BROOK HOUSE INQUIRY

Witness Statement of Dr Brodie Paterson

I provide this statement in response to a request dated 11 January 2022 under Rule 9 of the Inquiry Rules 2006.

I, Dr Brodie Paterson, will say as follows:

Introduction

1. I am an experienced practitioner, academic and researcher, and a registered mental health and learning disability nurse.

2. I am a Fellow of the European Academic Nurses Association and an Honorary Fellow Ad Eundem of the Faculty of Nursing and Midwifery of the Royal College of Surgeons of Ireland.

3. I hold degrees and higher degrees in psychology, education, and social policy and have published more than 100 research papers, articles, and texts on the management of violence in health, social care, and education as a political, social, clinical, and technical problem.

4. I pioneered restraint reduction in the UK following the publication of groundbreaking publications on restraint-related deaths[1] and the development of corrupted cultures[2.]

5. I hold lifetime achievement awards from Conflict Pro and the British Self Defence Association for my work in reducing restraint.

6. I have to date been instructed in more than 150 civil and criminal cases involving the use of physical interventions.

7. I am a Trustee of the UK Restraint Reduction Network and presently chair the European Network for Trainers in the Management of Aggression.

8. I am currently a member of the Scottish Government Restrictive Intervention Reduction Network.

9. I was a Tutor / Senior Tutor in Control and Restraint and then Control and Restraint General Services from 1986-2005 and then led the development of

1 Paterson B., Bradley P., Stark C., Saddler D., Leadbetter D. and Allen D.,(2002) Deaths Associated with Restraint Use in Health and Social Care In the United Kingdom: The Results of A Preliminary Survey, *Journal of Psychiatric and Mental Health Nursing,* 10,3-1.

2 Paterson B., McIntosh I., Wilkinson D., McComish S. and Smith I. (2013) Corrupted cultures in mental health inpatient settings. Is restraint reduction the answer? *Journal of Psychiatric and Mental Health Nursing.* 20(3):228-35. 2013

Scottish NHS network of trainers in the Therapeutic Management of Aggression and Violence.

Instructions

10. I have been instructed on behalf of Medical Justice to provide a statement to the Brook House Inquiry by reference to the following instructions:

    (a) Given that IRCs are not penal institutions, comment on the appropriateness of the use of prison control & restraint (C&R) techniques in that setting, both in relation to use of force and use of segregation, and how this compares with expectations in clinical settings.

    (b) Comment on the use of removal from association, both formal and informal, in E Wing as a response to the care of those with a mental disorder and as a form of management of mental disorders and the risk of suicide and/or self-harm.

    (c) Comment on what the material (including the Panorama film and other documents) relating to the period covered by the Inquiry demonstrates about the institutional culture operating at Brook House IRC in relation to the treatment of those with a mental disorder at a management and staff level including medical staff.

    (d) Comment on how the institutional culture contributed to any mistreatment of detained persons and the actions of other staff including medical staff who did not report or were prepared to cover up abuse.

Executive Summary

11. There is substantive evidence of the development of a corrupted culture within Brook House IRC. A corrupted culture being an "active betrayal of the values upon which the organisation is supposedly based" (Wardhaugh and Wilding 1993:5). The misuse of coercion is one of the key indicators of the development of a corrupted culture.

12. The development of a corrupted culture at Brook House IRC, given the context in which it was operating, could reasonably have been predicted/anticipated and actions could and should have been taken by G4S and the Home Office at the most senior level to prevent it.

13. The policies and measures in place to safeguard the welfare of vulnerable detainees, including the Visitor's Committee, failed.

14. Senior staff within Brook House IRC failed to model and use appropriate attitudes and behaviour, used degrading and inappropriate language, failed to challenge

inappropriate behaviour by DCO's and DCM's and did not follow the reporting and recording procedures for the use of force.

15. There was an inappropriate use of National Offender Management Service ('NOMS') Prison modelled policy and practice on Control and Restraint ('C&R') in Brook House IRC.

16. NOMS prison modelled policy and practice on C&R has been allowed to infect the culture and management of individuals within Brook House IRC thus feeding into and exacerbating a corrupted culture.

17. NOMS prison modelled policy and practice on C&R involving pain were misused / used inappropriately.

18. There was a systemic failure by the Home Office to properly analyse whether NOMS prison modelled policy was an appropriate model for use in the IRC setting where a very substantial number of detainees were vulnerable.

19. The use of C&R within an IRC should be used on a limited and exceptional basis i.e. in a medical emergency and to save life and should not be used as a matter of routine on the mentally vulnerable/unwell.

20. Detainees were subject to unacceptable racist abuse.

21. Vulnerable detainees with significant mental health needs were treated without compassion, subject to unnecessary segregation and subject to unnecessary and excessive use of force.

22. There was evidence of failure by health professionals to fulfil their contractual requirements and of serious breaches of their professional codes.

23. A culture of disbelief appears to have existed within Brook House IRC leading to consistent failures to ensure that vulnerable people were treated in an adequate, humane, compassionate and therapeutic environment. In some instances this may have exacerbated their existing illnesses.

24. The failure by the Home Office to adequately respond to previously expressed concerns about the adverse impact of detention and the use of restraint and segregation on vulnerable detainees contributed to multiple instances in which detainees' human rights were violated.

25. In my opinion, G4S and the Secretary of State for the Home Department were in breach of their duties to those suffering from a disability under the Equalities Act 2010 as it cannot be demonstrated that reasonable adjustments were made to the NOMS/Prison based C&R system relied on to reflect the particular needs of vulnerable individuals with mental vulnerabilities and disorders.

Prison C&R techniques for use of force

26. The current use of NOMS/ prison service C&R techniques within IRCs in relation to the use of force is, in my opinion, not appropriate because it is based on a system which: does not sufficiently recognize the particular vulnerabilities and unique context in which individuals are held in immigration detention, does not provide a hierarchy of interventions, is not compliant with the Equality Act 2010 or consistent with the law, practice and current thinking on the use of C&R techniques more generally in the clinical and mental health context and does not rely on an appropriate public health model.

Use of force in IRCs – history

27. The model adopted across the IRC estate is predicated on NOMS/ prison service C&R techniques. The concepts within the 2006 NOMS Guidance which is the document that I have seen has its origins in concerns over high levels of injury to staff and prisoners in the English Prison Service in the 1980s arising from violent incidents. In response, the service developed a standardized system of training that drew heavily on martial arts in its development and subsequent implementation.

28. The use of force in the context of immigration removals was reviewed in 2014 by the Independent Advisory Panel on Non-Compliance Management following the death of Jimmy Mubenga and under Stephen Shaw. A series of extensive recommendations were made but underlying this review was the assumption that prison-based C&R techniques should remain the starting point in immigration removals.

29. In my view the use of prison based C&R techniques (including pain compliance) in the removal context is inappropriate and has been allowed to infect the everyday culture and management of individuals within immigration detention, thus feeding into and exacerbating a corrupted culture as discussed below. In my view that is because there has been a systemic failure by the Home Office to properly analyse and understand whether prison-based C&R techniques are in fact an appropriate model for use in the IRC setting. A fundamental rethink is required.

30. The Report of The Independent Advisory Panel On Non-Compliance Management (Home Office 2014:15) observed that *"Restraint minimisation is central to the concept of safe custodial managemen*t". Successful restraint minimization requires the adoption of what are described as whole organisation, public health-based approaches (Huckshorn 2004, Huckshorn et al 2014). Such approaches seek to address the root causes of restraint usage in organizational values, culture, policies working practices and practice models. They frame prevention as having four distinct elements (Leadbetter and Paterson 2009):

(a) 'Primary' prevention involves systematically identifying and addressing the root causes of crisis and distress at the level of the organisation, the unit, the team and both the individual officer and detainee (Duxbury et al 2019). An example of primary prevention at the level of the individual detainee might be to identify that the individual dissociates readily under stress and to both train staff to recognise and respond to those signs and how to respond and to enable a referral from health care to an appropriately skilled therapist to treat the underlying trauma. One example at the level of the organisation might be to urgently seek a resolution to the long standing wi-fi issues that seem to have been a source of significant distress to detainees. A more significant example would be to ensure adequate staffing levels enabling staff to develop working relationships involving trust with detainees.

(b) 'Secondary' prevention encompasses how individual officers identify and respond to indicators of distress that may escalate into crisis. Two examples of intervention at the level of the organisation to facilitate this may be given. Firstly, in any service data analysis will reveal particular potential flashpoints associated with restraint misuse often involving conflict of some kind. In depth training in non-violent conflict resolution and de-escalation can therefore help but reviewing whether the policies and procedures associated with such flashpoints may play a bigger role (Putkonen et al 2013).

(c) 'Tertiary' prevention describes how services and individual staff and teams respond to those crises that they have been unable to predict or prevent. This may include a variety of strategies including staff temporary withdrawal. For some individuals where this represents the last resort in order to avoid serious injury or enable treatment in a medical emergency this may involve the potential use of physical restraint or segregation.

(d) 'Recovery' involves rebuilding the relationships of trust which are ultimately the basis of relational security and takes time. Developing a shared understanding of what contributed to a particular crisis is always an important part of the process. Consequently, post incident debriefs which enable such learning to take place play a very important role.

31. The model adopted across the IRC estate focusses only on the physical intervention dimensions of tertiary prevention. It does not involve either a whole organizational approach or use a public health mode.

Control & Restraint Methods / Pain Compliance

32. Critically C&R techniques must be systematically assessed to understand whether the physical intervention system in use is appropriate for the context in which it is being used. The use of force within the IRC context is in my view controversial given the very different context in which individuals are being held. An IRC is

not a prison nor is it equivalent to detention under the Mental Health Act 1983 with a connected Code of Practice and the protections that provides.

33. Any such systemic analysis should have as its starting point that there are a series of criteria that should be used to judge the appropriateness of any system of physical intervention techniques for any setting and any population (Paterson 2005a, Paterson and Leadbetter 2005). These are as follows:

    (a) Does the system minimise the risk of injury to those subject to restraint?

    (b) Does the system minimise the risk of injury to those executing the restraint?

    (c) Does the system have ecological validity (Zarola and Leather 2006) i.e. is it appropriate to the needs of the range of people the service supports and the range of assessed risks identified (British Institute of Learning Disability 2014):

        (i) Does it provide a range of techniques covering the operational requirements of the service? For example, will it enable staff to move an aggressively resisting person against their will, will it enable staff to relocate somebody to their room and exit with a reasonable degree of safety, will it enable staff to move someone up and down stairs?

        (ii) Is it appropriate for the specific population who will be subjected to the interventions? For example, a system designed for a prison population comprised largely of young adult males is likely to be wholly unsuitable for care settings involving older adults whose dementia related distress may sometimes result in violence.

        (iii) Is it capable of application by the average member of the staff group concerned of average fitness and strength? For example, the social care workforce in England is largely female with an average age of 40 +. They are not on average young, male, fit martial arts enthusiasts.

        (iv) Can competency in the procedures be taught and a reasonable expectation held that such competency will transfer to an operational scenario after what may be a course of short duration?

    (d) Does the system provide a hierarchy of physical interventions such that staff can adjust the nature and degree of their intervention in order to respond in proportion to the circumstances of the incident they are in such that the principle of least restrictiveness may be demonstrated? For example, does it contain standing and sitting restraints as opposed to only prone or supine interventions, does it contain both pain and non-pain based procedures? Does it emphasise the need to prioritise de-escalation?

(e) Do the relevant governance arrangements for usage ensure restrictive interventions including restraint and segregation are being used:

(i) only as the last resort;

(ii) in accordance with an appropriate manual;

(iii) in accordance with the relevant and appropriate sectoral / organizational guidance the range of people being supported; and

(iv) proportionally in response to the level of threat posed. Physical intervention techniques can be thought of as involving a hierarchy from 'low tariff' interventions involving the minimal restriction of movement by guiding a distressed person through to 'high tariff procedures involving the almost complete restriction of any movement and the use of locked joints and pain compliance (Paterson and Leadbetter 1999).

34. The principles underpinning prison C&R techniques seek essentially to compensate for what may be height, weight, fitness, or strength inequalities between officers and inmates through the use of a combination of four elements: i) coordinated interventions by a team (usually of 3 or 4 staff) with clearly defined roles; ii) techniques that 'lock' aggressors' limbs limiting their ability to move or exercise any advantage in strength; iii) techniques that routinely applied pain to gain compliance; iv) 'positioning' most often involving face down or prone on the ground which allowed staff to use gravity and their body weight as well as pain to hold a resistant inmate until they had calmed or handcuffs could be applied to facilitate their safe movement (Paterson and Leadbetter 1999).

35. The rationale underlying the use of pain compliance is not to use pain as a punishment but to reduce the likelihood of the recurrence of the behaviour of concern. It is to facilitate the more rapid achievement of control by coercing the compliance of the person being restrained with the aim being to reduce the risk of injury to all of those involved (Paterson 2005b). However, there are specific concerns about relying on pain compliance and restraint practices associated with increased risk especially prone and supine in individuals who may be acutely mentally ill (Nelstrop et al. 2006). I understand that following the Shaw Review [2014] pain compliance was recommended only for limited and exceptional use even in the end process of removal at the point of departure.

36. Underlying the use of pain compliance is the assumption of sufficient capacity in the person subject to it to apprehend what is being done and why, understand whatever instructions are being given to them and crucially what they need to do in order for the pain to stop being applied (Paterson 2005b). Given that people experiencing mental health problems may, especially during crisis, lack such an understanding and may consequently continue to struggle or even struggle more vigorously and for longer because of the application of pain, the approach has

been criticized as wholly inappropriate in the support/management/care of people with mental health needs (MIND 2013). The presence of any form of language or communication barrier such as one would expect to find in the IRC estate would pose further challenges.

37. The NICE guidance (2015) states, "*the deliberate application of pain has no therapeutic value and could only be justified for the immediate rescue of workers, service users and/or others*'. It also violates section 26.62 of the Mental Health Act Code of practice, which states that, "*staff should not cause deliberate pain to a person in an attempt to force compliance with their instructions except in the most exceptional circumstances to mitigate an immediate risk to life*" (Department of Health 2015: 291).

38. A wide range of disruptive, distressed, agitated, and violent behaviours can be managed using alternative procedures that do not rely on coercion whether or not including the use of pain, that seek to minimise the overall use of restraint, and are less likely to cause psychological harm (Barnett et al. 2018). The recently published Restraint Reduction Network Training Standards (Ridley and Leitch 2019) - which NHS / NHS funded providers of care must be able to demonstrate their compliance with - goes further in mandating that, "*techniques intended to inflict pain as a means of control must never be used"* (Riddley and Leitch 2019:254) in NHS Mental Health (and Learning Disability) Services.

39. All of the above critical thinking and research appears absent from the approach to C&R adopted and applied in practice in Brook House.

Control and Restraint in the Clinical Setting

40. C&R techniques have now been dropped from use in mental health and learning disability health settings after being widely adopted during the 1980s (Paterson et al. 2009, Leadbetter and Paterson 2009). Critics suggested its reactive approach led to a system in which staff in mental health settings were being taught how to physically manage crises but not how to prevent them, with C&R becoming the only intervention being considered and used when faced with conflict or violence (Paterson et al. 2009). This reflects the approach seen in the context of Brook House.

41. Research found that C&R did not help staff to find solutions to the root causes of the individual's behaviour. Its implementation in health settings caused trauma to many of those who experienced it (Strout 2010) and re-traumatised many of those with a history of physical and/or sexual abuse (Sequeira and Halstead 2001, Robins et al., 2005, MIND 2013).

42. A number of years ago this led to a number of Mental Health services, including the High Secure Hospital estate, moving away from what was an approach that was historically heavily based upon prison service C&R techniques in order to demonstrate that a hierarchy of interventions was both available and used. E.g.,

the High Secure Hospital Network Positive and Safe Violence Reduction and Management Program Advanced Manual (West London NHS Trust 2015) retains the option of using pain compliance and prone restraint only in extremis i.e. situations of high risk in which life may be at risk. Critically it also contains a wide range of non-pain based breakaway and escape procedures as well as standing and seated as opposed to only floor restraints.

43. Local Mental Health in-patient services in England have also for a number of years been seeking to reduce the use of restraint and restrictive interventions. This has led to increased scrutiny of the physical interventions, which continue to be used, and to widespread attempts to reduce or eliminate the use of prone (face down) and supine (face up) restraint and pain compliance (MIND 2013). Positive and Proactive Care (Department of Health 2014), the guidance produced in response to the Winterbourne View scandal (Department of Health 2012), recommended that prone restraint should never be deliberately employed and recommended that if should staff find themselves in such a scenario they should seek to reposition the patient immediately. This guidance was later tempered by that contained within the MHA Code of Practice (2015:205) which observed that unless "*there are cogent reasons for doing so, there must be no planned or intentional restraint of a person in a prone position (whereby they are forcibly laid on their front) on any surface, not just the floor*."

The IRC setting and the facts relevant to Brook House Inquiry

44. In my opinion prison C&R techniques as exemplified in the NOMS 2006 Guidance are not an appropriate system to adopt within the IRC context for the reasons set out below.

45. These C&R techniques fail to provide an adequate hierarchy of interventions that include non pain-based interventions and de-escalation strategies. The Home Office therefore cannot demonstrate that by using prison C&R techniques its physical intervention system is in principle and practice hierarchical, providing an adequately wide range of low tariff and high tariff interventions which may be applied in proportion to the level of risk evident. As a result, the Home Office cannot demonstrate compliance with its legal responsibilities to ensure any use of force is proportionate and thus not excessive. As the relevant Prison Service (2005. Annex A 21) guidance says explicitly if *'excessive force is applied, or where the application of force is maintained for longer than necessary this may amount to torture, inhumane or degrading treatment*". In my opinion where high tariff interventions such as those involving pain are routinely deployed in situations involving vulnerable mentally ill adults when non-pain based and/or non-restrictive procedures could be deployed with equal effectiveness this also amounts to torture, inhumane or degrading treatment.

46. Any system that does not use physical intervention/ C&R techniques as a last resort to manage a severe crisis should be considered inadequate and inappropriate unless the use of C&R techniques forms only one component of a

multi-element whole organizational restraint reduction plan and based on the public health model. The current usage of NOMS/ prison service C&R techniques within IRCs, as evidenced in the context of Brook House, is not such a system as C&R appears to have become the default primary intervention.

47. As a consequence of a lack of a hierarchical approach, high-tariff restraint interventions were used in Brook House when less intrusive / restrictive interventions should have been used. There are particular reasons why the use of pain compliance-based and high-tarrif restraint procedures are inappropriate with people experiencing mental illness. The 2006 NOMS Guidance [31] states that "*it may be dangerous to use C & R techniques to control psychotic patients without the benefit of medical support, because the prisoner's responses to pain may be abnormal, resulting in them struggling violently against persistent attempts to bring them under control through restraint*". In my opinion and in my personal experience this observation holds true not just for those experiencing psychosis but also for those who have experienced trauma who may readily dissociate under stress altering their sensory experience (Dell 2009, Utzon 2014). Overall the use of high tariff interventions is extremely problematic in the IRC setting and not consistent with good clinical practice.

48. The prison service may seek to argue, by way of justification for the use of its NOMS C&R model, that the higher proportion of violent offenders it accommodates means that the routine teaching and use of locks, pain compliance, and prone restraint is a reasonable response to the overall nature of the challenge they face. Brook House and IRCs in general in my opinion cannot advance the same justification, given the context in which individuals are detained (i.e. it is not a penal institution) and the much more diverse population within an IRC with a much higher proportion of detainees being vulnerable.

