii; [INQ000052_037](#) para 147; [INQ000052_060](#) para 230

²⁹ [CPS000025_037](#)

extreme vulnerability to self-harm and suicide at the time this incident occurred. Despite this, the officers repeatedly used aggressive and threatening language to D728, and it is plain from the footage that D728 felt bullied by them. Indeed, he specifically said, *“I’ve tried to take my life and you bully me.”* This, combined with D728 being entirely dependent on staff permitting him to shower so that he could perform rituals fundamental to his religion, left him particularly vulnerable to mistreatment. Taken together, the behaviour of the officers showed a lack of respect for D728’s human dignity. In my view, there is credible evidence that D728’s treatment during the incident was capable of amounting to degrading treatment.

ISBN 978-1-5286-4421-1

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