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

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Introduction

1. I, Jonathan Stephen Collier, am currently employed within the National Incident Management Unit (NIMU) of HM Prison and Probation Service (HMPPS), and I produce this report within the wider scope of a review into a number of Use of Force incidents at Brook House Removal Centre. My report will contribute to the public inquiry into a number of concerns at the treatment and management of detainees at Brook House over the period from 1st April to 31st August 2017. My knowledge and experience are as a Use of Force (UoF) instructor and national lead for training delivery and development, and as an operational manager when responding to serious incidents. I act as the group's litigation and subject matter expert on all Use of Force matters and I have previous experience from assisting with external agency investigations within my field of expertise.

2. Full details of my expertise and experience are listed at the end of the report as Appendix 1.

3. In order to complete my report I have been provided with a range of evidence, both in written form and from CCTV/Body Worn Video Camera (BWVC) footage. Additional footage comes from a BBC reporter working within the centre, which was the subject of a televised documentary on national TV.

4. I have been provided by the Inquiry with access to material including:

    a. Home Office Professional Standards Unit investigation reports;
    b. G4S Use of Force reports and spreadsheets pertaining to UoF incidents at Brook House;
    c. G4S policy and procedure documents, management reports, training documents and risk assessments;
    d. Walk through videos and plans of the physical environment of Brook House;
    e. IMB logs and reports;
    f. Gatwick IRC meeting minutes and policies;
    g. Broadcast and unbroadcast BBC footage – full details of which can be found in Appendix 3;
    h. CCTV footage and footage from BWVCs/handheld devices – full details of which can be found in Appendix 3;

i. Detainee records; and

j. Complaints.

5. I have specifically been asked to provide my opinion[1] on the following matters:

a. Background to the UoF – i.e. setting out: (i) the legislative and policy context of UoF in detention centres; (ii) a summary of the approved UoF techniques; (iii) the governance/oversight of UoF in detention centres;

b. The standards to be expected between April and August 2017 of staff using force and/or control and restraint in immigration removal centres, with reference to: (i) PSO 1600[2] (ii) Rule 41 of the Detention Centre Rules 2001[3]; (iii) The Use of Force training manual version 2.1 (2015)[4] (the UOF training manual); (iv) Her Majesty's Inspectorate of Prisons: Expectations for immigration detention: Criteria for assessing the conditions for and treatment of immigration detainees (Version 4, 2018)[5]; (v) any other generally recognised standards and techniques; and/or (vi) training commercially available or available through government sources;

c. The training of detention centre staff in UoF/Control and Restraint (C&R), whether appropriately qualified staff were employed, and whether they received adequate training.

d. In relation to individual instances of UoF, whether: (i) the use of force was reasonable in the circumstances; (ii) the use of force was necessary; (iii) no more force than was necessary was used; and (iv) it was proportionate to the seriousness of the circumstances. I have also been asked to comment

[1] Letters of Instruction dated: 9 July 2021, 20 July 2021 and 14 September 2021

[2] Prison Service Order, Order 1600, first issued 31/8/2005: https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwi95L-NhOn0AhXKN8AKHRnBB5wQFnoECAMQAQ&url=https%3A%2F%2Fwww.justice.gov.uk%2Fdownloads%2Foffenders%2Fpsipso%2Fpso%2Fpso-1600.doc&usg=AOvVaw0YClZdsk0ai9905BRYEt7b

[3] The Detention Centre Rules 2001, UK Statutory Instruments, 2001, No. 238, Part III , Rule 41 - https://www.legislation.gov.uk/uksi/2001/238/article/41/made

[4] NOM00001

[5] Expectations for immigration detention: Criteria for assessing the conditions for and treatment of immigration detainees, Version 4, 2018 - page.138, paragraph 8: https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwjv3O3Hren0AhX6QkEAHY9cA-QQFnoECAgQAQ&url=https%3A%2F%2Fwww.justiceinspectorates.gov.uk%2Fhmiprisons%2Fwp-content%2Fuploads%2Fsites%2F4%2F2018%2F03%2FImmigration-Expectations-FINAL.pdf&usg=AOvVaw2FQ4LkU3M8gaLNJcRLe9XN

specifically on appropriate techniques and whether they were used in each instance.

e. The recording of UoF incidents and whether the individual incidents I have reviewed were appropriately recorded in the documentation.

f. Whether the UoF is subject to rigorous governance and oversight.

g. Examination of any particular or different considerations which apply when force is used or contemplated against individuals who are (1) under the influence of drugs, (2) attempting self-harm and/or (3) vulnerable for reasons related to mental illness.