49. The 2006 NOMS guidance is not compatible with the state's obligations in respect of human rights legislation and the Equalities Act 2010 and the requirements to make reasonable adjustments. The presence of a mental illness is highly likely to be considered to constitute a disability under section 6 of the Equality Act 2010. Where a disability is evident in an individual or as in the case of the IRC known to be widespread the Home Office have a statutory duty to make reasonable adjustments to their policies, procedures and staff training. The failure to adapt the 2006 NOMS Guidance or use an alternative approach such as that developed by the High Secure Hospital Network (West London NHS Trust 2015) to reflect the very different and unique nature of an IRC population constitutes a failure to make the reasonable adjustments required by the Equality Act 2010.

50. C&R prison techniques do not represent and are not equivalent to the practice and level of care which would be provided in an NHS mental health inpatient setting or an NHS General Hospital Setting (Joint Prison Service and National Health Service Executive Working Group 1999, Council of Europe 2004, Committee for The Prevention Torture 2007, NHS Protect 2016).

51. Current C&R techniques identified in the evidence before this Public Inquiry, which can be found in part in the 2006 NOMS Guidance, clearly breached the Mental Health Act 1993 Code of Practice (Department of Health, 2015) which represents the minimum acceptable standard of practice for the use of physical force for people with mental health issues.

52. The training of staff who may be expected to restrain individuals with a mental disorder as a last resort must encompass much more than just how to restrain. It must include the impact of mental disorder, the impact of trauma, the impact of previous physical or sexual abuse, the indicators of excited delirium and the requirement to protect and promote human rights. It must encompass awareness of primary and secondary prevention and not only reactive strategies, i.e. restraint or segregation. These are not adequately covered by the 2006 NOMS Guidance and highly relevant as the individuals detained in the IRC context will be a mixed population with a high proportional of mental health vulnerabilities.

53. Training involving restraint transmits more than technical skills and relevant knowledge. It transmits culture (Hollins and Paterson 2009). The evidence before this Public Inquiry suggests that an inappropriate set of values and a culture of confrontation and violent control associated with C&R has contributed to the development of a corrupted and toxic culture within Brook House IRC in which pain compliance specifically and restraint more generally appear to have been misused.

54. In my view given the mixed population within an IRC including a high proportion of individuals who are mentally vulnerable any use of control and restraint must be used on a limited and exceptional basis only i.e. in a medical emergency and to save life and should never be used as a matter of routine on the mentally vulnerable/unwell.

55. In my view a culture which relied on prison-based C&R techniques (including pain compliance) in the removal process has been allowed to infect the culture and management of individuals within immigration detention both contributing to and feeding into and exacerbating the corrupted culture operating at Brooke House in 2017.

56. In my view there has been a systemic failure by the Secretary of State to properly analyse whether prison-based C&R techniques are in fact an appropriate model for use in the day to day non removal context in the IRC setting.

57. Allowing the use of restraint and segregation inevitably creates the possibility of misuse. This is an internationally recognised problem and there is widespread agreement that it is incumbent on any organisation that allows their use in extremis to ensure that they have put in place sufficiently robust governance arrangements to prevent misuse (World Health Organisation 2019).

58. In practice the use of C&R techniques within Brook House illustrates rather perfectly what Kaplan (1964:28) memorably described as "*the law of the instrument",* observing that if we "*Give a small boy a hammer, he will find that everything he encounters needs pounding".* If the systems use is not robustly regulated and constitutes only one component in the multi-level whole organisation interventions needed, staff will almost invariably use it manage of incidents that might even have been avoided. The situation described by Kaplan is clearly illustrated in the material I have considered in relation to the treatment of individuals within Brook House which is under consideration in this public inquiry. This does not of course mean that restraint can or should always be avoided. Interventions in emergency situations such as those involving a serious and immediate threat to life may sometimes be necessary.

59. The facts indicate a corrupted toxic culture was allowed to develop within Brook House in which vulnerable individuals with mental health problems / mental illnesses were neglected and abused, psychologically and on occasion physically. Central to this particular variant was a pervasive disbelief shared by DCO, DCM and Senior Management within Brook house and within the Home Office itself in the legitimacy of asylum seekers mental health issues. This resulted in a default approach by some staff to treat symptoms and behavior related to mental illness and distress as non-compliance or disruptive or manipulative. The experience of D1234 who describes being subject to the use of C&R (Transcript day 14) illustrates the brutal reality involved in the application of C&R and its potentially dehumanizing and traumatising impact in a case involving a young man described as having psychotic features.

60. Such beliefs were not shared by all staff but it is important to note that while not all staff actively participated in abuse many by their inactions on witnessing ill-treatment colluded in it and must accept their responsibility for doing so.

Governance

61. The absence of robust governance arrangements including rigorous post-incident review means that the responsibility for such failings lies not only with individual officers but the contractors' senior management team and ultimately the commissioners of the service, i.e. the Home Office.

62. Examples of the system failing in practice are evident in the Panorama film.

63. For example, the Use of Force Forms provide a critical means for the institution to monitor both any trends or patterns in the use of force e.g. the disproportionate involvement of particular staff or an increase in incidents involving a particular detainee warranting investigation. In completing the form members of staff must describe their judgments, identify the decisions they made and justify the actions they took in the circumstances in which they took place (National Offender Management System 2015).

64. Such reports *'must make as clear a picture as possible as to the facts as they saw* them' and this should include reference to:

- *Where the member of staff was when they became aware of the incident.*
- *Details of any briefing given to them by the supervisor.*
- *What circumstances they are aware of that led up to the use of force.*
- *What instructions were given to the prisoner before force was used – this must include that the prisoner was made aware of the consequences of non-compliance.*
- *Their perception as to the behaviour of the prisoner and what he/ she was saying and doing.*
- *The names of others present (both staff and prisoners).*
- *What their role was (e.g. position in C&R team).*
- *A detailed description of how they applied force.*
- *How the member of staff felt about the incident.*
- *Their perception of the resistance offered by the prisoner.*
- *Quote any instructions given to the prisoner and the response received.*
- *De-escalation efforts made (try to quote words used).*
- *Whether ratchet handcuffs were applied (and who authorised their use).*
- *Where the prisoner was relocated to and how the relocation took place e.g. in locks, walking, in ratchet handcuffs.*
- *Any injuries observed to staff and/or prisoner.*

(HM Prison Service 2006:90)

65. It appears however that these were not always being completed and from the example shown where a DCO deviated from his training and placed pressure on the detainee's airway that deviations from the procedures taught were not questioned by DCO, DCMs or the healthcare staff, or reported but instead deliberately covered up. Any deviation from the procedures taught should be a matter for serious concern as unless identified and corrected such field modifications may become standard practice posing serious and even fatal risks to the welfare of those detained (Youth Training Board 2006). Even where the forms were completed it appears the primary aim was not to promote learning and reflection regarding how the detainee might be better supported and future incidents reported. Rather they were "written with a specific agenda, simply to cover themselves and to justify what they had taken part in" (Testimony Owen Syred).

What is wrong with the current system

66. It appears that restraint generally and high tariff procedures more specifically i.e. locks, pain compliance have become the default option rather than an intervention of last resort. Although it has been recommended that pain compliance should only ever be used to expedite removals, "It's very clear that use of force was used wholly inappropriately, simply for moving people around to prepare for deportation, moving them to E wing" (Owen Syred witness statement).

67. The IRC is detaining individuals with a mental disorder. The content of training for staff as should therefore have complied with the Council of Europe Committee of Ministers (2004) Recommendation No. Rec (2004) 10 of the Committee to Ministers of Member States concerning the protection of the human rights and dignity of persons with a mental disorder This requires that any staff likely to be involved in the use of restraint or seclusion receive training on how to manage the risks involved but also in the '*correct application of such measures*, in "*measures to prevent the use of seclusion"* and critically in "*protecting the dignity, human rights and fundamental freedoms of persons with a mental disorder".* I have not reviewed the content or learning outcomes of any such training however the evidence available suggests the training provided did not address the particular issues around the use of coericive interventions with people with a mental disorder being instead generic with "*very little, if any, emphasis" (*Testimony of Owen Syred). This suggests either or both the current program of training and the oversight by G4S management of practice are inadequate.

68. The immediate antecedent to the use of both force and segregation is invariably some form of conflict. This may not always take the form of violence and prolonged agitation, but also includes actual or threatened self- harm or non-compliance may all lead to the use of force and segregation. Improving staff skills in de-escalation and non-violent conflict resolution may help resolve conflicts that have already developed. It has, though, been recognised for some time in mental health that such 'secondary prevention' must complement an explicit whole organisation commitment to 'primary prevention'. If the root causes of conflict and violence are to be addressed (Paterson et al. 2005).

69. A number of systemic, albeit diverse, approaches have been applied successfully or shown promise in this regard. Six core strategies is an approach developed in the US that has been applied in the UK and elsewhere (Putkonen 2013) and has been adapted as the basis of 'Restrain Yourself (Duxbury et al. 2019). The 'Safewards' model developed by Bowers et al. addresses six discreet sources of conflict arising from the staff team, the physical environment, outside hospital, the patient community, patient characteristics, and the relevant regulatory framework. Patient Safety Improvement strategies used widely to address a range of concerns in health care have also been used with success (Bell and Gallacher, 2016). Patient safety interventions in mental health services may focus on a range of areas of concern. These include inpatient to inpatient sexual abuse, violence, aggression, restraint, and seclusion but also medication errors and environmental deficiencies e.g., ligature points (Berzin et al. 2018). However, self-harm is the incident most likely to result in death (usually by suicide), and is, therefore, a key safety concern (National Patient Safety Agency, 2006). Such approaches have been slow to be adopted in settings beyond traditional in-patient and community settings but hold considerable promise (Stern et al 2010).

70. Positive Behaviour Support, a model recommended by the DoH (2014) and originally developed within services for people with a Learning Disability has also now been applied in a number of secure mental health services (Davies et al.

2015, Davies et al 2016, Tolisano et al. 2017). Hughes 2018). As awareness has increased of the significance of trauma at an individual, family, and community / societal level and its relevance to the practice of individuals, teams, and services and multiple initiatives based on the principles of trauma-informed care have also been developed.

Prison C&R techniques for use of segregation

71. Rule 42.—(1) Allows that "*The Secretary of State (in the case of a contracted-out detention centre) or the manager(in the case of a directly managed detention centre) may order a refractory or violent detained person to be confined temporarily in special accommodation, but a detained person shall not be so confined as a punishment, or after he has ceased to be refractory or violent*".

72. It is widely acknowledged that the use of involuntary segregation is associated with a significant risk of harm (Van Der Merwe et al. 2013). A review of the literature on patients' experience by Askew et al. (2019) identified that the experience of seclusion threatened participants' mental health. Patients described themselves as disconnecting and perceived the actions of staff as neglectful and abusive.

73. The impact on mental health may be significant with a systematic review of the literature finding that rates of post-traumatic stress disorder after the use of restrictive interventions including isolation varied from 25% to 47% (von Werthen et al 2019). Any negative effects are likely to be increased when the individual has a pre-existing mental health condition with asylum-seekers with a history of torture identified as particularly vulnerable to negative mental health outcomes from isolation (Royal College of Psychiatrists 2016:4). However, a history of life-threatening events more generally has also been found to be associated with an increased risk of traumatization / re-traumatisation as a consequence of isolation (Steinert et al. 2007, Kira et al. 2008).

74. Consequently, the use of segregation must be considered with considerable caution in the care of those with a mental disorder especially in the presence of self-harming or suicidal behaviour irrespective of the setting (Chieze et al. 2019). Careful assessment of the potential effects of seclusion by a clinician as opposed to a manager however senior is warranted in order that a risk-benefit analysis informs the decision-making process and that it represents both the last resort and the least restrictive intervention (Gaskin et al. 2007).

75. Such concerns were raised in the first Shaw report (Shaw 2016) with suggestions that a multi-disciplinary review of such decisions was required. The evidence in the Panorama documentary was that, if this mechanism was introduced, it had failed. Segregation appeared to be being used to manage behaviours such as self-harm which was a completely unacceptable practice. The National Preventative Mechanism (2017:12) recommend that '*There must be a clear, rigorous risk assessment carried out by competent individuals (including health care*

professionals where appropriate) to support decision-making around isolation. In my view this guidance did not appear to be being complied with.

76. The use of such interventions is, however, also a source of concern in many settings because expediting segregation with a person who is refusing and actively resisting may lead to the use of restraint by staff attempting to move the person. Moving an individual who is being restrained involves a number of technical challenges which create a significantly increased risk of injury to all those involved.

77. As with any scenario involved increased risk the preferred strategy will therefore be avoid it whenever this is practicable. This requires that an organizational strategy to reduce it based yet again on the principles of public health is needed. The literature suggests there are two key strategies that may reduce the need for seclusion in mental health and these are essentially the same for an IRC. Firstly, staff need to maintain an active presence in the unit on the floor in order that they can establish working relationships involving trust creating an element of relational security and get to know detainees well enough in order to detect early and possibly subtle changes in their mood (Taylor et al., 2012). If detected, earlier interventions using less restrictive measures such as empathy, distraction, de-escalation or even where prescribed, medication may avert a crisis. Secondly, there needs to be an explicit focus on the culture with the aim of promoting a culture of routine, predictability, calmness, and collaboration, rather than control (Bowen, Privitera, and Bowie, 2012). The success of such interventions requires explicit proactive management of the milieu an active commitment to relational security and an adequate number of well trained and well-led staff and a low staff turnover allowing consistency of presence. Unfortunately, it appears all may have been lacking in Brook House IRC (Testimony Owen Syred).

78. However, the literature also tells us that whilst such interventions may be harmful in and of themselves, how they are carried out and the perceptions of the individual being segregated of the attitudes and motivation of those carrying out the segregation may significantly mediate its impact. It appears that DCO's "were never told why people were ill with mental health conditions were moved to solitary confinement" (Testimony of Callum Tulley). It is though in my opinion likely based on what appears to have been the widespread culture of disbelief that the perception of at least some staff was that such behaviour was attention-seeking or manipulative and the act of removal to segregation provided an opportunity to punish the person for exhibiting the behaviour. In so doing to exorcise their own frustration and anger. Consequently, it appears that scenarios that may have been capable of resolution by dialogue and de-escalation were instead used as to legitimize the use of restraint including pain compliance.

79. This suggests the existence of a regime in which the routine use of C&R and segregation itself were used as punishments for behaviour framed as willfully bad as opposed to indicators of severe mental illness. Such practice would be a direct breach of Rule 42. Relocation to Rule 42 accommodation must take place only if

the available information strongly indicates that relocation is deemed necessary in the interests of security or safety and must never be used as a punitive measure.

80. In many ways segregation when combined with constant observation may be considered the equivalent of intensive care for an individual experiencing a physical disorder and should be provided by qualified, experienced, clinical staff with the additional training required. In my view where the risk of self-harm or suicide is so high as to warrant the use of constant observation the detainee is no longer fit to be detained and should be transferred to an appropriate mental health facility or released.

The use of removal from association in E Wing at Brook House IRC

81. Rule 40 (1) of the Detention Centre Rules 2001 provides that: ***"****Where it appears necessary in the interests of security or safety that a detained persons should not associate with other detained persons, either generally or for particular purposes, the Secretary of State (in the case of a contracted-out detention centre) or the manager (in the case of a directly managed detention centre) may arrange for the detained person's removal from association accordingly"*

82. The negative impact of detention in and of itself on the mental health of detainees increases the longer detention persists, but negative effects may be present even after relatively short periods of detention (Shaw 2016, Royal College of Psychiatrists 2016, von Werthern et al. 2018). The negative effects of detention are, however, likely to be mediated by the general conditions and the mental health care available (Bosworth 2016). Georgieva et al. (2012) reported more adverse consequences following the use of seclusion when it was combined with restraint than when seclusion was used on its own. Removal from association, whether formal or informal, as practiced within the IRC, represents a form of isolation and is a form of restrictive intervention in itself: "*The physical isolation of individuals who are confined to cells or rooms for disciplinary, protective, preventive or administrative reasons, or who by virtue of the physical environment or regime find themselves largely isolated from others. Restrictions on social contacts and available stimuli are seldom freely chosen and are greater than for the general detainee population*" (The National Preventative Mechanism 2017:1).

83. The use of segregation and restriction on association in the management of individuals who are actively attempting self-harm or are acutely suicidal are of particularly grave concern. Multiple case reports have evidenced that providing the level of supervision required to safely manage the risk of suicide is hindered not helped by isolation (Nelstrop et al. 2006). The use of jointly developed safety plans developed in conjunction with those in crisis over the time period covered by this inquiry should have been a core aspect of good practice and used routinely by the health care team within Brook House (National Institute of Clinical Excellence 2011, Cole-King 2013 Nuij, 2021). I noted no reference to the use of such plans in the IRC setting. Compassionate empathy and hope inspiration are

central to addressing the trauma, distress, shame, hopelessness, and despair that may underlie such behaviours (Cutcliffe and Barker 2002). Such interventions require contact, engagement, and significant skills and should be undertaken by clinical staff of appropriate seniority (National Confidential Inquiry Into Suicide and Safety in Mental Health 2015).

84. The use of segregation and restriction of association in Brook House IRC and in particular in E wing is therefore of serious concern. Multiple respondents talk about a barren noisy cold environment and although there appears to be higher staffing ratio mechanical observation in and of itself create the culture needed. The necessary infrastructure represented by a compassionate therapeutic culture, an expert workforce, an appropriate policy framework, regular clinical supervision for the staff involved and an appropriate external regulatory framework appear absent. I note the recommendation that staff working with vulnerable detainees must receive appropriate '*Advanced mental health training*' (Independent Monitoring Board Brook House 2019:5). Something previously recommended by the board in their 2017 report. However, such training is in my opinion wholly unlikely to create the knowledgably, skilled compassionate workforce needed to resolve needed to stabilize and promote recovery in those in acute mental health crisis

85. There may be instances where an emergency scenario arises involving a mental health crisis where this could not reasonably have been anticipated prior to detention. However, if C&R and segregation are having to be used routinely due to cultural issues, a lack of expertise or of resources, in order to enable the service to contain the behavioural manifestations of mental health crisis the individuals concerned should be released and supported to gain access to appropriate services.

86. The Assessment Care and Detention Teamwork (Home Office 2008:1) guidelines does identify the need to establish who is at risk at risk of self-harm and/or suicide in order to ensure the provision of appropriate care and support for such detainees. I note the suggested training matrix (Home Office 2008.5) but tasking non-clinical staff with the assessment of risk and the development of support plans on the basis of what may be minimal training causes me significant concern. Providing training such that staff may both understand self-harm and suicide better is if course desirable. As are the clear identification of where responsibility lies and the emphasis on multi-disciplinary / agency practice.

87. However, I note the suggestion (Home Office 2008) that 'The Duty Manager/Shift Manager must audit the quality of ACDT Plans at least twice a week, draw deficiencies to the attention of the Centre Manager and line managers, monitor the response, and record that they have made these checks. Given their lack of expert knowledge and training in my opinion such plans should be reviewed by a clinician not a manager.

88. Segregation and monitoring by Detention Officers does not offer an acceptable level of care. Individuals in significant mental health crisis should either be released or transferred to an appropriate therapeutic setting. The Panorama film indicated that segregation was being routinely used to manage detained individuals with significant mental health problems. This was inappropriate.

