First Report of Mr. Jon Collier

Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017

FIRST REPORT OF MR. JONATHAN COLLIER, HMPPS – 14 JANUARY 2022

77. Mr Tulley narrates to the camera a conversation with another DCO, named only as Dan, where he makes racist and inappropriate comments. This includes how on a trip to America he was going to miss Cleveland because it has a high black population and he doesn't like blacks. When asked why, he said 'don't like blacks'.

78. There is no mention of challenging these comments or reporting what was said, although he mentions a manager walked past and said nothing. All staff are expected to challenge inappropriate behaviour and report any form of racist or discriminatory behaviour. A conversation takes place on the restraint involving D149 and that it was a 'messy restraint', 'he fought', 'kicked off in cell' 'made threat to kill'.

Good practice

79. There was a justifiable reason to move D149 based on the security information. DCM Loughton made numerous attempts for D149 to walk to the CSU and rightly organised for a planned intervention if all efforts were not successful.

80. The planning for an intervention followed all procedures as documented in the UOF training manual and PSO 1600, the only omission was recording the briefing.

81. D149 was a difficult and challenging detainee who made several attempts to assault staff by kicking and knee striking and was verbally abusive and threatening toward staff. They maintained a professional approach despite the difficulties encountered.

82. It was good practice to stand D149 outside of the CSU room as an effort to de-escalate the situation.

Areas of concern

83. The inexperience of some staff was evident from the footage and at times they lacked an understanding of how to manage the situation. DCM Loughton assisted on several occasions, notably with the application and then removal of handcuffs.

84. Once it became evident that this was complex and difficult removal consideration could have been given to summoning additional experienced staff. The original purpose of staff in full PPE was for entry into a room where the detainee could access potential weapons, or that being in close confines the potential for injuries during the

initial restraint are more likely. Support staff did not require PPE once D149 was out of the room and in handcuffs.

85. Once it became apparent the handcuffs were not applied correctly they should have been re-applied. This may have been difficult at the time but would have assisted staff later during the movement.

86. The relocation process was not carried out with any degree of understanding and D149 D149 was kept in the prone position for longer than was necessary. Although not a deliberate action the inexperience of staff could have prolonged this position, which is highlighted within UOF training as a medical risk. The misapplication of the leg restraint was potentially injurious and although using the technique was justified and reasonable the ability of the officer to perform it correctly highlights a training need.

87. The procedure for exiting the cell did not follow training and once the handcuffs are removed the staff appear unsure of how to execute a safe exit. When instructed to apply a figure four leg restraint the officer is positioned incorrectly and tries to compensate by forcibly pulling on the legs. At one point the feet appear to be twisted, which caused pain to D149. Eventually they talk the officer through the technique, which does not have any painful effect on D149

88. Prolonged restraint in the prone position is identified within the medical DVD and practical training of being a high risk. The time spent on this occasion in the prone position was extended as staff were incompetent in their execution of the relocation technique.

89. When staff apply a Pain Inducing Technique (PIT) they should have followed the guidance for use within the UOF training manual[42], giving a verbal instruction, explaining what they would apply (PIT), repeat the instruction before applying for no more than 5 seconds. None of the above commands are heard. The use of a PIT was reasonable during what was a difficult restraint involving a detainee who constantly attempted to unbalance staff and even tried to kick out at them.

90. The office conversations involving Mr Tulley included a reference to a colleague using racist and inappropriate comments. These instances must be challenged and reported through the appropriate channels. Staff have a duty to report inappropriate

[42] Section 7, pp. 185-198

CJS0073777[47] (CCTV)

112. Although the footage is in reverse order, ending first then onto the initial entry into the room, it covers the whole movement and relocation into the CSU. It also provides evidence of handcuffs being maintained throughout and that D1914 was upright and walking whilst supported by staff.

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113. The footage includes staff preparing for the intervention and Mr Tulley asking colleagues how the shield is used. I find this strange as he would have been taught this on his Initial training course. The response was technically incorrect and seemed to imply that the bottom edge is deliberately used against the detainee. The correct application is for the shield to be held at approximately 45 degrees, but the bottom edge is not supposed to drive into the areas stated-between the knees and throat. The flat of the shield should make contact in order to control the torso whilst colleagues isolate and control the arms. This is taught to staff during UOF training in the planned intervention section of the syllabus.

114. The briefing by DCM Dix is covered and there is reference to D1914 having undergone triple by-pass surgery.

Areas of concern

115. My first concern is why it was decided for full PPE be issued for this incident. The fact it is a planned removal does not automatically result in PPE being issued, each situation should be individually risk assessed and a decision made if PPE is appropriate. If it was assessed as necessary, I would ask why the helmets were not removed before moving through the centre when it became clear D1914 was not offering any physical risk to staff. The evidence seen does not in my opinion give cause for PPE to be required.

116. As a non-medical person I observed what in my opinion was an unwell man being reluctant to move. I appreciate the requirement to move him but feel more time sitting him down and trying to explain the situation should have been adopted. Any physical restraint on someone with health issues carries a risk and should be only

[47] Disk 51 27May2017 2129
[48] dated 27/05/2017

when all other options have been fully exhausted. The presence of healthcare somewhat mitigated the risk but considering the health factors force should have been delayed until other attempts had been fully exhausted. My opinion is that staff should have continued with the persuasion and negotiation and looked at trying to move D1914 without applying UOF techniques as in my view they were not reasonable in the circumstances due to no apparent risk being presented. Force in this instance was not the last resort as more efforts should have been made to gain compliance and was not a reasonable or proportionate to the circumstances based on the condition of D1914

117. The description of how to use a shield was incorrect and appeared to imply that staff use the bottom edge to deliberately target specific areas of the body with the shield edge. Correct training is for a 45 degree angle initially before covering the torso and any weapon arm, if applicable. The technique described would carry a high risk of injury and does not reflect training in the use of a shield, which has been medically approved and authorised for use as part of a three-officer team. By deliberately trying to inflict pain in this manner amounts to excessive and pre-meditated force being used than is disproportionate and not necessary. If this type of message is cascaded amongst staff it quickly becomes accepted practice. Training must explain the correct use of a shield and highlight it acts as a defence for staff, not an offensive tool.

118. I am not sure why the footage from Disc 50 CAM 3 froze at the point of exiting the room.

Summary

119. *Lawful under Detention Centre Rule(s)* - Rule 43 (10).

120. *Last resort* - Using force was not the last resort as there was ample opportunity to continue with dialogue and engage with D1914. His flight was not until the next day and if they did not want to risk any attempts at postponing his removal they could have continually engaged and observed him.

121. *Necessary, reasonable, proportionate* - The deployment of staff in PPE was not necessary or reasonable considering the health condition of D1914. Neither was using force to remove him under the circumstances listed above.

122. *No more than was necessary* - On this occasion the use of handcuffs was more than necessary. Consideration should have been given to the size and health of D1914, and to have an awareness of the risks by placing him in handcuffs with his arms behind his back.

123. Rule 41 (2) - provoke or punish a detainee – There is no evidence to support this.

124. My opinion and the reason for this incident being of high concern is that D1914 did not offer a level of threat to staff that justified their actions. If a full assessment had taken place prior to the intervention I would not have expected to see in full PPE. The force used was not necessary and more time should have been taken to try and persuade compliance with the Instruction to move. I am even more concerned at the lack of consideration for the condition of D1914 who appeared unwell and unlikely to present a safety risk toward staff.