Legal and policy framework underpinning the approach to this Report

Lawful application – Legislation- Policy

6. When reviewing the respective incidents I have referenced various forms of legislation to establish the lawful background to force being used. Even when force is lawful it must still be justified and only used when other methods of resolution have been tried and been unsuccessful, or deemed not likely to succeed, due in the main to the immediate risk or threat. The use of force must always be viewed as the last available option.

7. Within Use of Force (UOF) training in the custodial environment, and in line with the UOF training manual 2015 V2.1[6] (which was the system used by G4S at Brook House at the time), force must follow the general principles of it being:
   - *Necessary;*
   - *Reasonable in the circumstances;*
   - *Proportionate to the circumstances; and*
   - *No more than necessary.*

8. The first distinction to make is between force used in 'self-defence' (which can more easily be demonstrated to be 'necessary') and force used because someone has refused to obey a lawful order. It is not enough that a prisoner be given any 'lawful order' to do something and has refused to do so.

[6] NOM00001

9. It is important to take into account the type of harm that the member of staff is trying to prevent – this will help to determine whether force is necessary in the particular circumstances they are faced with. 'Harm' may cover all of the following risks:
    - *Risk to life;*
    - *Risk to limb;*
    - *Risk to property; or*
    - *Risk to the good order of the establishment*

It is clearly easier to justify force as 'necessary' if there is a risk to life or limb.

10. These principles have been adapted from The Criminal Law Act 1967.

Section 3 (1)[7] *of that Act provides:*

"(1) Any person may use such force as is reasonable in the circumstances in the prevention of a crime, or in the affecting or assisting in the arrest of prisoners or suspected prisoners unlawfully at large.".

The Common Law

11. The common law has always recognised a person's right to act in defence of themselves or others and has established a principle of "duty of care".

12. The UOF must be based on an honestly held belief at the time of the incident that it is necessary.

13. Detention Centre Rules 2001

Rule 40- removal from association[8]

(1) Where it appears necessary in the interests of security or safety that a detained person should not associate with other detained persons, either generally or for particular purposes, the Secretary of State (in the case of a contracted-out detention

[7] The Criminal Law Act 1967, UK Public General Acts, c.58, Part I, Section 3 - https://www.legislation.gov.uk/ukpga/1967/58/section/3

[8] The Detention Centre Rules 2001, UK Statutory Instruments, 2001, No. 238, Part III , Rule 40 - https://www.legislation.gov.uk/uksi/2001/238/article/40/made

centre) or the manager (in the case of a directly managed detention centre) may arrange for the detained person's removal from association accordingly.

Rule 41- use of force [9]

(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.

(2) No officer shall act deliberately in a manner calculated to provoke a detained person.

Rule 42 - Temporary confinement [10]

(1) 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.

Rule 43 - Special control or restraint [11]

(1) 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 detained person to be put under special control or restraint where this is necessary to prevent the detained person from injuring himself or others, damaging property or creating a disturbance.

(10) Except as provided by this rule no detained person shall be put under special control or restraint otherwise than for safe custody, to give effect to directions lawfully given for his removal from the United Kingdom, or on medical grounds by direction of the medical practitioner.

Rule 45 - General duty of officers [12]

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[9] The Detention Centre Rules 2001, UK Statutory Instruments, 2001, No. 238, Part III , Rule 41 - https://www.legislation.gov.uk/uksi/2001/238/article/41/made

[10] The Detention Centre Rules 2001, UK Statutory Instruments, 2001, No. 238, Part III , Rule 42 - https://www.legislation.gov.uk/uksi/2001/238/article/42/made

[11] The Detention Centre Rules 2001, UK Statutory Instruments, 2001, No. 238, Part III , Rule 43- https://www.legislation.gov.uk/uksi/2001/238/article/43/made

[12] The Detention Centre Rules 2001, UK Statutory Instruments, 2001, No. 238, Part III , Rule 45- https://www.legislation.gov.uk/uksi/2001/238/article/45/made

(1) It shall be the duty of every officer to conform to these Rules and the rules and regulations of the detention centre, to assist and support the manager in their maintenance and to obey his lawful instructions.

(2) An officer shall inform the manager and the Secretary of State promptly of any abuse or impropriety which comes to his knowledge.

(3) 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.