The institutional culture operating at Brook House IRC

89. In my view, the material reviewed including the Panorama films shows that what had been allowed to develop within Brook House was a corrupted or toxic culture. Such cultures are unfortunately neither rare nor even unusual. The cause of such corruption is primarily labelling where the label is stigmatising and serves to create 'moral distance'. This renders those affected by the label less than human and thus undeserving of the natural human empathy that might otherwise prevent abuse. Corrupted cultures are particularly likely to develop in socially isolated, 'closed' institutions where there are marked power inequalities such as Brook House (Department of Health 2012). That such cultures are often described as 'closed' refers to situations where there are few opportunities for outsiders to observe conditions or interactions enabling closed, punitive abusive culture to develop without challenge in which there is "*complete hostility towards raising concerns*" (Testimony of Owen Syred). It does not mean that such cultures may not be influenced by developments outside their walls.

90. The development of a corrupted culture is not an inevitable eventuality but rather something whose prevention requires constant attention (Farquharson, 2004). In any scenario involving detention, staff must contend not only with the normal demands and emotions associated with work but with issues unique to their role. Exposure to behaviour that challenges, including violence, will always involve significant emotional labour. In order to practice de-escalation effectively staff must stay present, attuned, regulated, and empathic, recognising, and overtly acknowledging their internal attribution processes. In order to establish relational security, we need to maintain our openness to the emotional distress and suffering of another in order to provide the basis for connection, a means of containment for the others distress, and the foundation for the development of the human connections that are needed.

91. Unsurprisingly, some staff will, at times find themselves temporarily or chronically overwhelmed by such demands. Burnout is widely recognised as being manifested by low mood, exhaustion, cynicism, and disillusionment caused by inadequate resources, poor job design, and working conditions and may occur in any occupation. However, there are two often less recognised but interlinked dimensions of burnout of particular reference to Brook House and the IRC estate more widely. The first involves 'Depersonalisation', a process by which the individual seeks emotional distance from the demands placed on them by recipients by reducing them to objects. The second involves a process involving a change to the individuals' personal values and their value systems in order to

improve ‘efficiency at work’ (Paterson et al. 2021). Both increase the risk of abusive practice.

92. The symptoms of compassion fatigue mirror elements of burnout including detachment, but their route cause is the continuous contact with victims of trauma where the worker is required to exhibit empathy to the distress underlying its behavioural manifestations e.g. in self-harm while feeling powerless to prevent it (Harris & Griffin, 2015). The person’s capacity to sustain empathy in response to overwhelming insatiable demand may over time simply become exhausted (Figley 1995).

93. Exposure of staff to distressed, dysregulated self-harming, suicidal or violent behaviour (including involvement in restraint, seclusion, and compulsory medication) may result in trauma for all those directly involved or vicariously exposed including staff (Bonner et al. 2002). The likelihood of developing a mental health condition is increased by repeated exposure. Trauma may not always result but exposure to, or involvement in such events will often generate very strong feelings typically characterised by fear, anger, and frustration (Maier1999). Even if appropriately acknowledged and proactively managed via organisational debrief and clinical supervision, the power of these feelings of staff is such that they may struggle to maintain positive relationships and empathy with detainees (Blumenthal 2010). As (Bloom 2006a:13) suggests, *“The negative effects associated with exposure to violence are so noxious that the individual cannot contain them without resorting to protective defences that are often destructive.”* As described eloquently in the evidence given by Owen Syred *“at the point of dehumanisation, you're in the slippery slope to despair.”*

94. Such despair and helplessness may turn all too readily into anger, frustration to aggression, and fear into resentment. In extremis, we see the development of 'malignant alienation' (Watts and Morgan 1994). Those charged with guarding the welfare of the vulnerable, instead of acting to prevent suicide or self-harm, lost in frustration, rage and hatred seek instead to inspire it.

95. The deeply disturbing remark by DCO B to the concerns of the undercover reporter regarding how to undertake the extremely challenging task of and engaging with someone who is acutely suicidal, that they should “*turn away, Hopefully, they’re swinging*” is indicative of the phenomenon. As is reference also by Owen Syred to the observation by staff that after a fire in a detainee’s room that “*we should have let him die. He was an arsehole*” The references in relation to the forcible removal of a detainee with heart problems by firstly DCO D “*if he dies he dies”* and secondly DCO E that *“all you* (reporter) *have to worry about, all you have to know is to roll his fucking head or him hit with a shield”* is similarly indicative of this extreme phenomenon in corrupt and toxic institutional cultures. The Immigration and Asylum Act 1999 s155 specifies the duty of custody officers in relation to a detained person whom he is exercising custodial functions. These include: *(d)* "*to attend to his wellbeing*". The Detention Centre Rules 2001 indeed require that Detention Custody Officers must pay “special

attention" to the observance of this duty. That such a culture has therefore been allowed to develop is a matter of the most profound concern. It suggests that there have been serious failures to adequately support the staff who may be involved in the care and support of individuals who may self-harm or attempt to complete suicide (Home Office 2006).

96. Evident at multiple points throughout the documentary is the use of de-humanising and derogatory language to refer to detainees. Terms such as '*div*', used by DCO A, '*Scrotum*' used by DCM, and '*penis'* used by a DCM to refer to a detainee refusing food. The material presented in the Panorama document will, of course, represent a selection from that filmed but that evidences an institution seemingly bereft of compassion. An institution in which the distress of others was the source not of concern but of humour. In which it was responded to not with compassion but derision and hostility. A number of staff seemed intent not on avoiding conflict but instead on engineering it in order to provide an excuse to use restraint in order to cause pain or to punish those evidencing distress.

97. Such language, attitudes, and behaviours are clear evidence of a corrupted or toxic culture. Irrespective of the original root cause of the misuse of coercive measures, if such misuse is sustained over time such patterns of behaviour can gradually become embedded as part of the service culture subtly passed on to new members of staff via modelling rather than explicit endorsement as simply the "*the way things have always been done around here*" (Bloom, 2006a:32). The problem is not one of bad apples it is of a rotten barrel (Farquarson 2004).

98. Bloom (1997) has, however also stressed that we must recognise the role played by trauma and understand its manifestations at an individual, team, and organisational level. Unfortunately, amongst the consequences of trauma at the level of the individual may be a combination of hyperarousal and hypersensitivity to threat that results in repeated activation of the fight / flight mechanism overwhelming the individual's ability to problem-solve. When repeatedly exposed to extreme stress, what should be transient hyperarousal in the form of fight /flight can turn instead into a persistent trait. In such circumstances, human beings can "*lose their capacity to accurately assess and predict danger leading to avoidance and re-enactment instead of adaptation and survival*" (Bloom 2006b:6). This may present on a day to basis as emotional and behavioural dysregulation leading all too readily to conflict.

99. The sense of ever-present danger results in hyper-vigilance and hypersensitivity to potential threats such that even neutral facial expressions may be perceived as indicating imminent danger (Taylor 2020). Staff supporting those affected by trauma need therefore to be extraordinarily skilled in the conscious management of their own verbal and nonverbal behaviours in order that they do not trigger aggressive reactions in service users hypersensitive to any form of threat. For staff, the constant 'firefighting' involved, unless its emotional manifestations are acknowledged and safely managed, may lead to teams and even whole organisations to mirror the pathology of the population they support. Lacking

insight, empathy, or the capacity for reflection trapped in a cycle of conflict, despair, and anger.

100. The risk is that a dynamic develops in which staff may come to believe in not just the necessity but the desirability of violence as a means to inspire fear. Such fear serves to ensure compliance and ultimately their safety but also their status at the top of a violent hierarchy recreating thereby the *'patterns of blame and vengeance that permeate wider society* (Fisher 2002:69). For some staff, this may reinforce their existing worldview prior to their appointment.

101. The misuse of restraint, whether in the form of notionally approved techniques or various forms of violence, has been suggested to be a defining characteristic of a corrupted culture. In my view, there are multiple instances of this. The actions of DCO Yan Paschali (R v (MA and BB) v Secretary of State for the Home Department [2019] EWHC 1523) described as "*in holding MA's head between his knees while apparently "digging his fingers in" to MA's neck and whispering in his ear, "Don't move you fucking piece of shit. I'm going to put you to fucking sleep"* as the detainee gasped for breath, breached multiple pieces of authoritative guidance, never to obstruct the airway during restraint. The force used, if sustained for even a period of minutes, could readily have been fatal. There was no justification for its use in that form. It breached rule 41.1(1): "*A detainee custody officer dealing with a detained person shall not use force unnecessarily and, when the application of force to a detained person is necessary, no more force than is necessary shall be used*". It breached rule 41.2.(2): "*No officer shall act deliberately in a manner calculated to provoke a detained person*."

102. The failure of DCM as the supervising officer to replace DCO Paschali for "*not using correct C&R techniques*" breaches the guidance contained in annexe F of the NOMS guidance on the use of force. Further, the instructions of the DCM observing the situation not to report it breached rule 41.3 (3) "*Particulars of every case of use of force shall be recorded by the manager in a manner to be directed by the Secretary of State, and shall be reported to the Secretary of State*". Unfortunately, it appears this may not have been an isolated case with it seems assaults perpetrated by staff also not being reported even when witnessed by managers (HOM004880 – Telephone Interview of D2953 – 18 OCT 2017).

103. The observations of DCO, a C&R trainer, whilst standing on the stairwell are of particular concern. The role of instructors in modelling appropriate attitudes, conflict prevention, concern for the welfare of detainees, and the need to prioritise safety has a critical influence on culture and practices both around the use of force and more widely (Hollins and Paterson, 2009). Consequently, his suggestion that others should use racist language in the form of the 'N' word in order to engineer a confrontation with a detainee, which may then be managed with restraint, is unconscionable and represents a breach of rules of 45.3, 45.5 and 45.6. His observations that members of the C&R team should "*Fuck him up round the corner*," "*Can't fuck about*", "*I'll scrub the CCTV*" and "*He has had his fucking chance*" are indicative of a culture in which it appears the misuse of restraint to

punish perceived infractions was endemic, modelled by those charged with promoting best practice including senior staff DCM and not challenged by others who witnessed it including both fellow DCO's or health care staff.

104. The saturating effect of such cultures once developed may become so powerful that they redefine what staff would ordinarily interpret as abuse if not criminal behaviour as merely conformity (Leele and Gaile 2007). Newly appointed staff can come under significant implicit and sometimes explicit pressure not only to accept the inappropriate behaviour of other staff but to themselves engage in institutionally sanctioned violence in order to be accepted and trusted (Farquarson 2004). '*I was told to do the first hit and then it would be Ok'* (Cambridge 1999,296). Such acquiescence in the context of an IRC breaches the DCR 2001 Rule 45(2) to report any abuse or impropriety by colleagues. However, reporting or even challenging inappropriate attitudes and practice is much more difficult when they are demonstrated by senior staff as illustrated by the behaviour of a DCM in the Panorama documentary responding to the threatened self- harm by Detainee A who has tried to swallow batteries by suggesting that "*if he wants to suck batteries plug him up like a duracell bunny*".

105. Unfortunately, a variety of cognitive mechanisms enable staff to distance themselves from responsibility from the consequences of their behaviour. (Zimbardo 2005). Such mechanisms include the dehumanisation of the victim, previously noted and described by Arendt (1951) in the context of the holocaust. Framing the behaviour as instrumental, e.g. attention-seeking or manipulative as opposed to distress. Relabelling the behaviour of staff, e.g. as restraint rather than violence and even seeking to justify such behaviour as a morally justified punitive response, necessary because of the bad choices or character which the victim themselves brought about and was therefore actually responsible for because order must be maintained (Bandura et al. 1972). There are multiple examples at Brook House: "*if you're self harming you're an attention seeking little prick*" (SXP000120 – 007 – 008 – Witness Statement of Callum TULLEY – 23 NOV 2017).

106. De-humanisation is more likely to happen more where the victim is already a member of a marginalised or stigmatised group or where action is justified on the basis of the transgressions of that individual or group. As Arendt (1951) observed, labelling in some circumstances creates 'moral distance'. This serves to render those affected by the label less than human and thus undeserving of the natural human pity that might otherwise serve to prevent abuse. Unfortunately, there is little doubt that a series of narratives have served over time to distance or other asylum seekers from 'us' (van Dijk,2000a, van Dijk2000b). Of particular significance to the context of an IRC such as Brook house is a theme in the narrative distinguishing between 'genuine' asylum seekers, i.e. those seeking refuge and bogus asylum seekers framed as only entering the country for economic benefits and deserving of sanction and punishment (Layton-Henry, 1992; Sales, 2002 Greenslade, 2005). This narrative has gained prominence as a result of UK government policy since 2012, which has sought to create a 'hostile

environment'. The aim being to create a life "*so unbearable for undocumented migrants that they would voluntarily choose to leave*" as their access to public services becomes increasingly restricted (University of Portsmouth, 2021: n.p.). Central to the frame underpinning the policy is that of threat. Immigration is depicted as threatening British values, culture and living standards, public services, and security through rising extremism and criminality (Hubbard 2005). Community integration and public order are framed as being at risk if tough action is not taken (Goodman 2008). These themes are considerably more heightened in discussions of non-white and more culturally distinct individuals (Dempster and Hargrave, 2017).

107. The relationship between government policy, media and social media coverage of an issue and the attitude and behaviour of individual people and institutions is complex (DiMaggio1997). However, it appears that the more publicly available cues are, the more likely they are to exert an influence whilst simultaneously diminishing the impact of competing narratives (Lizardo, 2016). Kira et al. (2014:390), discussing the impact of the intersection between different forms of trauma that an individual or community may experience, proposes that we must recognise a phenomenon she calls "*backlash trauma*" in which as a consequence of alleged transgressions by that group "*an intensified reactive discrimination or micro and macro aggressions toward a minority group*" takes place. When the transgressive nature of bogus asylum seekers is repeatedly highlighted by both government and the media and tough action is called for an increase in hostility is clearly more likely to happen across wider society and within institutions. This will in at least some instances materially influence how individual asylum seekers are treated whether they are detained or not. It appears that both anti-immigrant rhetoric and racism more generally were both common amongst staff in Brook House (testimony of Callum Tulley).

108. There will, in many settings which have a custodial element, be legitimate concerns about those who may feign a physical or psychological ailment in order to gain some benefit up to and including release or transfer. Such factitious disorders must be distinguished from genuine disorders of concern which, requires careful assessment of the patients' history and symptoms and often the exclusion of any underlying physiological condition. However, the dangers posed by failing to acknowledge and respond to the presence of a genuine mental disorder are manifest. Self-harm, suicide, or a significant deterioration in the individual's mental health may occur if care and treatment are not provided in an appropriate environment and distress is instead responded to with cynicism, hostility, and punishment.

109. Sadly, it appears that there has been a "*widely held view within the Home Office that the safeguarding mechanisms used to identify and protect vulnerable detainees were and are being abused. While staff insisted that they were scrupulous in applying the Adults at risk policy, many acknowledged that they viewed claims of vulnerability with suspicion"'*. (Independent Chief Inspector of Borders and Immigration 2021:7).

110. However, even in the context of what appears to have been widespread culture of disbelief promulgated by and within the Home Office I find it almost wholly inconceivable that there is reported never to have been an instance where a rule 35.2 report was completed between 2013 and 2021 within Brook House. Rule 35.2 requires that: "The medical practitioner shall report to the manager on the case of any detained person he suspects of having suicidal intentions, and the detained person shall be placed under special observation for so long as those suspicions remain, and a record of his treatment and condition shall be kept throughout that time in a manner to be determined by the Secretary of State" completed between 2013 and 2021. Accordingly, no reports will have been submitted to the Secretary of State as required by rule 35.4 "*The manager shall send a copy of any report under paragraphs (1), (2) or (3) to the Secretary of State without delay".*

111. The attitudes and actions/inactions of health care staff are a source of particular concern given their duties and professional obligations. The Detention Centre Rules 2001 state that medical practitioners "*shall pay special attention to any detained person whose mental condition appears to require it, and make any special arrangements (including counselling arrangements) which appear necessary for his supervision or care*". The European Court of Human Rights has previously found that a failure to identify disabled prisoners, which would include those with mental illness and make appropriate arrangements for humanitarian assistance may represent a violation of Article 3 of the ECHR35 considering it as degrading treatment (Lehtmets and Pont 2014).

112. I saw limited evidence of any such arrangements beyond the segregation and use of increased observation of detainees considered to be at risk. The latter appeared to be carried out by DCO's with no training in mental health or additional specialist training in engaging with individuals who were suicidal. This suggests non-compliance with ACDT.

113. HM Prison Service (2005) Guidance on the use of force notes that:

> *6.1 When healthcare staff (registered nurse, hospital officer, or doctor) are on duty in the establishment they MUST attend a planned C&R intervention*
> *6.2 A member of healthcare (e.g. a registered nurse, hospital officer or doctor) must, whenever reasonably practicable, attend every incident where staff are deployed to restrain violent or disturbed prisoners*
> *6.3 The member of healthcare staff attending a C&R incident must monitor the prisoner (and members of the C&R team in an extreme circumstance)*
> *6.4. They must provide clinical advice to the supervisor and/or team in the event of a medical emergency.*
> *6.5. Any clinical advice offered must be adhered to by the supervisor and/or team*

114. Rule 34 Minimum Rules for the Treatment of Prisoners (United Nations 2015) requires that health care practitioners *must "If, in the course of examining a prisoner upon admission or providing medical care to the prisoner thereafter, health-care professionals become aware of any signs of torture or other cruel, inhuman or degrading treatment or punishment, they shall document and report such cases to the competent medical, administrative or judicial authority. Proper procedural safeguards shall be followed in order not to expose the prisoner or associated persons to foreseeable risk of harm."*

115. The duty of any care professional to those experiencing mental disorder is to respond personally and professionally in ways that support clinical and personal recovery (Slade 2013) protecting and promoting the human rights of their patients. Good practice does occur but Shaw (2018) notes that Healthcare staff working within IRCs may find themselves expected to acknowledge and take into context in their decision making the challenging circumstances that IRC staff must face. Dual loyalties may readily develop (Shaw 2018) compromising their ability to exercise their independent safeguarding role and health care practitioners are sadly not immune from the impact of corrupted cultures as multiple inquiries into abuse have consistently demonstrated (Martin and Evans 1984).

116. Shaw (2016) describes a widespread culture of disbelief in the IRC setting and observed there was a risk that healthcare staff might become inured to abusive or negligent practices. This culture of disbelief is evident in the behaviour of Nurse X . Observing a scenario in which a detainee is in crisis she describes him as '*an arse basically'*. She then fails to intervene to stop the behaviour of DCO E who is pushing his fingers into Detainee A's neck and restricting his airway. Neither does she report the restraint. In my opinion her behaviour constitutes serious professional misconduct with evidence of multiple violations of Section 1.1, 3.4,10.3, 16.1,16.3, 17.1, 17.2, 20.1, and 20.2 of the NMC Code (https://www.nmc.org.uk/standards/code/read-the-code-online/). I am also mindful that it is repeatedly documented (Shaw 2016, Shaw 2018) that Nursing post vacancies are a chronic problem. Such gaps may be filled by agency staff but this is not satisfactory. Agency staff may be less aware of their specific responsibilities under Rule 34 and perhaps less willing to raise concerns although their professional obligations are not affected by their employment status (Independent Monitoring Board 2019).