14. Immigration and Asylum Act 1999, Schedule 11 [13]

Powers and duties of detainee custody officers

2(1) a detainee custody officer exercising custodial functions has power—

(a) To search (in accordance with rules made by the Secretary of State) any detained person in relation to whom the officer is exercising custodial functions; and

(b) To search any other person who is in, or is seeking to enter, any place where any such detained person is or is to be held, and any article in the possession of such a person.

(2) The power conferred by sub-paragraph (1)(b) does not authorise requiring a person to remove any of his clothing other than an outer coat, jacket or glove.

(3) As respects a detained person in relation to whom he is exercising custodial functions, it is the duty of a detainee custody officer—

(a) To prevent that person's escape from lawful custody;

(b) To prevent, or detect and report on, the commission or attempted commission by him of other unlawful acts;

(c) To ensure good order and discipline on his part; and

(d) To attend to his wellbeing.

(4) The powers conferred by sub-paragraph (1), and the powers arising by virtue of sub-paragraph (3), ***include power to use reasonable force where necessary.***

Human Rights Act 1998 [14]

Article Two: The right to life

1. Everyone's right to life shall be protected by law…;

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[13] Immigration and Asylum Act 1999,UK Public General Acts, c.33, Schedule 11- https://www.legislation.gov.uk/ukpga/1999/33/schedule/11

[14] Human Rights Act 1998, UK Public Acts, C.42, Schedule 1 - https://www.legislation.gov.uk/ukpga/1998/42/schedule/1

15. Article Two imposes an obligation to take measures to protect a person if it is known, or ought to be known, that there is a real or immediate risk to life. This could include, for example, regular monitoring of a person. It also includes protecting people, yourself or another staff member from serious physical harm. In exceptional circumstances, it may be necessary to use force in order to meet the obligations under Article Two:

Article Three: Prohibition of Torture

No one shall be subjected to torture or to inhuman or degrading treatment or punishment

Article Eight: The right to respect for private and family life

16. This right includes the right to bodily (physical) integrity. In the context of physical restraint, this does interfere with a person's bodily integrity. However, the use of physical restraint will not breach Article Eight if it is used in accordance with the law and if it is necessary (for a democratic society).

UOF Training manual 2015 v2.1[15]

17. In addition to the legislation surrounding using lawful force there is a section from the UOF training manual specifically for managing planned interventions. Whenever possible any planned incident should follow these guidelines and incorporate the identified personnel to support the effective management and safety of those involved.

18. The recording of planned incidents is covered in the Role of a Supervisor section from both PSO 1600[16] and the UOF Training Manual 2015 v2.1[17]. Since the implementation of the training manual HMPPS have included BWVC into the prison estate as part of the safety in prisons initiative. They are promoted to act as an addition to other safety and rehabilitative measures being introduced. The policy that supports the use of BWVC is PSI 04-2017, which came into force on 20.03.2017. In

[15] NOM00001

[16] PSO 1600, p.11, paras 4.34-4.34 - https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwi_hvfWu-n0AhWi8bsIHZKOB8IQFnoECAUQAQ&url=https%3A%2F%2Fwww.justice.gov.uk%2Fdownloads%2Foffenders%2Fpsipso%2Fpso%2Fpso-1600.doc&usg=AOvVaw0YClZdsk0ai9905BRYEt7b

[17] NOM00001, pp.119-121, section 3.1

respect of their activation during UOF incidents the following guidance has been produced;

Where BWVC is deployed within a prison it must be used:

- *When a user has or may be required to exercise force against a person or persons (refer to para 2.8)*
- *When a user believes an interaction presents or is likely to present a risk to the safety of the user, other members of staff prisoner or other persons present*
- *When a user is responding to an alarm bell or Incident*
- *When a user considers the use of BWVC to be a necessary and proportionate means of recording any other interaction or event* [18]

The use of handheld cameras for planned interventions is covered in Annex F of PSO 1600 which states;

- *consider the use of a video camera to record the intervention and relocation.* [19]

Review section

19. I have been asked to review 43 use of force incidents. A large percentage of the incidents that have been reviewed are listed as failure to comply with removal orders or move to the Care and Separation Unit (CSU) on safety grounds for the Good Order and Discipline (GOAD) of the centre, or for removal from the centre. Other incidents involve the prevention of potential self-harm, although none involved actual acts of self-harm and use of officer personal safety techniques.