117. The effect of these multiple failings was, it appears, a culture in which abuse and ill-treatment occurred and was allowed to develop and become normalized. The willful and unnecessary use of force and segregation against people with significant mental health issues given the known adverse consequences of such interventions would in this instance in my opinion constitute a form of mistreatment. In my opinion, the use of segregation for those experiencing a mental health crisis, even if not intended as a punishment, in many instances is likely to have been experienced as such and may cause severe suffering. In my opinion, the abuses perpetrated against individuals experiencing mental health

crises, particularly the use of force and segregation, is part of what appears to be a clear pattern of bullying, punishment, and humiliation.

118. The stated values underpinning the Detention Centre Rules 2001 Rule 3 to provide "*secure but humane accommodation of detained persons in a relaxed regime with as much freedom of movement and association as possible, consistent with maintaining a safe and secure environmen*t "are laudable. Few would also question that in order to maintain the safe and secure environment required that physical restraint, removal from association, and isolation may regrettably sometimes be needed. Their use may in some instances represent the only practicable means by which a Detention Centre may discharge its duty of care.

119. The rules governing the overall operation of Immigration Detention Centres and their use of force, in particular, are described in Section 4.1. of the DCR 2001 and if followed provide for an acceptable minimal level of care.

> "*A detainee custody officer dealing with a detained person shall not use force unnecessarily and, when the application of force to a detained person is necessary, no more force than is necessary shall be used*"
>
> "*No officer shall act deliberately in a manner calculated to provoke a detained person*".
>
> "*Particulars of every case of use of force shall be recorded by the manager in a manner to be directed by the Secretary of State, and shall be reported to the Secretary of State*"
> The rules go on to mandate Rule 45 the General Duties of Officers. These require that:
>
> "*An officer shall inform the manager and the Secretary of State promptly of any abuse or impropriety which comes to his knowledge*"
>
> "*Detainee custody officers exercising custodial functions shall pay special attention to their duty under paragraph 2(3) (d) of Schedule 11 to the Immigration and Asylum Act 1999 to attend to the well-being of detained persons*."

120. In ensuring the well-being of those detained significant responsibilities are placed in the health care team. Rule 33 (2) notes they "*shall be responsible for the care of the physical and mental health of the detained persons at that centre*". Rule 35 (5) details that "*The medical practitioner shall pay special attention to any detained person whose mental condition appears to require it, and make any special arrangements (including counselling arrangements which appear necessary for his supervision or care*".

121. Unfortunately, as is evident from the multiple failings illustrated in the Panorama film and described above, the explicit rules and values of the IRC appear

substantially divorced from the reality on the ground. The safeguards i.e. Rule 34/35 (DCR 2001) put in place to identify and secure release of the vulnerable appear to have significantly failed (Shaw 2016 and 2018). The consequences are that vulnerable people are detained in conditions where their needs cannot be met. In an environment which is unsuitable, supported by a workforce inadequate in number to provide care, insufficiently trained in mental health, and with no access to an appropriate range of mental health services including those for trauma. Even where their mental health needs are identified there appear to have been difficulties facilitating their release or transfer to a hospital setting leading, it would appear, to prolonged stays in settings acknowledged to be having an adverse impact upon their mental health. In these settings, at least in part because their needs cannot be met, their behaviour is managed via the use of prison service C&R techniques including pain and the inappropriate use segregation. Rule 35 is it appears not working as anticipated and requires either revision or replacement.

122. Wardhaugh and Wilding's writing about an abusive culture that had developed in residential childcare in Staffordshire defined corruption as involving an "*active betrayal of the values upon which the organisation is supposedly based*" (Wardhaugh and Wilding's 1993:5). This corruption does not appear to have been prevented by the framework or mechanisms intended to do so. These include the Home Office Immigration Enforcement Department. Their stated role (Home Office 2016) includes both: *(1) acting as the interface between detainees and their Home Office caseworkers*; and *(2) monitoring service delivery to ensure that the standards, specifications and statutory requirements in the contacts with the Home Office are being met*"

123. However, it appears that the Home Office was aware, prior to the Panorama film, that there were systemic failings in the application of the policies and procedures put in place to safeguard vulnerable adults with severe mental health needs. These had been highlighted by Shaw (2016). The Home Office responded to these concerns by introducing the Adults at Risk (AAR) policy and Statutory Guidance. Unfortunately, AAR represented a different approach to determining eligibility for detention and in doing so abandoning the previous policy of detaining vulnerable people only in "very exceptional circumstances". Central to the decision-making process of AAR is a judgement about levels of evidence of harm and which seeks to balance identified evidence of risk against the priorities around the individual's immigration status. This appears to have resulted in the ongoing detention of significant numbers, possibly even more than previously, of people with serious and even severe mental health problems in a service not designed or resourced to meet their needs (Shaw 2018). The previous policy set out in Chapter 55 of the Enforcement and Immigration Guidance (EIG), i.e.: a general presumption against detention, and that vulnerable person should not be detained in the absence of exceptional circumstances, represents a stronger safeguard (Shaw 2018).

124. In addition to the Home Office Immigration Enforcement Department, the Independent Monitoring Board (IMB) provides an important further level of safeguarding in principle. The IMB, referred to as the Visiting Committee in the context of immigration detention, is appointed by the SSHD under s.152 of the Immigration and Asylum Act 1999. Each detention centre has its own visiting committee with all members being volunteers. Their primary duty under the Detention Centre Rules is to satisfy themselves as to "*the state of the detention centre premises, the administration of the detention centre and the treatment of the detained persons*". In exercising their duties, the Visiting Committee should meet at the detention centre 8-12 times annually and conduct a schedule of visits, including visits by at least one member of the Committee each week. The committee should visit any detainee:
    - removed from association under rule 40;
    - temporarily confinement under rule 42;
    - subject to special control or restraint under rule 43 within 24 hours of the detainee being subject to such

125. Their role in hearing and inquiring into any complaint or report that a detained person or any other person wishes to make to them or him including where a detained person's health, mental or physical, is likely to be injuriously affected by any conditions of his detention is also potentially significant (Detention Centre Rules 2001).

126. Unfortunately, in this instance, it would appear either that such complaints did not come forward, or that they were not acted upon. The reasons why potential individual complainants may not have raised issues with the Visiting Committee or other agency or body will be diverse, reflecting the unique circumstances of the detainee. The reasons identified in multiple inquiries into abusive practice as to why people did not use the complaints procedures available tend to group into three main areas:

    (a) Abuse normalization. The victims came to accept the practices they were subject to as 'just the way things were around here'. They were therefore not seen as abusive and did not cross the individuals' threshold for reporting which had been shifted by their experience.

    (b) Distrust of the institutions and the people involved in the reporting processes. The victims thought that i) they would not be believed ii) the accounts of staff would be preferred iii) even if they were believed no action would be taken against the perpetrators. Their experience of torture is very likely to make them vulnerable. Those who have experienced torture may find it particularly difficult to trust others (Faculty of Forensic Medicine 2019). This is supported by the testimony of D1851 "*There is nothing you can do. You have a feeling that the people you might actually report them to are probably even worse than they are*". It is also supported by the testimony of Anna Pincus who observes that "*most people that we met did not feel safe enough to make a complaint*". Such perceptions are supported

by the initial lack of response to allegations made by D2953 that he had been assaulted (CJS001506_20-37 – Physical Assault Allegation Made by D2953 – 13 FEB 2018)

(c) A belief that reporting abuse would result in retaliation by those against whom the complaint was made, by their colleagues and by those involved in decisions in their case (Witness statement Jamie McPherson). The means for staff to retaliate i.e. C&R and segregation being readily available and evidently used without sufficient oversight to prevent their misuse to such an end. As the testimony of D1851 observes *"Is better you just shut up, because if I complain, in my understanding, if you make complaint and they listen, which in my experience no complaint, even through verbal, has ever -- anything has been done about it, but if they ever did, they will have to get the person involved. And according to information that goes around about some of them, you don't want to have any bad stuff with people like that. You don't".*

127. In a scenario such as an Immigration Detention Centre, all three are possible and it seems from the chat of a Control and Restraint Officer about the need to 'fuck' a detainee up entirely credible. What this means in practice for detainees is that they are profoundly vulnerable with no credible source of help should they experience abuse, *"no system of oversight at Brook House and no safe place in which to report staff who had crossed the line*" (Witness statement D1713). A situation unfortunately which only too many detainees may have had previous experience of.

128. Given, however, that it is widely known that institutions sharing the characteristics of Brook House are particularly prone to corruption it can be argued that such reactive approaches essentially designed to detect non-compliance will always represent an unsatisfactory and failure prone approach. A view recently expressed by the (Care Quality Commission (2019). Reactive systems depend on data being reported or complaints or allegations being made. As discussed, the first condition depends on staff and the institution management adhering to the relevant policies and is failure-prone. The second condition as explored depends on complaints being raised when doing so may be perceived as involving significant risks to the complainant and cannot, therefore, be relied upon. It is clear that the fear of potential negative consequences of raising complaints applied not only to detainees but also to staff.

129. Rule 45.2 of the Detention Rules 2001 states that: "*An officer shall inform the manager and the Secretary of State promptly of any abuse or impropriety which comes to his knowledge*".

130. However, it is clear that although staff do appear to have been told during training "that DCOs could raise concerns to DCMs" such training had little effect. This is unsurprising given it appears it was "DCMs who were involved in abuse" and staff "*who complained about treatment*" faced "*marginalization, bullying,*

intimidation". Staff, "*could flagrantly brag about the mistreatment of detainees and speak in derogatory or even racist terms about them in front of groups of officers in the culture of silence which allowed the abuse to persist because they knew staff would never complain*". (Callum Tulley witness testimony) Owen Sayed (witness testimony) observes that "*having a reputation of a snitch would make job difficult*" reporting misconduct could lead to ostracization and victimization such that potential complainants "*were silenced and became complicit by their silence*".

131. Even proactive strategies have significant weaknesses. Pre-announced inspections that allow services time to prepare and to stage-manage demonstrations of appropriate attitudes and practice whilst inspectors are present and revert to poor and abusive practice when they are gone are of limited value (Department of Health 2012). In depth inspections where inspectors spent several days on site including shadowing staff they choose to work alongside on shifts and unannounced inspections are needed (Department of Health 2014). in order to assess compliance and prevent abusive practices "*that may be well hidden from those who do not have direct access*"

132. Whilst a more robust inspection process is needed it is of course better to prevent the development of toxic and corrupted cultures and all that goes with them. The quest for such preventative approaches is not new, Tuke (1813:54) describing one of the earliest approaches to the reduction of the use of restraint which came to be known as ' moral treatment', explained that it was "*A system which, by limiting the power of the attendant*" made "*it his interest to obtain the good opinion of those under his care*". This approach, he argued, provided more "*effectually for the safety of the keeper, as well as of the patient"* than the *"chains, darkness, and anodynes*" (Tuke 1813: 54) that might otherwise be used.

133. Whilst Tuke's observations continue to hold true in some respects more contemporary thinking would stress the need to embrace 'whole organisation' approaches based around trauma informed applications of the public health model (Gooding, 2018) The public health approach to prevention stresses that prevention must always be thought as having three discreet elements i.e. primary, secondary and tertiary. In its most recent expositions, a fourth element i.e. recovery is added.

134. Primary prevention encompasses both action at every level of the organisation to address systemic triggers and action at the level of the individual to identify his or her individual triggers. The former encompasses environmental design, resources, staffing, training, leadership, supervision, and culture. The approach stresses the need to establish and sustain relational security in order that relational holding whereby the distress of a detainee is managed via empathy built on trust and not restraint. Such an approach does not neglect or seek to underplay the need for either procedural security i.e. the policies and procedures designed to maintain safety and security or physical security i.e. the physical means e.g. fences, locks, personal alarms, etc., that help keep people safe (Allen 2010).

Developed and piloted in secure and high secure mental health services that share a number of key characteristics with Immigration Detention Centres it focuses on the climate of the setting an area clearly requiring explicit attention at Brook House. There is now substantial expertise and experience in its application within Forensic Psychiatry and Psychology which could readily be drawn upon to facilitate its implementation (Allen 2016).

135. Safewards (https://www.safewards.net), an approach now widely used in the UK and internationally, was developed from a program of research into the root causes of conflict in acute mental health and contains a series of discreet interventions. There are ten discreet interventions each of which targets a source of conflict or the better management of conflict via de-escalation. These include: Clear Mutual Expectations, Soft Words, Talk Down, Positive Words, Bad News Mitigation, Know Each Other, Mutual Help Meeting, Calm Down Methods, Reassurance, and Discharge Messages. The approach has been used and evaluated within a number of forensic mental health settings (Maguire et al. 2018) and could readily be adapted.

136. Six core strategies (National Association of State Mental Health Program Directors 2014), an approach originally developed in the US to underpin efforts to reduce the misuse of restraint in mental health services, has now been robustly evaluated in a number of forensic mental health settings including high secure (Repo-Tiihonen et al 2013). As with Safewards it has a number of discreet elements, in this instance as the name suggests six. These comprise:
    - Leadership in organisational culture change. (a 3 day training package for senior management staff up to and including CEO)
    - Using data to inform practice.
    - Workforce development.
    - Inclusion of families and peers.
    - Specific restrictive intervention reduction interventions (using risk assessment, trauma assessment, crisis planning, sensory modulation, and customer services).
    - Rigorous debriefing.

137. The program has now been adopted for use in UK mental health services forming a core element of 'restrain yourself', a multi site project seeking to reduce the use of seclusion and restraint (https://www.health.org.uk/improvement-projects/restrain-yourself-reducing-physical-restraint-within-mental-health-inpatient). There is thus substantive UK experience and expertise which the Home Office and Brook house could draw upon in order to develop an adapted intervention.

138. What six core strategies appears to do is to combine what have sometimes been described as two discreet approaches, i.e. the explicit targeting of the use of specific coercive measures through oversight, analysis, and robust review and the

introduction of an overt therapeutic model (Bryson et al 2017). The need for an overt therapeutic model reflects concerns that in its absence there will instead be a series of implicit models used typically somewhat below the level of consciousness that practitioners use to inform their judgments decisions and actions. In secure settings classic 'discourse of deviancy' is often encountered. This is a frame of some antiquity whose assumptions are that deviants (whether real or imaginary) are readily identifiable, the reasons for their deviance exist wholly within the individual and social actions to control or punish them are thus readily justifiable. Moreover, because such actions serve to clarify moral boundaries between the good and the bad that must always be maintained, a failure to punish the deviant cannot be tolerated (Leadbetter et al. 2005).

139. In six core strategies, the deviancy frame is challenged and replaced with a trauma lens. This seeks to change the focus from 'whats wrong with you?' an approach that frames the problem as one residing within the individual which may be cured by medication or suppressed by punishment. Instead, the focus becomes 'what happened to you'? This frames the problems as a consequence of trauma and promotes interventions that acknowledge and address the impact of trauma on the individual, the team, the organisation and the wider community (Miller et al. 2012). The values of trauma informed approaches are explicit and encompass Safety, Trustworthiness, Choice, Collaboration, and Empowerment.

140. These approaches are already being trialed in the UK in a number of prisons and there may be some existing expertise within the Home Office that may readily be called upon for advice and guidance. See https://www.rsph.org.uk/about-us/news/trauma-informed-prisons-project-tipp.html.

141. Irrespective of the primary prevention strategy, it must be complemented by the training and use of secondary prevention strategies (Skills for Care and Skills for Health 2014). Such strategies encompass a range of verbal and non-verbal distraction, diversion, and calming strategies often described under the broad heading of de-escalation (Spencer and Johnson 2016). I note Shaw (2016) called for staff DCOs to be trained in de-escalation and the reference to de-escalation in the relevant prison service guidance (HM Prison Service 2005) but I noted no evidence of any use of a recognised de-escalation technique in the Panorama documentary or any of the documentation I reviewed suggesting either that staff had not been trained or as noted previously that the culture within Brook House did not support the use of the practice

Conclusion

142. Unfortunately, it has long been observed that the legitimatization of forms of coercion such as restraint or seclusion may result in scenarios in which staff acquire "*the wrong sense of their personal power*"(Page 1904:592). Empowered by their role and their ability to restrain and segregate detainees dehumanized by their reduction to a failed asylum seeker label, staff may neglect the need to build the relationship of trust necessary to engender safety opting in favour of

"*peremptory and sometimes arbitrary commands whose disobedience will result in intervention*" (Page 1904:592).

143. There are a number of substantive initiatives with at least some supporting evidence of their effectiveness potentially available, which could be adopted by Brook House and mandated by the Home Office. A note of caution in the advocacy of any specific intervention or combination thereof is though warranted. Summed up eloquently by Pawson et al (2005:21) "*we are dealing with complex social interventions, which act on complex social systems...These are not magic bullets which will always hit their target, but programmes whose effects are crucially dependent on context and implementation".*

144. It cannot thus be assumed with confidence that interventions, which may have achieved success in some mental health settings will necessarily be successful even in other notionally similar mental health settings, never mind in the very different context of an IRC. Acceptance and adherence to the intervention in question represent critical variables and these are in my view much more likely to be problematic when an intervention designed for one setting is attempted to be applied in a very different one (Baumgardt et al. 2019). There would in my view be significant challenges in attempting to do so and absolutely no guarantee of success.

145. Ultimately therefore it would in my view be insufficient for the Home Office to mandate the adoption of such approaches by their contractors despite the potential benefits some may offer. Reducing the misuse of restraint and segregation is desirable and would be likely to reduce the risk of trauma to all IRC detainees and also staff and not just those who are vulnerable. IRC are not prisons and while both restraint and segregation may be necessary in extremis the use of NOMS C&R has contributed to the development of a corrupted culture. One in which it appears all too many staff may profess they "*love doing C&R*" (testimony of Owen Syred). Such a culture requires very deep change indeed.

146. The overarching purpose of an IRC is though fundamentally not about providing treatment, it is to contain prior to enabling removal from the country. Addressing its present evident toxicity is needed but the environment will always remain unsuitable, the staffing levels inadequate, the workforce insufficiently trained, and access to services such as psychology and occupational therapy severely lacking in comparison to specialist mental health services. The lack of access to the necessary reflective practice supervision and the mix of people being supported would continue to create a fertile environment in which a corrupted culture could flourish. The culture of disbelief that is pervasive across the institution "*heard not only from DCO's*", "*but from some managers*" and "*some senior managers*" interview with Dominic Aitken) would in my opinion be likely to result in passive or active sabotage of efforts to provide an appropriate level of care for those with mental health issues. Stating in policy that segregation should "*not be used as a normal means to manage detained individual with serious psychiatric illness or presenting with mental health problems"* is laudable (Home

Office 2020: 11). However, such warm words do not address the fundamental unsuitability of the setting of an IRC to support such vulnerable individuals, which is the root cause of the misuse of force and segregation.

147. 'Detention Services Order 03/2016: Consideration of Detainee Placement in the Detention Estate' (Home Office 2016) provides guidance for Home Office staff on how to complete a risk assessment before any person is placed in immigration detention. This process is it appears failing to identify individuals with mental health conditions whose condition is at serious risk of deterioration if they are detained. One of the stated intentions of the Immigration Act 2016 s 59 is to contribute to a "*reduction in the number of vulnerable people detained and a reduction in the duration of detention before removal*". However, clinical studies continue to report high levels of mental illness including clinically significant levels of PTSD, depression and anxiety symptoms within the detained population (Royal College of Psychiatrists Position Paper: Detention of people with mental disorders in immigration Removal Centres: Updated Position Statement in 2021, RCPsych PS 02/2021). More anecdotally the GDWG group report prepared for the Shaw inquiry in 2017 notes that whilst they saw only a limited proportion of those detained within Brook House some 25% of the 220 seen disclosed they had a diagnosis of mental illness many with multiple diagnosis and complex presentations including psychosis (VER000106 – GDWG Evidence for Stephen Shaw Inquiry – NOV 2017). Importantly, they noted that many others who might not meet strict diagnostic thresholds appeared psychologically vulnerable with high levels of anxiety and depressed mood. The perspective from within the Detention Centre was "over a ten year period at least 20% of detainees were suffering from severe mental illness, and approximately 60% were suffering from minor to moderate mental health issues such as depression" (Testimony Owen Syred).

148. Shaw (2016) recommended that an unequivocal presumption against detention for those with a serious mental illness unless there were compelling grounds of public safety should be adopted and rejected the notion that serious mental illness can be satisfactorily managed in a setting such as Brook House IRC. I would concur with his assessments. That vulnerable individuals with significant mental health issues should not be admitted to a service that is not designed, staffed or resourced to meet their needs and because it cannot meet their needs makes recourse to restraint and segregation to manage crises which are manifestations of their condition and potentially exacerbated by the conditions of their detention should be self-evident. The MH Act Code of Practice (Department of Health 2015: 245) states that patients '*including those who may present with behavioural disturbance should receive treatment in a safe environment.* The Department of Health (2012) in its final report into the corrupted culture involving abuse and the misuse of restraint, which had developed within Winterbourne view a private hospital for people with learning disabilities and autism concluded '*we should no more tolerate people being placed in inappropriate care settings than we would people receiving the wrong cancer treatment'.* The abiding principle applicable must always be that of the 'equivalence of care' (Joint Prison Service and

National Health Service Executive Working Group, 1999, Council of Europe 2004, World Health Organisation 2007, Committee for The Prevention Torture 2007).

149. In any scenario when a significant mental health crisis presents the individual should either be transferred to an in-patient mental health facility for treatment or where the conditions of detention are causing or contributing to the crisis and it is judged that release from detention will produce improvement and avert further deterioration, then the person should be released to a community setting. Supporting individuals with significant mental health issues in acute crisis particularly those at high risk of self-harm or suicide requires continuous access to the levels of expertise only available in mental health services. These should be staffed by suitably trained and qualified mental health staff with particular expertise in trauma-informed practice, cross-cultural mental health issues, and in mental health issues relevant to asylum seekers and victims of torture. A persistent failure to do so has left vulnerable detainees at risk of mental and physical abuse by a minority of uncaring disbelieving staff "*whose default position was to make their life difficult*" (Testimony of Owen Syred) and others who by their inactions enabled it.

150. It is my opinion that the fact that failings of Brook House were not identified and action not taken by G4S indicates a failure by the provider to develop and implement robust oversight mechanism and internal quality assurance strategy. However, it also reflects a critical failure at the most senior level of both G4S and the Home Office to apprehend and take seriously the very real danger of a corrupted culture developing in a closed institution such as Brook House. The frequency of whistle blowing complaints submitted to G4S from Brook House (Testimony of Owen Syred) should have served as a red flag. The complete absence of rule 35.2 reports being submitted to the Home Office should have served as another (Testimony of Owen Syred). The known vulnerability of closed institutions to becoming corrupted mandated the development and implementation of robust oversight, monitoring and inspection methods. Such failings ultimately allowed a culture to develop and be perpetuated in which the human rights of vulnerable individuals were routinely violated and in which the individuals who suffered and staff who had concerns felt unable to safely raise their concerns.

Statement of Truth

I confirm that I have made clear which facts and matters referred to in this statement are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

I am content for this statement to form part of the evidence before the Brook House Inquiry and to be published on the Inquiry's website.

Name Brodie Andrew Paterson

Signature

Date 21.01.22

References

Allen E. (2010) See Think Act: Relational Security in Secure Mental Health Services. London. Department of Health.

Allen E. Your Guide to Relational Security: See Think Act (2nd edn). (2016) Royal College of Psychiatrists Quality Network for Forensic Mental Health Services.

Arendt H. (1951) The Origins of Totalitarianism. New York. HarcourtBrace/

Askew L, Fisher P, Beazley P.(2019) What are adult psychiatric inpatients' experience of seclusion: A systematic review of qualitative studies. (2019) J Psychiatr Ment Health Nurs. 26(7-8):274-285.

Bandura, A., Underwood, B., & Fromson, M. E. (1975). Disinhibition of aggression through diffusion of responsibility and dehumanization of victims. Journal of Personality and Social Psychology, 9, 253-269.

Barnett R, Bower E, Chan A, Stirling C. (2018) An Investigation into the Range of Movement and Forces Involved by the Application of Wrist Flexion Restraint Techniques - Pain Inducing or Not?. J Emerg Med Care 1(2): 203

Baumgardt J, et al (2019) Preventing and Reducing Coercive Measures—An Evaluation of the Implementation of the Safewards Model in Two Locked Wards in Germany , Frontiers in Psychiatry, DOI=10.3389/fpsyt.2019.00340

Bell A., Gallacher N. (2016) Succeeding in Sustained Reduction in the use of Restraint using the Improvement Model. BMJ Quality Improvement Reports 2016; 5: u211050.w4430. doi:10.1136/bmjquality. u211050.w4430

Bell S., Hopkin G., Forrester A. (2019) Exposure to Traumatic Events and the Experience of Burnout, Compassion Fatigue and Compassion Satisfaction among Prison Mental Health Staff: An Exploratory Survey. Issues Ment Health Nurs. 40(4):304-309. doi: 10.1080/01612840.2018.1534911. Epub 2019 Feb 11. PMID: 30742547

Berzins, K., Baker, J., Brown, M., & Lawton, R. (2018). A cross-sectional survey of mental health service users', carers' and professionals' priorities for patient safety in the United Kingdom. *Health Expectations*, *21*(6), 1085–1094. doi:10.1111/hex.12805

Bloom S.L. (1997) Creating sanctuary: Toward an evolution of sane societies. New York: Routledge.

Bloom, S.L. (2006a) Organizational Stress As A Barrier To Trauma-Sensitive Change And System Transformation. Philadelphia. www.sanctuary.com

Bloom S.L (2006b) Societal Trauma: Danger And Democracy In Totton, N., (Ed.) The Politics Of Psychotherapy: New Perspectives. London: Open University Press
Bosworth M. (2016) Mental Health in Immigration Detention: A Literature Review. Review into the Welfare in Detention of Vulnerable Persons (Cm. 9186). TSO (The Stationery Office). Available at SSRN (http://ssrn.com/ abstract=2732892).

Bowen, B., Privitera, M.R. & Bowie, V. (2011). Reducing workplace violence by creating healthy workplace environments. Journal of Aggression, Conflict and Peace Research, 3(4):185-198.

Bowers L.(2014) Safewards: a new model of conflict and containment on psychiatric wards. J Psychiatr Ment Health Nursing 21(6):499–508.

Bryson SA., Gauvin E., Jamieson A., Rathgerber M., Faulkner-Gibson L, Bell S., Davidson J., Russel H., and Burke S., (2017)What are effective strategies for implementing trauma informed care in youth inpatient psychiatric and residential treatment settings? A realist systematic review Int J Ment Health Syst 11:36

Cambridge P. (2002) The First Hit. A case study of the physical abuse of people with a learning disabilities and challenging behaviour in a residential service, Disability and Society 14(3), 285-30

Care Quality Commission (2019) Identifying and responding to closed cultures Supporting information for CQC staff. Newcastle on Tyne. Care Quality Commission.

Care Quality Commission (2020) Out of sight – who cares? A review of restraint, seclusion and segregation for autistic people, and people with a learning disability and/or mental health condition. Newcastle on Tyne. Care Quality Commission .

Cassese, A., (1993) Prohibition of Torture and Inhuman or Degrading Treatment or Punishment, in: MacDonald, R.J., Matscher F., and Petzold, H., (eds.), The European System for the Protection of Human Rights, Dordrecht, Martinus Nijhoff.

Chieze, M., Hurst, S., Kaiser, S., & Sentissi, O. (2019). Effects of Seclusion and Restraint in Adult Psychiatry: A Systematic Review. Frontiers in psychiatry, *10*, 491. https://doi.org/10.3389/fpsyt.2019.00491

Cole-King, A., Green, G., Gask, L., Hines, K., & Platt, S. (2013). Suicide mitigation: A compassionate approach to suicide prevention. Advances in Psychiatric Treatment, 19(4), 276-283. doi:10.1192/apt.bp.110.00876

Council of Europe Committee of Ministers (2004) Recommendation No. Rec (2004) 10 of the Committee to Ministers of Member States concerning the protection of the human rights and dignity of persons with mental disorder and its Explanatory memorandum. Strasbourgh. Council of Europe.

Council of Europe. (2019). Ending coercion in mental health: the need for a human rights based approach. Strasbourg: Council of Europe Committee on Social Affairs, Health and Sustainable Development.

Cutcliffe, J.R. and Barker, P.(2002) Considering the care of the suicidal client and the case for 'engagement and inspiring hope'or 'observations'. Journal of Psychiatric and Mental Health Nursing, 9(5), 611-621.

Davies B., Griffiths J., Liddiard K., Lowe K., and Stead L. (2015) Changes in staff confidence and attributions for challenging behaviour after training in positive behavioural support, within a forensic medium secure service. The Journal of Forensic Psychiatry & Psychology, 26(6), pp847-861.

Davies B., Griffiths J., John-Evans H., Lowe K., Howey S., and Artt A. (2016). Changes in staff confidence and attributions for challenging behaviour after training in positive behavioural support, within a forensic medium secure service: a replication study with follow-up. The Journal of Forensic Psychiatry & Psychology, 27(6), 886-906.

Dell, P.F. (2009) The Phenomena of Pathological Dissociation. In P.F. Dell & J.A. O'Neil (Eds.) *Dissociation and the Dissociative Disorders: DSM V and Beyond*, Routledge, New York.

Department of Health (2012) Transforming care: A national response to Winterbourne View Hospital Department of Health Review: Final Report. London. Department of Health.

Department of Health (2014) Positive and Proactive Care: reducing the need for restrictive intervention. London. Department of Health.

Department of Health (2015) Mental Health Act 1983: Code of Practice. London. Department of Health. London.

DiMaggio, P., 1997. Culture and cognition. Annu. Rev. Sociol. 23 (1), 263–287

Duxbury J., Baker J., Downe S., Jones F., Greenwood P., Thygesen H., McKeown M., Price O., Scholes A., Thomson G., Whittington R.(2019) Minimising the use of physical restraint in acute mental health services: The outcome of a restraint reduction programme Int J Nurs Stud. 95:40-48.

Faculty of Forensic & Legal Medicine (2019) Quality Standards for healthcare professionals working with victims of torture in detention. Faculty of Forensic & Legal Medicine

Farquarson, G. (2004) How good staff become bad, in Eds Penelope Campling, Steffan Davies and Graeme Farquharson, From Toxic Institutions to Therapeutic Environments: Residential Settings in Mental Health Services, London

Figley, C. R. (1995). Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized. New York. Bruner Maze.

Fisher J.Al (2003) Curtailing the use of restraint in psychiatric settings, Journal of Humanistic Psychology. 43(2), 69-95.

Gaskin C.J., Elsom S.J, Happell B. Interventions for reducing the use of seclusion in psychiatric facilities: review of the literature. (2007) Br J Psychiatry. 191:298–303. doi: 10.1192/bjp.bp.106.034538

Georgieva I., Mulder C.L., Wierdsma A. (2012) Patients' preference and experiences of forced medication and seclusion. Psychiatric 83:1–13. 10.1007/s11126-011-9178-y

Gooding, P., McSherry, B., Roper, C. and Grey, F (2018) Alternatives to Coercion in Mental Health Settings: A Literature Review, Melbourne: Melbourne Social Equity Institute, University of Melbourne.

Goodman, S (2008) . Justifying the Harsh Treatment of Asylum Seekers on the Grounds of Social Cohesion. Annual Review of Critical Psychology , 6 , 110 -124 . https://thediscourseunit.files.wordpress.com/2016/05/goodman.pdf

Greenslade R. (2005) Seeking Scapegoats. The Coverage of Asylum in the UK Press. London and Manchester. Institute for Public Policy Research.

Harris, C., & Griffin, M. T. (2015). Nursing on empty: Compassion fatigue signs, symptoms, and system interventions. *Journal of Christian Nursing, 32*(2), 80-87.

Her Majesties Prison Service (2005) Prison Service order. No 1600 Use of Force.

Hollins L. P. and Paterson B. (2009) Physical intervention trainers: the case for greater accountability *Journal of Psychiatric and Mental Health Nursing* 16, 376–381.

Home Office (2016) Adults at risk in immigration detention Version v2.0. London. Home Office.

Hubbard, P. (2005) Accommodating Otherness: anti-asylum centre protest and the maintenance of white privilege. Transactions of the Institute of British Geographers, 30 (1): 52-65.

Hughes JA., and Davies B. (2018). Developing a ward ethos based on positive behavioural support within a forensic mental health 'Psychiatric Intensive Care Unit'. Mental Health and Prevention, 10, 28-34.

Home Office (2020) Detention Services Order 02/2017 Removal from Association (Detention Centre Rule 40) and Temporary Confinement (Detention Centre Rule 42)

Joint Prison Service and National Health Service Executive Working Group (1999) The future organisation of prison health care. London: Department of Health,

Kaplan K. (1964). The Conduct of Inquiry: Methodology for Behavioral Science. San Francisco: Chandler Publishing Co. p. 28.

Kira, I., Lewandowsk, L., Templin, T., Ramaswamy, V., Ozkan, B., & Mohanesh, J. (2008a). Measuring Cumulative Trauma Dose, Types and Profiles Using a Development-Based Taxonomy of Trauma. Traumatology: An International Journal, 14, 62-87

Kira, I. A., Lewandowski L., 2, Chiodo L., and Ibrahim A. (2014). Advances in Systemic Trauma Theory: Traumatogenic Dynamics and Consequences of Backlash as a Multi-Systemic Trauma on Iraqi Refugee Muslim Adolescents. Psychology, 5, 389-412. http://dx.doi.org/10.4236/psych.2014.55050

Kudla vs Poland, Judgment of 26 October 2000, para. 92; and Kalashnikov vs Russia, Judgment of 15 July 2002, para. 95.

Leadbetter D., Paterson B., and Crighton, J. (2005) 'Physical Intervention In Human Services: From Moral Panic To Moral Action', Paper Presented At 'Examining The Safety Of High Risk Interventions With Children And Young People An International Symposium For Researchers Policy Makers Advocates And System Providers', Cornell University, New York.

Leadbetter, D., Paterson, B. (2009) Towards Restraint Free Care - in Hughes, R (Ed) - A Balance of Care: Practice and Policy Perspectives on Reducing Restraint in Health and Social Care. London. Kings College.

Leele, M.T. and Gaile J.A. (2007) Who Is To Blame For Deviance In Organizations?: The Role Of Scholarly Worldviews, Sociology Compass 1(2), 536–551.

Lehtmets A. and Pon J. (2014) Prison health care and medical ethics A manual for health-care workers and other prison staff with responsibility for prisoners' well-being. Strasbourg. Council of Europe**.**

Lizardo, O., (2016). Cultural symbols and cultural power. Qual. Sociology. 39 (2), 199–204.

Miller, N. A., & Najavits, L. M. (2012). Creating trauma-informed correctional care: a balance of goals and environment. *European journal of psychotraumatology*, *3*, 10.3402/ejpt.v3i0.17246. https://doi.org/10.3402/ejpt.v3i0.17246

Maguire T, Ryan J, Fullam R, McKenna B.(2018) Evaluating the Introduction of the Safewards Model to a Medium- to Long-Term Forensic Mental Health Ward. J Forensic Nursing. Oct/Dec;14 (4):214-222. doi: 10.1097/JFN.0000000000000215. PMID: 30433910.

Martin, J. P. and Evans, D. (1984) Hospitals In Trouble, Basil Blackwell, Oxford.

MIND (2013) Mental health crisis care: physical restraint in crisis. A report on physical restraint in hospital settings in England. London. MIND.

Ministry of Justice National Offender Management Service (2006) Use Of Force Training Manual Version 1. HM Prison Service Training & Development Group

Ministry of Justice (2020) Government response: Independent review of the use of pain-inducing techniques in the youth secure estate. https://www.gov.uk/government/publications/independent-review-of-the-use-of-pain-inducing-techniques-in-the-youth-secure-estate Accessed 10.11.21.

National Association of State Mental Health Program Directors. (2014). National executive training institute: A training curriculum for the reduction of seclusion and restraint (12th ed.). Alexandria, VA:.

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). (2015) In-patient Suicide Under Observation. Manchester: University of Manchester.

National Patient Safety Agency. (2006). *With safety in mind: Mental health services and patient safety. Patient Safety observatory Report*. July 2006. National Patient Safety Agency. UK.

NHS Protect (2013) Meeting needs and reducing distress Guidance on the prevention and management of clinically related challenging behaviour in NHS settings. London. NHS Protect.

Nelstrop, L., Chandler-Oatts, J., Bingley, W., Bleetman, T., Corr, F., Cronin-Davis, J., Fraher, D.-M., Hardy, P., Jones, S., Gournay, K., Johnston, S., Pereira, S., Pratt, P., Tucker, R. and Tsuchiya, A. (2006), A Systematic Review of the Safety and Effectiveness of Restraint and Seclusion as Interventions for the Short-Term Management of Violence in Adult Psychiatric Inpatient Settings and Emergency Departments. Worldviews on Evidence-Based Nursing, 3: 8-18. https://doi.org/10.1111/j.1741-6787.2006.00041.x

NICE (2015). Violence and Aggression: short-term management in mental health, health and community settings. NICE guideline NG10. Available at: https://www.nice.org.uk/guidance/ng10 [Accessed 22.11.20].

Nuij, C., Van Ballegooijen, W., De Beurs, D., Juniar, D., Erlangsen, A., Portzky, G., Riper, H. (2021). Safety planning-type interventions for suicide prevention: Meta-analysis. *The British Journal of Psychiatry, 219*(2), 419-426. doi:10.1192/bjp.2021.50

Paterson B and Leadbetter D, (1999) Managing Physical Violence, in Turnbull J and Paterson B, Aggression and Violence: Approaches to Effective Management, Macmillan. Houndsmill.

Paterson B.,(2005a) Standards for Violence Management Training. Security Journal, 13(4), 7-17.

Paterson B., (2005b) Thinking the unthinkable: A Role for pain compliance and mechanical restraint in the management of violence? Mental Health Practice, 8(7), 18-23.

Paterson B. and Leadbetter D., (2005) Standards for Violence Management Training. In, Gill M., Fisher B. and Bowie V. (Eds.), Violence in the Workplace: causes, patterns and prevention, Willan Publishing, Uffcolme, Devon, 2000.

Paterson B., Miller G. and Leadbetter D (2005) Beyond Zero Tolerance a varied response to workplace work place, British Journal of Nursing, 14(15), 811-815, 2005.

Paterson B. and Miller G (2006) Promoting Safe and Therapeutic Services: Trainers Guide, London. National Health Service Security Management Service

Paterson B., Bowie V., Miller G. and Leadbetter D. (2009) Reframing the problem of violence towards mental health nurses - A work in progress? ,International Journal of Social Psychiatry. 56(3) 310-320.

Paterson B. et al. (2009) Control and restraint: Changing Thinking, Practice and Policy, Mental Health Practice, 13(2) 16-20.

Page C.W. (1904) Mechanical restraint and seclusion of insane persons. Boston Medical and
Surgical Journal, 590–595.