20. I have identified 22 key incidents because they demonstrate incidents where I have concerns. These included the original 19 prioritised for my review and 3 additions that became apparent at a later stage. A breakdown of the reasons listed for the key incidents:
    - 15 incidents for removing to the CSU on GOOD or non-compliance

[18] PSI 04/17, page 11,para 2.7; issue date 20 March 2017 - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/903462/PSI-2017-04-Body-Worn-Video-Cameras.pdf

[19] PSO 1600, p.40

- 3 incidents to prevent self-harm
- 2 officer using personal safety techniques
- 1 incident following a fight
- 1 to prevent assault on a third party

Key findings

Good practice

21. There are many examples of good engagement by staff, notably the DCM group, when trying to resolve difficult situations, especially removal for transfer from the centre. The tone and demeanour is mostly non-threatening and non-aggressive, but conducted with the correct level of authority. A good example is incident 164/17 managed by DCM Robinson, where he demonstrates a calm assertive figure during a particularly difficult situation.

22. Good de-escalation after the initial restraint and early removal of restraints once they are no longer required. An example being when releasing the head support position to allow the detainee to stand upright, which occurred during most interventions.

Areas of concern

23. Failure to activate all available BWVC during incidents, and when responding to a general alarm. Effective use of BWVC includes when pre-empting a difficult conversation or challenging situation and informing the detainee that the recording device has been activated for the benefit of both parties.

24. The lack of understanding between a planned and unplanned incident. Some incidents observed were actually planned, in that sufficient staff were in attendance and there was no immediate requirement to use force. The procedures set out in PSO 1600 and the UOF training manual should be adopted in these circumstances. Unplanned incidents follow a spontaneous, undetected action that requires force to be used with the available resources to prevent harm to an individual or to prevent serious disorder or damage. It is important that the type of incidents are recorded correctly to allow a detailed review of the range of incidents within the centre, and to highlight regular occurrences so that preventive measures can be adopted.

25. UOF documents not being fully completed with sections left blank. It is a requirement for all sections to be completed, especially confirmation that healthcare have assessed the detainee and that all incident documentation has been collated by the Orderly Officer. It should then be preserved as an evidence pack.

26. Lack of senior management presence during incidents as set out in section 4.34-4.35 of PSO 1600[20]. I did observe the equivalent of the Orderly Officer attend, but seldom observed any senior management grade in attendance. Senior managers should attend and take on the role of incident manager, allowing the DCM to supervise the actual UOF. This provides effective management oversight and governance.

27. The incident review system in place at the time amounted to no more than a 'tick box' exercise that's does not satisfy the process of assurance and scrutiny of incidents. There is a box for any learning needs or other further action, although this is rarely used. An example being incident 135/17 where the application of handcuffs was incorrect, which then caused problems when moving the detainee. This should have been identified as a training need for the staff involved.

28. No clear negotiation strategies in place during planned removals. I appreciate previous conversations would have taken place but at the time the DCM gives an instruction which if not complied with results in staff using force. PSO 1600 states 'It must only be used as a last resort after all other means of de-escalating (e.g. persuasion or negotiation) the incident, not involving the use of force, have been repeatedly tried and failed'[21]. Considering the number of planned removals a set briefing would allow a structured process to be used by all relevant staff. A strategy would provide consistency during the calming phase and seek to build a rapport before progressing to the persuasion for compliance.

29. Poor understanding and execution of techniques within the training syllabus, for instance the carry option, detainee in the supine position and moving up/down stairs. Both carrying and negotiating stairways present a risk to all involved. Poor execution of technique can result in injuries either from falls/trips or muscular injuries to staff.

[20] PSO 1600, p.11 -Role of a supervisor
[21] PSO1600, p.10, para 4.24

30. Lack of challenge to inappropriate and racist comments made in the perceived safety of offices, staff rooms.

Approach to my review of UOF incidents

31. It has been requested that the reviewed incidents are set out in order based on the severity of concern after reviewing the evidence. Each individual incident will include a comment on what the concerns are and why they have been set in the order of severity. For reference, the order of key incident logs I have reviewed below is as follows:

1. 105/17
2. 135/17
3. 134/17
4. 86/17
5. 81/17
6. 109/17
7. 186/17
8. 120/17
9. 400/17 or 137/17
10. [No UOF incident log] – D275
11. 114/17
12. 162/17
13. 164/17
14. 165/17
15. 129/17
16. 133/17
17. 142/17
18. 88/17
19. 153/17
20. 130/17
21. 136/17
22. 158/17
23. 174/17

Part 1

UOF Incident log (not recorded - possibly 105/17) - D1527

Detainee concerned: D1527

Date of incident: 25th April 2017

Documents available: No incident log completed nor are there any UOF documents available at the time of this report. If the incident is 105/17 however, a UOF report and staff statement completed.