Pawson R, Greenhalgh T, Harvey G, Walshe K.(2005) Realist review-a new method of systematic review designed for complex policy interventions. J Health Serv Res Policy. 10(suppl 1):21–34.

Public Health England (2016) Rapid review of evidence of the impact on health outcomes of NHS commissioned health services for people in secure & detained settings to inform future health interventions and prioritisation London. Public Health England.

Putkonen A, Kuivalainen S, Louheranta O, Repo-Tiihonen E, Ryynanen OP, Kautiainen H, et al. (2013) Cluster-randomized controlled trial of reducing seclusion and restraint in secured care of men with schizophrenia. Psychiatr Serv. 64(9):850–5. doi: 10.1176/appi.ps.201200393

Quinlivan, L. Littlewood, D.L., Webb R.T. & Kapur N. (2020) Patient safety and suicide prevention in mental health services: time for a new paradigm? Journal of Mental Health, 29:1, 1-5, DOI: 10.1080/09638237.2020.1714013

Riddley J., Leitch S. (2019) Restraint Reduction Network Training Standards
First edition, Restraint Reduction Network. Birmingham. British Institute of Learning Disabilities**.**

Repo-Tiihonen, E., Ryynänen, O.-P., Kauti- ainen, H., & Tiihonen, J. (2013). Cluster-randomized controlled trial of reducing seclusion and restraint in secured care of men with schizophrenia. Psychiatric Services, *64*, 850-855. doi:10.1176/appi.ps.201200393

Robins, C. S., Sauvageot, J. A., Cusack, K. J., Suffoletta-Maierle, S., & Frueh, B. C. (2005). Consumers' perceptions of negative experiences and "sanctuary harm" in psychiatric settings. Psychiatric Services, 56(9),1134–38.

Royal College of Psychiatrists. (2016) Position Statement 07. Definition of torture in the context of immigration detention policy. 2016. http://www.rcpsych.ac.uk/pdf/PS072016.pdf. Accessed 12 Sept 2020.

Sequeira H. and Halstead S. (2001) "Is It Meant to Hurt, Is It?: Management of Violence in
of Violence inWomen With Developmental Disabilities. Violence Against Women, 7 (4), 462-476

Shaw S. (2016) Review into the Welfare in Detention of Vulnerable Persons (https://www.gov.uk/government/uploads/system/uploads/attachment data/file/490782/52532ShawReviewAccessible.pdf).

Shaw S. (2018) Assessment of government progress in implementing the report on the welfare in detention of vulnerable persons. A follow-up report to the Home Office by Stephen Shaw. Lonson. HMSO.

Skills for Care and Skills for Health (2014) A Positive and Proactive Workforce. A Guide to Workforce Development for Commissioners and Employers Seeking to Minimise the Use of Restrictive Practices in Social Care and Health. Leeds: SFC & SFH

Slade M. (2013) 100 ways to support recovery. A guide for mental health professionals London. Rethink Mental Illness.

Steinert T., Martin V., Baur M., Bohnet U., Goebel R., Hermelink G, et al. (2007) Diagnosis-related frequency of compulsory measures in 10 German psychiatric hospitals and correlates with hospital characteristics. Social Psychiatry and Psychiatric Epidemiolgy 42(2):140–5. 10.1007/s00127-006-0137-0

Stern, M. F., Greifinger, R. B., & Mellow, J. (2010). Patient safety: moving the bar in prison health care standards. American journal of public health, *100*(11), 2103–2110. https://doi.org/10.2105/AJPH.2009.184242

Strout, T. (2010) Perspectives on the experience of being physically restrained: an integrative review of the qualitative literature. International Journal of Mental Health Nursing. 19, 6, 416-427.

Taylor, K.,Mammen, K., Barnett,S, Hayat, M. & Gross, D. (2012)."Characteristics of Patients With Histories of Multiple Seclusion and Restraint Events During a Single Psychiatric Hospitalization. Journal of the American Psychiatric Nurses Association, *18*(3):159-165.

Taylor C. (2020) A review of the use of pain-inducing techniques in the youth secure estate. Ministry of Justiceand Her Majesty's Prison and Probation Service https://www.gov.uk/government/publications/independent-review-of-the-use-of-pain-inducing-techniques-in-the-youth-secure-estate Accessed 10.11.21.

Tolisano P., Sondik T., and Dike CC. (2017). A positive behavioral approach for aggression in forensic psychiatric settings. Journal of the American Academy of Psychiatry and the Law, 45, pp31-39.

Tuke, D.H. (1882) Chapters in the history of the insane in the British Isles. London, Kegan Paul.

Utzon-Frank N., Breinegaard N., Bertelsen M., Borritz M., Eller N.H., Nordentoft M, Olesen K., Rod N.H., Rugulies R., Bonde .JP. (2014) Occurrence of delayed-onset post-traumatic stress disorder: a systematic review and meta-analysis of prospective studies
Scand J Work Environ Health 40(3):215-229

United Kingdom Central Council for Nursing, Midwifery and Mental Health Visiting (2002) The recognition, prevention and therapeutic management of violence in mental health care.
London. United Kingdom Central Council for Nursing, Midwifery and Mental Health Visiting.

United Nations, Standard Minimum Rules for the Treatment of Prisoners, (the Mandela Rules). Geneva. United Nations.

University of Portsmouth (2021) 'What is the "hostile environment"? An introduction to immigration policy in Britain'. Portsmouth: University of Portsmouth (www.port.ac.uk/ news-events-and-blogs/blogs/democratic-citizenship/what-is-the-hostile-environment). Accessed 08.11.21

van Dijk, T A (2000a) On the analysis of parliamentary debates on immigration. In Reisigl M. and Wodak R. (eds.), The semiotics of racism. Approaches to critical discourse analysis. (p. 85-103). Vienna: Passagen Verlag.

van Dijk, T.A. (2000b) Ideologies, racism, discourse: Debates on immigration and ethnic issues. In der Wal, J. & Verkuyten, M. (eds.) Comparative perspectives on racism. (p.91-116). Aldershot: Ashgate.

Van Der Merwe M, Muir-Cochrane E, Jones J, Tziggili M, Bowers L.(2013) Improving seclusion practice: implications of a review of staff and patient views. J Psychiatr Ment Health Nurs 20(3):203–15. doi: 10.1111/j.1365-2850.2012.01903.x

von Werthern, M., Robjant, K., Chui, Z. (2018) The impact of immigration detention on mental health: a systematic review. BMC Psychiatry 18, 382 (2018). https://doi.org/10.1186/s12888-018-1945-y

Wardhaugh, J. and Wilding, P. (1993). Towards an explanation of the corruption of care, Critical Social Policy, 37, 4-31.

Watts D., Morgan G. (1994) Malignant alienation: dangers for patients who are hard to like. British Journal of Psychiatry 164: 11–5.

West London NHS Trust (2015) Positive and Safe: Violence Reduction and Management Programme – Instructors Manual. London: Broadmoor Hospital PMVA team; 2015. URL: https://westlondon. nhs.uk/pmva-manual/

World Health Organisation (2007) Health in prisons A WHO guide to the essentials in prison health. Geneva, World Health Organisation.

World Health Organization (2019) Strategies to end seclusion and restraint. WHO Quality Rights: Specialized training. Course guide. Geneva: World Health Organization;

Youth Training Board (2006) Memorandum From Youth Training Board: Inquiry Into The Use Of Restraint In Secure Training Centres (STC 3) https://publications.parliament.uk/pa/jt200607/jtselect/jtrights/1057/memo/stc3web.pdf

Zarola, A,. Leather, P., (2006) - Violence and Aggression Management for Trainers and Managers : A National Evaluation of the Training Provision in Health Care Settings . Research Report 440. University of Nottingham for the Health and Safety Executive , Nottingham

Zimbardo P. (2007) The Lucifer Effect: Why Good People Turn Evil, New York: Random House.

Materials made available for purposes of this statement

DL0000149 – Witness Statement of D2033 – 19 NOV 2021

CJS0072752 – ACDT Shift Handover Notes – 06 APR 2017

BHM000018 – Witness statement of D1713

VER000198_001 – Meeting with James Wilson – 24 OCT 2017

VER000110 – Minutes from IMB and GDWG – 14 NOV 2017

HOM003398_003 – Crime Report of Assault Pertaining to D1234 – 05 SEP 2017

HOM002750 – D1234 Investigation Report – 04 OCT 2017

HOM002495 – D1234 Use of Force Incident – 28 MAR 2017

GDW000003_001_010-011_013-015_018_027_029_036_040-041_043-046 – Emails Between Brook House IRC and GDWG – 25 SEP 2017

GDW000008_001 – Email by James Wilson – 08 AUG 2017

GDW000001 – Second Witness Statement of James Wilson 19 SEP 2018

HOM002492 – Complaints Made by D1234 – 23 JUN 2017

VER000222 – Interview with Anton Bole – 11 MAY 2018

INQ000094 – Dominic Aitken Witness Statement – 25 NOV 2011

INQ000007 – Blog Post by Dominic Aitken – 1 NOV 2017

FWT000001 – Witness Statement of Anton Bole – 19 NOV 2021

FFT000012 – Freedom from Torture Submission – 19 MAR 2021

FFT000002_001_010 – Home Office Guidance – 03 MAR 2019

FFT000001 – Witness Statement of Sile Reynolds – 17 NOV 2021

CJS006120_001_011 – The Detention Centre Rules – 02 APR 2001

CJS005089_001,002,005 – Detention Services Security Report – 14 APR 2017

CJS000731_001,008 – Home Office Detention Services Order – FEB 2017

CSJ000911 Gatwick IRC Sec Meeting Minutes 23 June 2017

CSJ000917 Gatwick IRC Sec Committee Meeting 11 May 2017

CJS007112 – D687's Medical Records – 28 APR 2020

FWT000002 – Anton Bole Witness Statement

GDW000001 – Witness statement of James Wilson – 13 SEP 2018

GDW000003_021_022 – Emails between Brook House IRC and GDWG – 25 SEP 2017

INQ000027 – First Witness Statement of Jamie Macpherson – 19 MAY 2021

DL0000099_007 – Psychological Report D1851 – 30 APR 2018

HOM002564 – PSU Investigation into Complaints made by D668 – 18 JAN 2018

Brook House Inquiry Day 13 Transcript 09 Dec 2021

DPG000002 – First Witness Statement of Anna Pincus – 10 NOV 2021

DPG000005 – Second Witness Statement of Anna Pincus – 18 NOV 2021

GDW000003_001,032-033 – Emails between Brook House IRC and GDWG – 25 SEP 2017

GDW000006_017-022 – D687 GDWG Notes – 18 MAY 2017

GDW000010 – Anonymised GDWG Client Summaries – 25 OCT 2021

VER000249_015 – Interview with Members of GDWG – 13 FEB 2018

CJS001419 – D87 Care and Separation – 30 JUN 2017

CJS001506_20-37 – Physical Assault Allegation Made by D2953 – 13 FEB 2018

CJS001616 – Details of a Detainee Complaint – 05 JUL 2017

CJS001627 – Complaint Made by D2054 – 15 SEP 2017

CJS003531_004_006 – Supplementary Information of D87 – 15 JUL 2017

CJS004739_002 – D87 Security Information Report – 12 APR 2017

CJS0073644 – Injury Report of D2953 – 29 JUN 2017

CJS0073658 – Mistreatment of D2953 – 06 NOV 2017

GDW000007_001 – Stakeholder Interview with the IMB – 29 SEP 2015

HOM002361 – Letter to D87 – 26 JUL 2017

HOM002363 – Closure Report on D87's Complaints – 21 SEP 2017

HOM002364 – Letter from Home Office regarding D87 – 21 SEP 2017

HOM002388 – Home Office Care of D2054 – 21 JUN 2017

HOM002419 – Witness Statement of Detainee D71 – 06 JUL 2017

HOM002520 – Use of Force Complaint Made by D1747 – 20 JUN 2017

HOM002521 D1747 Use of Force Complaint – 26 JUL 2017

HOM002721 – Telephone Interview of D87 – 11 JUL 2017

HOM003105 – 1st Complaint Made by D87 – 29 JUN 2017

HOM003106 – 2nd Complaint Made by D87 – 30 JUN 2017

HOM003107 – 3rd Complaint Made by D87 – 02 JUL 2017

HOM003492 – Police Statement from D1747 – 09 JUL 2017

HOM003493 – Statement of D1686 – 20 JUN 2017

HOM003522 – D1747's Complaint Against DCO Derek Murphy

HOM004880 – Telephone Interview of D2953 – 18 OCT 2017

HOM015482 – Detention Review of D2054 – 21 JUN 2017

HOM022941 – Medical Report Review of D2054 – 08 JUN 2016

HOM032247_009 – Heathrow IRC Patient Record for D2953 – 25 SEP 2017

SXP000018 – Sussex Police Report of D2054 – 28 JUN 2017

SXP000055 – Sussex Police Report of D1747 – 20 JUN 2017

TRN0000077_007-016, 019-030, 035-039 – Transcript of D3405 and D1527 – 09 MAY 2017

VER000104 – Analysis of Medical Records – OCT 2017

VER000106 – GDWG Evidence for Stephen Shaw Inquiry – NOV 2017

VER000249_021 – Interview With Members of GDWG – 13 FEB 2018

HOM002747_001_017-018 – Letter from the Home Office

HOM002582 – Detention Centre Rule 35 form for D668 – 24 JUL 2017

DL0000158_001_002 – Complaints Letter to G4S – 27 SEP 2017

DL0000156_002 – D668 Diary Entry – 07 SEP 2017

DL0000040_032_034-041 – Medical Notes of D668 – 23 OCT 2017

HOM002540_001 – Care Officer Monthly Review – 16 OCT 2017

HOM002748_027-028_030-032_034-036_040_042 – PSU Investigation Report – 21 FEB 2018

HOM002578_001-003 – D668 Review of Detention – 25 JUL 2017

Hearing – Day 12 AM Live Stream 8 Dec 2021

Brook House Inquiry Day 12 Transcript 08 Dec 2021

Hearing – Day 12 PM Live Stream 8 Dec 202

GDW000003_45_46 – Emails Between Brook House and GDWG – 25 SEP 2017

Hearing – Day 11 AM Live Stream 7 Dec 2021

Hearing – Day 11 PM Live Stream 7 Dec 2021

Brook House Inquiry – Day 11 Transcript 7 Dec 2021

INN000007 – Owen Syred Written Statement – 16 NOV 2021

INN000010 – Second Written Statement from Owen Syed – 01 DEC 2021

DL0000154 – Second Witness Statement of Reverend Nathan Ward – 23 NOV 2021

DL0000141 – First Witness Statement of Rev Nathan Ward – 10 NOV 2021

CJS001425_01_02 – Complaints from D381 – 08 SEP 2017

CJS001425_05_06 – Complaints from D381 – 08 SEP 2017

Hearing – Day 10 AM Live Stream 6 Dec 2021

Hearing – Day 10 PM Live Stream 6 Dec 2021

Brook House Inquiry – Day 10 Transcript 6 Dec 2021

DL0000040_032_037-039_044_047-049 – Medical Reports of D668 – 23 OCT 2017

DL0000151 – First Annex to Witness Statement of D668 – 22 NOV 2021

DL0000152 – Second Annex to Witness Statement of D668 – 22 NOV 2021

DL0000153 – First Witness Statement of D668 – 22 NOV 2021

HOM002543 – Witness Statement of D668 – 12 OCT 2017

HOM002748_031-032, 042-043 – PSU Investigation Report – 21 FEB 2018

HOM0322022 – Immigration Removal Centre D668 – 17 MAY 2017

HOM002547 – Complaints Made by D668 – 29 JAN 2018

Hearing – Day 9 Live Stream 3 Dec 2021

Brook House Inquiry – Day 9 Transcript 3 Dec 2021

CJS001309_005 – Detainees Observation Notes – 30 JUL 2017

DL0000075_014-015_018 – Expert Psychiatrist Report – 10 NOV 2017

DL0000084 – Claim sent to Tascor Services Limited – 29 JUN 2018

DL0000094_012-013 – Witness Statement submitted by D185 – 27 JAN 2020

DL0000095_001-002 – Statement from D390 – 25 MAR 2017

DL0000099_009-010 – Psychological Report of D1618 – 30 APR 2018

DL0000143 – D1851 Witness Statement – 19 NOV 2021

HOM0322101_001 – Airline Risk Assessment – 22 AUG 2017

HOM0322267_004 – Detainee Detention History of D1618 – 29 SEP 2020

HOM0322313 – Letter to Home Secretary – 30 OCT 2017

HOM0322322 – Cancellation of D1618's Removal – 27 AUG 2017

HOM0322339 – Unlawful Removal of D1618 – 06 SEP 2017

INQ000055 – Witness Statement of D1618 – 03 NOV 2021

CJS005624_001_015-016 – G4S Use of Force Record – 05 JUN 2017

Hearing – Day 8 AM Live Stream 2 Dec 2021

Hearing – Day 8 PM Live Stream 2 Dec 2021

Brook House Inquiry – Day 8 Transcript 2 Dec 2021

CJS001084 – 001 – 005 – 006 – Incident Report – 13 MAY 2017

CJS005652 – 001 – 004 – 008 – 0011 – G4S Use of Force -13 MAY 2017

SXP000120 – 007 – 008 – Witness Statement of Callum TULLEY – 23 NOV 2017

TRN0000004 – 001 – Transcript 1 of D1527

TRN0000005 – 001 – 006-007 – Transcript 2 of D1527

TRN0000007 – 001-002 – 0011 – 0012 – D687 Transcript

TRN0000009 – 001-003-005-006 – D275 Transcript

TRN0000012_001 – Transcript

TRN0000013_002-003 – Transcript

TRN0000047_0015 – Callum Tulley BBC Video Diaries

TRN0000048_0015-0016 – Callum Tulley BBC Video Diaries – 14 MAY 2017

TRN0000085_0035_0044_0054_0077 – Transcript – 17 MAY 2017

TRN0000087_0016_0020 – Transcript – 27 MAY 2017

CSJ004347 _001-003 Security Information Report 26 June 2017

CJS005651_001_008-0011 – G4S Use of Force – 27 MAY 2017

CPS000025_0037 – BBC Incident Log – 07 MARCH 2017

TRN0000015_0021 – D1275 Transcript

TRN0000016_001-004 – Incident involving D1275

TRN0000017_0011 – Incident involving D728

TRN0000018_004-006 – Incident involving D1914

TRN0000033_002 – Transcript of Incident involving D865 – 04 JULY 2017

TRN0000063_006-009 – BBC Video Transcript Diaries of Callum Tulley

TRN0000069_005-006 – BBC Callum Tulley Video

TRN0000084_0010 – Transcript – 20 JUN 2017

TRN0000092_021_050 – Incident with D1275 – 14 JUN 2017

TRN0000094_0053-0056 – Transcript of G4S staff in IRC – 06 JUN 2017

TRN0000096_002 – Transcript of incident – 04 MAY 2017

TRN0000097_002 – Transcript of incident – 08 MAY 2017

Hearing – Day 7 AM Live Stream 1 Dec 2021

Brook House Inquiry Day 7 Transcript 1 Dec 2021

TRN0000047_031 Transcript – undated

BBC000059_003-005,008-009,015,018 Callum Tulley Notebook Entries – 04-12 MAY 2017

CJS000902_008 – Use of Force Review Meeting Form re D1527 – 17 JUL 2017

CJS001085_001-004,007,017 Ongoing Record of significant events, conversations and observations – 24-25 APR 2017

CJS005534_001-005,007-011 – Use of Force Report and Injury Report for D1527 – 25 APR 2017

SXP000120_004,007-008 Police Witness Statement of Callum Tulley – 23 NOV 2017

‘TRN0000001_001-003, 005-007, 009-012 – Transcript 1 of incident re D1527 – 25 APR 2017

TRN0000002_002,005-009,012,014-016 – Transcript 2 of incident re D1527 – 25 APR 2017

TRN0000003_001 Transcript of incident re unnamed detainee – undated

TRN0000076_045 Transcript – 04 MAY 2017

TRN0000089_019 Transcript between G4S staff in IRC – 06 JUN 2014

TRN0000038 – 005 – 007 – 008 – Callum Tulley BBC Video Diaries

CPS000025_001-002 – BBC Incident Log – 07 MAR 2017

Hearing – Day 6 AM Live Stream 30 Nov 2021

Hearing – Day 6 PM Live Stream 30 Nov 2021

Brook House Inquiry Day 6 Transcript 30 Nov 2021

BBC000066 – Callum Tulley’s notebook entries – 31 MAR 2017 to 30 APR 2017

CJS000707 – G4S Whistleblowing Policy – 01 MAY 2017

TRN0000002 – Transcripts re D1527 incident – undated

TRN0000065 – Callum Tulley BBC Videos Diaries – undated

TRN0000079 – Transcript – 31 MAY 2017

BBC000058 – Callum Tulley’s notebook entries – 4 JUL 2016 – 5 OCT 2016

IMB000029 – Date log of IMB visits to Brook House – 1 APR 2017

TRN0000076 – Transcript – 04 MAY 2017

TRN0000079 – Transcript – 31 MAY 2017

TRN0000091 – Callum Tulley Transcript – 10 JUN 2017

CPS000025_013 – BBC Incident Log – 07 MAR 2017

CPS000025_001-004 – BBC Incident Log – 07 MAR 2017

CPS000025_037 – BBC Incident Log – 07 MAR 2017

Hearing – Day 5 Transcript 29 Nov 2021

Hearing – Day 5 Live Stream 29 Nov 2021

BBC000651 – 2nd Witness Statement of Callum Tulley – 15 Nov 2021

CPS000025 – 001 – 002 BBC Incident Log

INQ000051 – Callum Tulley Exhibit 1 – 19 Aug 2021

INQ000052 – Witness Statement of Callum Tulley – 15 Nov 2021

INQ000062 – Brook House Photo 1 – 16 Nov 2021

INQ000063 – Brook House Photo – 16 Nov 2021

BBC000652 – Callum Tulley Exhibit 3 – 15 Nov 2021

Hearing – Day 4 Transcript 26 Nov 2021

INQ000060- Welfare in Detention of Vulnerable Persons by Stephen Shaw – JAN 2016

Hearing – Day 4 Live Stream 26 Nov 2021

Hearing – Day 3 AM Live Stream 25 Nov 2021

Hearing – Day 3 PM Live Stream 25 Nov 2021

Hearing – Day 3 Transcript 25 Nov 202

Hearing – Day 2 AM Live Stream 24 Nov 2021

Hearing – Day 2 PM Live Stream 24 Nov 2021

Hearing – Day 2 Transcript 24 Nov 2021

Hearing – Day 1 Live Stream 23 Nov 202

CJS004587 Map of Brook House IRC – undated

CJS000901_0001 – Use of Force Review Meeting Form re D149 – 21 JUL 2017

CJS001024_0001-0003 – Rule 35 Report re D1914 – 17 JUL 2017

CJS000901_0001 – Use of Force Review Meeting Form re D149 – 21 JUL 2017

CJS001024_0001-0003 – Rule 35 Report re D1914 – 17 JUL 2017

CJS001506_0032, 0035-0037 – Official Report re D2953 – 11 JUN 2017

INQ000062 Brook House Photo 1 – 16 NOV 2021

INQ000063 Brook House Photo 2 – 16 NOV 2021

CJS000872_0001-0004 – Rule 35 Report re D2567 – 13 APR 2017

Transcript of Preliminary Hearing 14 Dec 2020

Transcript of Preliminary Hearing 25 Sept 2020

Panorama. Broadcast xxxx

Independent Chief Inspector of Borders and Immigration (2021) Second annual inspection of 'Adults at risk in immigration detention' July 2020 – March 2021

'Annual inspection of 'Adults at risk in Immigration Detention'(2018–19)'8.193–8.196,https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachmentdata/file/881648/AnnualinspectionofAdultsatRIskinImmigrationDetention2018-29.pdf.

Home Secretary statement on immigration detention and Shaw report https://www.gov.uk/government/speeches/home-secretary-statement-on- immigration-detention-and-shaw-report

Shaw S. (2016) Independent Report . Review into the welfare in detention of vulnerable persons : Independent review of Home Office policies and operating procedures that affect the welfare of immigration detainees. London. Home Office.

Shaw S. (2018) 'Assessment of government progress in implementing the report on the welfare in detention of vulnerable persons: A follow-up report to the to the Home Office

Independent Monitoring Board at Brook House IRC (2019) Annual Report of the Independent Monitoring Board at Brook House IRC for reporting Year 2018.

Independent Monitoring Board at Brook House IRC (2020) Annual Report of the Independent Monitoring Board at Brook House IRC for reporting Year 2019

Report of the Independent Advisory Panel on Non-Compliance Management, March 2014, Stephen Shaw

No. 238 IMMIGRATION The Detention Centre Rules 2001

Immigration and Asylum Act 1999 c. 33 s.155 Custodial functions and discipline etc. at removal centres.

Ministry of Justice National Offender Management Service (2006) Use Of Force Training Manual Version 1. HM Prison Service Training & Development Group ("2006 NOMS Guidance")

National Offender Management Service (2015) National Security Framework Ref: NSF 2.1 Control And Order Function Amendments to Use of Force Policy. National Offender Management Service.

Immigration Act 2016: Guidance on adults at risk in immigration detention

Adults at Risk in Immigration Detention Version v2.0

Home Office (2020) Detention Services Order 02/2017 Removal from Association (Detention Centre Rule 40) and Temporary Confinement (Detention Centre Rule 42) September 2020

Detention Services Order 08/2016

Management of Adults at Risk in Immigration Detention July 2019

Detention Services Order 07/2016 Use of restraint(s) for escorted moves – all staff

Home Office Detention Services Order 08/2016 (2019) Management of Adults at Risk in Immigration Detention

Home Office Detention Services Order 6/2008 Assessment Care in Detention and Teamwork

Detention Services Order 02/2017 Removal from Association (Detention Centre Rule 40) and Temporary Confinement (Detention Centre Rule 42)

Immigration and Asylum Act 1999 c. 33

s.155 Custodial functions and discipline etc. at removal centres.

2001 No. 238 Immigration The Detention Centre Rules 2001

Detention Services Order 6/2008 Assessment Care in Detention and Teamwork

Royal College of Psychiatrists (2021) Detention of people with mental disorders in immigration Removal Centres: Updated Position Statement in 2021. London. Royal College of Psychiatrists.

HMIP: Expectations for Immigration detention, criteria for assessing the conditions for and treatment of immigration detainees, V 4, 2018.

Curriculum Vitae

A) **Name** Brodie Andrew Paterson

B) **Current Post(s)** Non-Executive Director Joblinkplus, Tamworth, NSW Australia

C) **Date of birth** 21 August 1960

D) **Qualifications**

Academic

Diploma in Professional Studies (Nursing) (With Distinction) Glasgow College of Technology, 1987. Dissertation topic : Quality Assurance in services for people with a learning disability and challenging behaviour.
Bachelor of Arts, (Hon) Psychology 1990 Open University
Graduate Diploma in Education (Nurse Teaching) 1992 University Of Stirling
Masters Degree in Education, University Of Stirling, 1995
Ph.D., University of Stirling, 2004
Edexcel \ Level 3 Award in the Delivery of Conflict Management Training (QCF) 2015

Professional Qualifications

Registered Nurse Mental Health	Current	1981
Registered Nurse Learning Disability	Current	1983
Registered Clinical Teacher	Current	1987
Registered Nurse Tutor	Current	1992
Registered Teacher (General Teaching Council for Scotland)		1992

E) Career: appointments held

JAN 1981 - JAN 1982	Staff Nurse, Bellsdyke Hospital, Larbert.
JAN 1982 - JAN 1983	Post Registration Student Nurse Royal Scottish National Hospital, Larbert
JAN 1983 - NOV 1983	Counsellor, Waterville Community Living Project, Waterville, Maine, U.S.A.
DEC 1983 - OCT 1984	Staff Nurse Challenging Behaviour, Royal Scottish National Hospital, Larbert
OCT 1984 - OCT- 1986	Charge Nurse Behavioural Rehabilitation Royal Scottish National Hospital, Larbert
OCT 1986 -JUNE -1988	Clinical Teacher, Royal Scottish National Hospital, Larbert
JUNE 1988-AUGUST 1996	Lecturer, Forth Valley College of Nursing and Midwifery, Falkirk
AUGUST 1998-AUGUST 2016	Senior Lecturer School of Health, Univ of Stirling
AUGUST 2016-MARCH 2021	Clinical Director CALM Training

Examining Roles

External Examiner Highland College of Nursing Miwidery 1997-2000
External Examiner. Glasgow Caledonian University 2003-2006 B.Sc. Psychosocial Interventions / Enduring mental health problems.
External Examiner. Dundalk Institute of Technology 2006-2012 B.Sc. Professional Management of Violence.
External Examiner. University of Glamorgan B.Sc. Violence Reduction, 2008 -2013
External Examiner. Dundalk Institute of Technology 2006-2012 M.Sc. Management of Complex Behaviour .

External Examiner PhD University of Wollongong, New South Wales 2009
External Examiner PhD University of Coventry, England 2010
External Examiner PhD University of Glasgow, Scotland 2011
External Examiner PhD University of Strathclyde, Scotland 2015
External Examiner PhD University of St Andrews, Scotland 2017
External Examiner PhD University of Cumbria, England 2019
External Examiner PhD University of Western Sydney, 2020

Invited seminars / papers

Invited Lecture. 'Risk Assessment and Occupational Violence in Nursing' Royal College of Nursing Safety Matters Conference Scottish Health Service Management Centre, Edinburgh May 1995.

Invited Lecture. 'Implications of the 'Community Supervision Order' legislation for Scotland, United Kingdom Central Council for Nursing and Midwifery Seminar, UKCC, London, October 1996.

Invited Seminar. 'Developing Good Practice Standards in responding to physical violence', United Kingdom Central Council for Nursing, Midwifery and Health Visiting Conference, Improving Practice in Restraint, London, November 1999

Invited Seminar. 'An Audit of Restraint Related Deaths in Health and Social Care in the United Kingdom,' European Violence in Psychiatry Research Interest Group, City University, February 2000.

Invited Lecture. 'Supporting Staff Exposed to Violence In The Workplace', British Institute Of Learning Disabilities, Conference, Restraint - Developing Good Practice, Stirling, February 2001.

Invited Seminar. 'Regulatory Council's Role and View on Restraint', British Association of Social Workers / Royal College of Nursing Conference, University of Stirling, November 2002.

Invited Seminar. 'Restraint Related Deaths Learning the Lessons for practice', City University London, April 2004

Invited Keynote. 'The Impact of violence on nursing', Nursing and Midwifery Council - The management of Violence – Changing a Culture, Liverpool, April, 2004.

Keynote. 'Public Health Based Approaches to Violence Prevention' Cornell University / Child Welfare League of America / University of Stirling Research Symposium Cornell University, Ithaca June 2005.

Invited Keynote. 'Improving the physical and psychological safety of service users when managing acute behavioural distress', European Network for trainers in the prevention of management and violence, Amsterdam, November 2005.

Invited Keynote. 'Implementing the public health perspective on violence prevention' – Conflict Prevention Institute, International Symposium, St Louis, May 2006.

Keynote. 'Reframing the problem of workplace violence in human services: A work in progress?' Cornell University / Child Welfare League of America / University of Stirling, Research Symposium, University of Stirling, Stirling, August 2006

Invited Keynote. 'Improving safety when physical interventions are the last resort' Conflict Prevention Professionals Association, Inaugural conference, Redding September 2006

Invited Seminar. 'Zero Tolerance and Workplace Violence In Human Services: Smarter Thinking Required? Social Justice Research Centre, University of Western Sydney, May 2007.

Invited Seminar. 'What works and what doesn't work in workplace violence prevention policy and practice: A European Perspective'. Social Justice Research Centre, University of Western Sydney, May 2007.

Invited Keynote. 'Leadership and beyond-reframing the task of workplace violence prevention', Scottish Institute of Residential Childcare/ Care Commission, Glasgow, September, 2007.

Invited Seminar. 'More Evidence Less Rhetoric: Evidence and the prevention of workplace violence in the health sector', Scottish Occupational Health Improvement Group Conference, Airth Castle, February 2008.

Invited Keynote. 'Corrupted cultures of care and high risk physical interventions, a toxic combination?, British Institute of Learning Disabilities Supporting People Who Challenge Conference, May 2008.

Invited Seminar 'Reframing the problem of violence directed towards mental health nurses': A work in progress? Public Administration Conference University of York, September 2008.

Invited Keynote. 'Workplace violence prevention. More evidence less rhetoric? Institute of Occupational Safety and Health, Annual Conference London. September 2009.

Invited Keynote. 'Ethics, evidence, effectiveness and economics: challenges facing the management of aggression trainer in the new decade', European Network for Training in the Management of Aggression Conference, Amsterdam September 2010

Presentation. 'Restraint reduction the answer to corrupted cultures in mental health?' Scottish Mental Health Nursing Research Conference, Ayr, April 2012.

Invited Keynote. 'Developing a European charter for trainers in the prevention and safer management of violence. Results from the first phase of a Delphi Study. Violence in Healthcare Conference, Vancouver, October 2012.

Invited Keynote 'Reducing Restrictive Interventions: what works? European Violence in Psychiatry Symposium Ghent , 2016

Invited Keynote. 'Trauma Informed Practice in Learning Disability. Understanding of contemporary perspectives on trauma and their implications'. International Journal of Positive Behaviour Support Conference, London 2017

Invited Keynote. 'Co-production and the role of debrief in the reduction of restrictive interventions', Cyget Healthcare Annual Conference London. 2017

Invited Keynote. 'Attachment and Trauma Informed Positive Behavioural Interventions'. Queensland Intellectual Disability Service Conference. Brisbane 2018.

Invited presentation. 'The role of de-briefing in the reduction of restrictive interventions'. Restraint Reduction Network Conference, Birmingham 2018.

Presentation. 'Turning Around Toxic Cultures'. Workshop presentation at the International Association for the Scientific Study of Intellectual and Developmental Disability, Glasgow 2019.

Publications

Monographs

Paterson B., *Two Percent of the Nation: A Health Strategy for People with Learning Disability in Scotland*, Royal College of Nursing, Edinburgh, 1998.

Dunleavy P. and Paterson B. *Review of National Audit Office Report HC 527 Session 2002-2003 - A Safer Place to Work: protecting NHS hospital and ambulance staff from violence and aggression,* London School of Economics, Public Policy Group, 2003.

Lindsay M., Hosie A., and Paterson, B. *Edinburgh Enquiry Recommendation 55 - The Independent Evaluation Report,* Centre for Residential Child Care, University Of Strathclyde, 2000.

Paterson B. The needs of adults with learning disabilities in Forth Valley, Forth Valley NHS, 2006.

Paterson B., Ryan D and McComish A. Research and best practice associated with the protection of staff from third party violence and aggression in the workplace – a literature review, Scottish Government. Edinburgh. 2009.

Journal articles

Turnbull J., Aitken I., Black L. and Paterson B. Turn It Around Short Term Management Of Violence and Aggression, *Journal of Psychosocial Nursing and Mental Health Services,* 26 (6), 6-12, 1990.

Paterson B., Turnbull J., Aitken I., An Evaluation of a Training Programme in the Short Term Management of Aggression, *Nurse Education Today,* 12, 368-375,1992. *Reprinted in Translation in KrankenPfelge (German Journal of Psychiatric Nursing), June 1993.*

Stark C. and Paterson B., Violence at Work, *British Medical Journal,* 308, 62-63, 1994.

Paterson B., Leadbetter D. and Stark C., *Guidelines On Purchasing Training In The Management of Aggressive and Violent Behaviour,* Multi Sectoral Special Interest Group In Staff Training In Managing Aggressive And Violent Behaviour, 1994.

Paterson B., Violence and Nursing: Practice, Policy and Training, *Advanced Hospital Management.* 3,18–23, 1995.

Paterson B. and Leadbetter D., Hostage Situations in Health and Social Care Settings, *Nursing Times,* Jan 18, 54 -56, 1995.

Stark C., Paterson B. and Kidd B., Incidence of Assaults On Staff In the NHS, *Nursing Times,* May 3, 20, 1995.

McComish A., Paterson B., The Development of Forensic Services In Scotland 1860-1960, *Psychiatric Care,* 3(4), 153-157, 1996.

Paterson B., Aitken I. and McComish A. Abuse and Bullying At Work, (Part 1) *Nursing Management*, 3(10) 8-9, 1997.

Paterson B., Aitken I. and McComish A. Abuse and Bullying At Work, (Part 2) *Nursing Management*, 4(1) 21-23, 1997.

Ferguson S., McComish A. and Paterson B., Clinical Outcomes Measures: Psychopathy A Developmental Framework, *Psychiatric Care*, 4(2), 71-74, 1997.

Paterson B., Tringham C., McComish A., Waters S., Managing Aggression and Violence - A legal perspective on the use of force, *Psychiatric Care*, 4(3), 128-131, 1997.

Paterson B., Leadbetter D. and McComish A., De-escalation in the Short Term Management of Violence - A Process Based Approach, *Nursing Times*, 93(7), 58-61, 1997.

Stark C., Paterson B. Kidd B. and Godwin M., Counting the dead: Serial Murderers In Health Care, *Nursing Times*, 12(46), 34-37, 1997.

Paterson B. and McComish S., The physical management of violent behaviour, *Psychiatric Care*, 5(6), 228-231, 1998.

Paterson B. Leadbetter D., Restraint and Sudden Death From Asphyxia, *Nursing Times*, November 4(9), 62-64, 1998.

Paterson B., McComish A, and Bradley P., Violence at Work, *Nursing Standard*, 13(21), 43-46, 1999.

Stark C., Paterson B., Lerpiniere P. and Sabbatini G., An Evaluation Of A Community Based Detoxification Service, Part 1, *Mental Health Practice*, 3(1), 20-24, 1999.

Stark C., Paterson B., Lerpiniere P. and Sabbatini G., An Evaluation Of A Community Based Detoxification Service, Part 2, Mental *Health Practice*, 3 (2), 18-19,1999.

Paterson B., Leadbetter D. and Bowie V., Supporting Nursing Staff Exposed to Violence at Work, *International Journal of Nursing Studies*, 36,6, 479-486, 1999.

Jamieson J., Leadbetter D. and Paterson B., Coping With Physical Violence: Some More Suggestions, *Emotional and Behavioural Difficulties*, 5, 3, 3-11, 2000.

Paterson B., Standards for Violence Management Training, *Security Journal*, 13(4), 7-17, 2000.

Paterson B. and Leadbetter D., Restraint & Sudden Death from Asphyxia, Journal *of Safe Management of Disruptive and Assaultive Behaviour Volume* VIII/ Issue III, Winter 2000.

Paterson B., Leadbetter D. and Bowie V., Zero in On Violence, *Nursing Management*, 8(1), 16-22, 2000.

Stark C., Paterson B., and Kidd B., Opportunity may be more important than profession in serial homicide, *British Medical Journal*, 322,993, 2001.

Paterson B. and Stark C. Social Policy and Mental Illness in England in the 1990's: Violence, moral panic and critical discourse, *Journal of Psychiatric and Mental Health Nursing*, 8(3), 257-267, 2001.

Paterson B., Bradley P., Stark C., Saddler D., Leadbetter D. and Allen D., Deaths Associated with Restraint Use in Health and Social Care In the United Kingdom: The Results of A Preliminary Survey, *Journal of Psychiatric and Mental Health Nursing*, 10,3-1, 2002.

Paterson B., Bradley P., Stark C., Saddler D., Leadbetter D. and Allen D., Restraint Related Deaths In Health and Social Care in the UK: Learning the lessons, *Mental Health Practice*, 6(9), 10-17, 2003.

Paterson B., Claughan P., and McComish S., New evidence or changing population? - Reviewing the evidence of a link between mental illness and violence, *International Journal of Mental Health Nursing*, 13, 39-52, 2004.

Paterson B. Leadbetter D., Learning the right lessons: Reflecting on the David Bennett inquiry recommendations with particular reference to violence management training, *Mental Health Practice*, 7(7), 12-14, 2004.

Paterson B., Ethical Approaches to Physical Interventions: Responding to Challenging Behaviour in People with Intellectual Disabilities, *Journal of Applied Research in Intellectual Disabilities*, 17 (3), 227-228, 2004.

Leadbetter D. and Paterson B., Exploring safe physical interventions, *Nursing and Residential Care*, 6(5), 232 – 234, 2004.

Leadbetter D. and Paterson B., Developing an agency approach to safe physical intervention, *Nursing and Residential Care*, 6(6), 280–283, 2004.

Paterson B.Stark C. and Gray D., Nurses Knowledge of mental health legislation, *Mental Health Practice*, 8(2), 35-37, 2004.

Stark C, Paterson B. and Devlin B., Newspaper coverage of a violent assault by a mentally ill person, *Journal of Psychiatric and Mental Health Nursing*, 11,635-643, 2004.

Paterson B., Thinking the unthinkable: A Role for pain compliance and mechanical restraint in the management of violence? *Mental Health Practice*, 8(7), 18-23, 2005.

Paterson B., Miller G. and Leadbetter D., Beyond Zero Tolerance a varied response to workplace work place, *British Journal of Nursing*, 14(15), 811-815, 2005.

Cassells C. Paterson B. Dowding D., and Morrison R., Long and Short-Term Risk Factors in the Prediction of Inpatient Suicide: A Review of the Literature, *Crisis: Journal of the International Association for Suicide Prevention*, 26(2), 53–63, 2005.

Mackay I. Paterson B. and Cassells C., Constant or special observations of inpatients presenting a risk of aggression or violence: nurses' perceptions of the rules of engagement, *Journal of Psychiatric and Mental Health Nursing*, 12(4), 464-71, 2005.

Paterson B. Safety in partnerships, *Diverse Minds*, October 14-15, 2005.

Duxbury J. and Paterson B., The Use of Physical Restraint in Mental Health Nursing: An examination of principles, practice and implications for training, *Journal of Adult Protection*, 7(4), 13-24, 2005.

Paterson, B. Newspaper representations of mental illness and the impact of the reporting of events on mental health social policy: the `framing' of Isabel Schwarz and Jonathan Zito, *Journal of Psychiatric and Mental Health Nursing*, 13(3), 294-300, 2006.

Miller G., Paterson, B. and Tucker R., The Millfields Charter an alternative view, *Mental Health Practice, 10(1), 22-23, 2006.*

Paterson B. La contenzione fisica nella cura dei disturbi acuti del comportamento nel paziente psichiatrico in regime di ricovero. Individuazione e gestione dei rischi potenziali, *Rivista Sperimentale di Freniatria*, CXXX (3), 85-103, 2006.

Paterson B. and Duxbury J. Developing a perspective on restraint and the least intrusive intervention, *British Journal of Nursing*, 14(22), 1235-1241, 2006.

Paterson B. Leadbetter D., J and Miller G. Preventing violence in residential care: A Public Health Perspective, *Residential Group Care Quarterly*, Summer 11-13, 2006.

Paterson B., Cassels C., Graham A., Dowding D. and McComish S., Ambiguity Uncertainty and Risk: Reframing the task of suicide risk assessment and prevention in acute in-patient mental health, *Irish Nurse*, 8(2), 22-25, 2007.

Paterson B., Least Restrictive Intervention Towards Consensus? *European Psychiatry:* Journal of the Association of European Psychiatrists, 22 (supplement 1) 45, 2007.

Paterson B., Drawing the wrong conclusions? *Learning Disability Practice*, 10(3), 30-34. 2007.

Paterson B. and Duxbury J., Restraint and the question of validity, *Nursing Ethics*, 14 (4), 535-545, 2007.

Paterson B.A., Discourse analysis of the construction of mental illness in two UK newspapers 1985-2000, *Issues in Mental Health Nursing*, 28,1-17. 2007.

Paterson B., Dowding D., Cassells C., Harries C. and Morrison R., Managing the risk of suicide in acute psychiatric inpatients: A clinical judgement analysis of staff predictions of imminent suicide risk, *Journal of Mental Health*. 17(4), 410-423.2008

Miller G., Paterson B., Benson R. and Rogers P., Violence reduction in mental health and criminal justice: recent and current developments, The Journal of Mental Health Training, Education and Practice, 2(1), 28-41, 2007.

Rogers P., Miller G., Paterson B., Turner P., Brett S., Flynn K. and Noak J., Is breakaway training effective? Examining evidence and the reality, The Journal of Mental Health Training, Education and Practice, 2(2), 5-12, 2007.

Paterson B., Bowie V., Miller G. and Leadbetter D., Discourse, Rhetoric and Failure: Zero Tolerance and Violence in Services for People with Mental health needs. *Mental Health Practice*, 11(8),26-31.2008

Paterson B., Dowding D., Cassells C., Harries C. and Morrison R., Managing the risk of suicide in acute psychiatric inpatients: A clinical judgement analysis of staff predictions of imminent suicide risk, *Journal of Mental Health*. 1-14, 2008

Stubbs B, Paterson B and Leadbetter D. Physical Interventions: A review of the literature on its use, staff and patients views and the impact of training, *Journal of Psychiatric and Mental Health Nursing* 16, 99-105. 2009

Paterson B Violence Towards Mental Health Nurses in England and the Nature of the Policy Response: A Frame Analysis. *Risk and Governance*, 1(2) 125-136. 2009

Hollins P and Paterson B Interventions in the management of aggressive and violent behaviour: Reflecting on the impact of training, *Journal of Psychiatric and Mental Health Nursing.*16(1) 99-105.2009

Hollins L. P. and Paterson B. Physical intervention trainers: the case for greater accountability *Journal of Psychiatric and Mental Health Nursing* 16, 376–381. 2009

Paterson B et al. Control and restraint: Changing Thinking, Practice and Policy, *Mental Health Practice,* 13(2) 16-20.2009.

Paterson B., Bowie V., Miller G. and Leadbetter D Reframing the problem of violence towards mental health nurses - A work in progress? ,*International Journal of Social Psychiatry.* 56(3) 310-320., 2009.

Robertson,M. Paterson, B Lauder, B. Fenton, R and Gavin J (2010) Accounting for Accountability: A Discourse Analysis of Psychiatric Nurses` Experience of a Patient Suicide, *The Open Nursing Journal* 4(8) 1-8. 2010

Stubbs B and Paterson B Physical restraint in mental health services: a gap in the knowledge regarding this extreme manual handling task, *Ergonomics*

54 (9), 876-878 . 2011

Paterson B., Leadbetter D, Steele G. and Martin A. Is Physical restraint ever necessary in your workplace? *Nursing & Residential Care*,13 (12), 606 - 608. 2011

Paterson B, Wilkinson D., Bowie V and Bradley P. How corrupted cultures lead to abuse of restraint interventions . *Learning Disability Practice* 14(7) Learning Disability Practice, 2011

Bowers, L Van Der Merwe, M., Paterson B., Stewart D. Manual restraint and shows of force: The City-128 study, *International Journal of Mental Health Nursing* 21(1):30-40. 2012

Paterson B., McIntosh I.,Wilkinson D., McComish S. and Smith I. Corrupted cultures in mental health inpatient settings. Is restraint reduction the answer? *Journal of Psychiatric and Mental Health Nursing*. 20(3):228-35. 2013

B Paterson, L Bennet, P Bradley. Positive and Proactive Care: Could new guidance lead to more problems? British Journal of Nursing | Vol.23 | No.17 | pp 93941 http://dx.doi.org/10.12968/bjon.201.23.17.939 2014

Paterson B., Young J and Bradley P. Recognising and responding to trauma in the implementation of PBS? *International Journal of Positive Behavioural Support*, 7(1) 4-14(11) 2017

Sethi F, Parkes J, Baskind, E Paterson B and O'Brien A. Restraint in mental health settings: is it time to declare a position? *British Journal of Psychiatry*. 2018

Patel M and Paterson B. *Joint BAP NAPICU evidence-based consensus guidelines for the clinical management of acute disturbance: de-escalation and rapid tranquillization.* NAPICU. Leeds. 2018.

Paterson B., Shewry B., Bradley P., and Bowie V., Why are all the restraint trainers men and why might this really matter? *Scottish Journal of Residential Child Care* 17.3. 2018.

Young, J., Taylor, J., Paterson, B., Smith, I., & McComish, S. Trauma-informed practice: a paradigm shift in the education of mental health nurses. *Mental Health Practice*, *22*(3), [1359]. https://doi.org/10.7748/mhp.2019.e1359. 2019.

Paterson B., Taylor J. and Young J. Compassion Fatigue In Teachers Working With Children Whose Distress May Present As Behaviour That Challenges. Action Urgently Needed? *Scottish Education Review.* 2021

Contributions to monographs

Leadbetter D. and Paterson B., De-escalating Aggressive Behaviour, in *Management of Violence and Aggression In Health Care,* Stark C and Kidd B (Eds.), Royal College Of Psychiatrists / Gaskell, London, 1995.

Paterson B. and Leadbetter B. De-escalation in the Management of Aggression and Violence,in Turnbull J and Paterson B, *Aggression and Violence: Approaches to Effective Management*, Macmillan. Houndsmill.1999

Paterson B and Tringham C. Legal and Ethical Issues in the Management of Violence, in Turnbull J and Paterson B, *Aggression and Violence: Approaches to Effective Management*, Macmillan. Houndsmill. 1999

Paterson B and Leadbetter D, Managing Physical Violence, in Turnbull J and Paterson B, *Aggression and Violence: Approaches to Effective Management*, Macmillan. Houndsmill. 1999

Paterson B., Leadbetter D. and Tringham C., Critical Incident Management: Aggression and Violence Case Study. In, Mercer D., Mason T., McKeown M. and McCann N. (Eds.), *Forensic Mental Health Care Planning, Directions and Dilemmas*, Churchill Livingstone, Edinburgh, 1999.

Stark, C., Paterson B., Henderson T., Kidd B. and Godwin M., Nurses Who Kill: Serial Murder in Health Care Institutions. In, Godwin M., (Ed.) *Criminal Psychology and Forensic Technology: A Collaborative Approach to Effective Profiling*, Taylor and Francis, CRC Press Washington, 2000.

Paterson B. and Leadbetter D., Standards for Violence Management Training. In, Gill M., Fisher B. and Bowie V. (Eds.), *Violence in the Workplace: causes, patterns and prevention*, Willan Publishing, Uffcolme, Devon, 2000.

McKenna K.J. and Paterson B., Locating Training Within a Strategic Organizational Response to Aggression and Violence. In, Richter, D. and Whittington, R. *Violence in Psychiatry; Causes Consequences and Control*, New York, Springhouse, 2006.

Whittington R., Baskind E., and Paterson B. Coercive measures in the management of imminent violence: Restraint, Seclusion and Enhanced Observation. In, Richter, D. and Whittington, R. *Violence in Psychiatry; Causes Consequences and Control* New York, Springhouse, 2006.

Paterson B., Leadbetter D., Crichton J. and Miller G., Adopting a Public Health Model to Reduce Violence and Restraints In, Children's Residential Care Facilities. In Nunno M., Bullard LB. and Day D. (Eds.), *For our own safety: Examining the safety of high-risk interventions for children and young people*. Washington, DC: Child Welfare League of America, 2008.

Paterson B., Leadbetter D., Miller G and Bowie V., Reframing the problem of workplace violence towards mental health nurses in the UK: A work in progress, In

Needham I., Kingma M., O'Brien-Pallas L., Tucker R., and Oud N, (Eds) *Workplace Violence in the Health Sector*, Kavanah, Amsterdam.2008.

Paterson B., Leadbetter D and McKenna K. The organisation and workplace violence prevention in Engelen V, Mckenna K and Miller G, *Promoting a shared vision of practice and organisational excellence in training*, European Network of Trainers in the Management of Aggression, Netherlands.2008

Paterson B., Leadbetter D Bradley P. and Allen D. Restraint related deaths. Learning from tragedy? in Engelen V., Mckenna K. and Miller G., *Promoting a shared vision of practice and organisational excellence in training,* European Network of Trainers in the Management of Aggression, Oud Consultancy. Netherlands.2008

Paterson B.,and Bradley P., Restraint related deaths: Lessons for policy and practice from tragedy? in Allen D. (Ed) *Ethical approaches to physical interventions. Vol 11 Responding to challenging behaviour in people with intellectual disabilities.* British Institute of Learning Disabilities. 2009

Martin A McDonell A., Leadbetter D and Paterson B Assessing the risks associated with physical interventions in Allen D (Ed.) *Ethical approaches to Physical Interventions Volume 11: Changing the agenda*, British Institute of Learning Disabilities, Kidderminster. 2009

Leadbetter, D, Paterson, B Towards Restraint Free Care - in Hughes, R (Ed) - *A Balance of Care: Practice and Policy Perspectives on Reducing Restraint in Health and Social Care*, Kings College, London.2009

Miller G and Paterson B McKenna K. Changing the culture of care *in* Hughes, R (Ed) - *A Balance of Care: Practice and Policy Perspectives on Reducing Restraint in Health and Social Care,* Kings College, London. 2009

Paterson B. and Stubbs B. Assessing your physical intervention procedures, in Paterson B., Van Engelen Y. and Mckenna K. *Evidence, Efficacy, Economics and Ethics : The challenges facing management of aggression training in the 21century* European Network of Trainers in the Management of Aggression, Amsterdam. Netherlands.2010

Paterson B Training in the prevention of management and aggression in a cold climate: Meeting the challenges, in Paterson B., Van Engelen Y. and Mckenna K. Evidence, Efficacy, Economics and Ethics : *The challenges facing management of aggression training in the 21century* European Network of Trainers in the Management of Aggression. Amsterdam Netherlands.2010

Paterson B. Restraint, seclusion and compulsory medication. Still valid after all these year? In Barker P (Ed) *Mental Health Ethics: The Human Context*, Routledge, London.2010

RP Liberman, GW. LaVigna, L Hume, B Paterson and H. Powell. Scope of Aggressive Behavior in People with Mental and Developmental Disabilities in (Eds) RP Liberman, GW. LaVigna, *New Directions for Treatment of Aggressive Behavior in Persons with Mental and Developmental Disabilities.* New York Nova Science Publishers. 2015

L. Hume, B Paterson, H Powell, R P Liberman and G W. LaVigna, Dissemination of Evidence-based Treatments for Aggressive Behavior in (Eds) RP Liberman, GW. LaVigna, *New Directions for Treatment of Aggressive Behavior in Persons with Mental and Developmental Disabilities*. New York. Nova Science Publishers. 2015

Paterson, B. (2017) in Nag T, Kristiansen GMB, Viste L, Fotland TS, Kjærvik K, Holtskog TE, et al. (2019) MAP – Møte med aggresjonsproblematikk. Opplæringsmanual versjon 1.0. Oslo: SIFER. Available from: https://sifer.no/wp-content/uploads/2021/02/MAP-Kapittel-5.pdf

Edited Books

Turnbull J, and Paterson B, (Eds.) Aggression *and Violence Approaches To Effective Management*, Macmillan, London, 1999.

Paterson B., Van Engelen Y. and Mckenna K. *Evidence, Efficacy, Economics and Ethics : The challenges facing management of aggression training in the 21century* European Network of Trainers in the Management of Aggression, Amsterdam. Netherlands.2010

In Development. *Seclusion. Still valid after all these years?* Mckenna K. and Paterson B. 2021

In Development. *Trauma and undergraduate health profession education. Delivering change.* Paterson B., Taylor J. and Young J.

Professional Contributions

Secretary of State appointed Member of the United Kingdom Central Council for Nursing and Midwifery 1996-2000

Member of the Professional Conduct Committee of the United Kingdom Central Council for Nursing and Midwifery 1996-2000

Member of the Scottish Executive Strategic Review of Services for people with a Learning Disability (Same As You) 1999-2000

Member of the European Violence in Psychiatry Research Interest group 2000-

Member of the scientific affairs committee of the European Violence in clinical psychiatry congress in 2006, 2007 and 2010

Member of the Editorial Board Mental Health Practice 2002-2008

Member of the International Association for Suicide Prevention (IASP) 2002-

Consultant to NHS Education Project - Prevention and therapeutic management of violence in adult mental health settings (2002-2005)

Scottish Government Representative on Department of Health Cross Government Working party on Violence in services for people with mental health problems 2005-2006

Member of the Scottish Institute for residential child care review group on physical interventions 2004-2005

Member of NHS Counter Fraud and Security Management Services Expert Reference Group 2004-2010

Member of the Editorial Board, Learning Disability Practice 2004-2014

Member of the review panel, Journal of Mental Health 2007-2016

Member of the review panel, Journal of Nursing Ethics 2008-2020

Organised (in conjunction with Cornell University). First International Research Symposium Examining the safety of high-risk interventions in human services. Cornell University, New York, 2005. Attended by 150 researchers, practitioners and policy makers.

Organised (in conjunction with Cornell University) Second International Research Symposium: Examining the safety of high-risk interventions in human services, University of Stirling, 2006. Attended by 150 researchers, practitioners and policy makers.

Member of the Forensic Psychiatry Research Group 2006-

Organised symposia on restraint reduction in services for people with mental health problems at the 5th European Congress on Violence in Psychiatry, Amsterdam, 2007.

Chair of the European Network of Trainers in the Management of Aggression (www.entma.eu) 2009-to date

Member of the UK Restraint Reduction Network Steering Group 2017-

Member of the Scottish Restrictive Intervention Reduction Network 2019-

Member of the Scottish Government Education Guideline Development Group. Management of behaviour that challenges in schools settings. 2019-2021

Member of the Scottish Residential Child Care Network 2021-

Member of the Reducing Rights and Safeguarding Children Group 2020-

Member of NNS Scotland NES PTSD Matrix review technical group 2021-

Awards

Fellow of The European Academy of Nursing Scientists 2010

Stirling University Research Enterprise Award. E-learning programme for the prevention of aggression and violence 2012

Lifetime Achievement Award. Improving Safety during Physical Interventions. Conflict Professionals Network 2012

Lifetime Achievement Award. British Self Defence Governing Body. Contributions to Restraint Reduction. 2016

Honorary Fellow of the Faculty of Nursing and Midwifery of the Royal College of Surgeons of Ireland 2021