Reason for force as listed on the UOF report: prevent injury to oneself, prevent self-harm

Background

32. A DCM, Steve Loughton, attended a constant supervision detainee and was informed by the DCO that he was in the toilet area and out of view. He entered the room and found D1527 curled up around the toilet with a ligature around his neck. After an unsuccessful attempt to remove it he used a fish knife to cut the ligature and then asked D1527 to sit on the bed, which he complied with.

33. This is the only document for this incident and if correct the only evidence I can use to describe the initial section of the incident.

Observations/Opinion

34. My report can only rely on the footage recorded covertly by Mr Tulley and listed as Disc KENCOV1007-BBC000071[22].

i. At 02:49 into the recording Mr Tulley moves toward a detainee residential room and shouts for staff assistance.

ii. 02:50 he makes reference to 'Steve', who I assume to be DCM Steve Loughton, and the ligature is cut and removed, although this is not seen on the footage. D1527 D1527 is then seen shouting and gesturing toward staff and stating 'I will die here'. Staff state that he has a battery in his mouth and they attempt to resolve the situation by persuasion. A voice is heard to ask 'call Oscar 1'. The healthcare staff are in attendance at this time. A comment of 'try to get him to take it out of his mouth' is heard.

[22] dated 25/04/2017

iii. 03:01 Mr Tulley engages in dialogue at the door with a fellow DCO named Yan. It appears that the room door is now shut.

iv. 03:07 Comments are heard to say 'he is calmer and that they think the battery has been removed'.

v. 03:09 the nurse engages in dialogue next to Mr Tulley.

vi. 03:13 the door is now clearly open and a white shirted member of staff is just inside the room. The male member of staff has a shoulder holster with what looks like a BWVC attached to it.

vii. 03:14 Voices heard to say 'don't do that, stop'. The footage then focusses on the officer Yan adopting a seated position alongside the head of D1527 who is in the supine position. The hands of Yan are around the throat and he is applying pressure through his fingers. He is then heard to say 'stop being a tool, stop being an idiot'. Staff are asking D1527 to calm down and then they decide to place him in the recovery position. Yan then says 'we are getting bored, are you man or mouse, stop being a baby'. The staff then adjust the controlling hold of **D1527** 's arms. After this the restraints are released and staff make observations from the door. Throughout the whole period of restraint D1527 is clearly distressed and letting out constant moaning/screaming noises and in this situation there should have had serious concerns for his health and well-being.

viii. 03:32 Mr Tulley has a conversation with Yan who says 'it's not C&R really, no need for UOF reports'. Later Mr Tulley states to a colleague 'it's Dixie's decision if we complete UOF reports'.

35. The initial actions of DCM Loughton when he identified the act of self-harm and took immediate action should be acknowledged. The footage then captures a physical restraint. This should have been recorded by either DCM Loughton, or whoever was the supervisor at the scene, on a UOF form as stated in PSO 1600[23], and all staff involved completing an Annex A statement[24], no matter in what capacity they were

[23] PSO1600, p.6, para 2.12
[24] PSO1600, Annex B, pp. 26-29

involved. It is unacceptable and not compliant with Home Office policy not to record a UOF. No UOF form was submitted for the follow-up incident involving DCO Yan Paschali, despite clear evidence that force was used and that he was not in isolation.

36. The force used by Yan Paschali does not replicate what is taught in training and is in fact a potentially dangerous and unlawful act. The medical advice provided to staff on all UOF training covers the medical risks associated with using force, and specifically applying any pressure to the head or neck area. I must question why colleagues and especially the supervising officer did not address this at the time and if necessary remove Yan from the incident. To my knowledge no other staff reported his actions at the time, and by not doing so they also fail to meet the expectations within the professional standards of staff.

37. If the white shirted member of staff did have a BWVC on their person it should have been investigated why it was not activated. It is positive that constant observations took place on D1527. However, the de-escalation dialogue by 'Yan' was totally unprofessional and should have also been challenged at the time. They did not help the situation or give any re-assurance to a young man in an obvious state of distress.

Documents:
CJS005534[25];
CJS001107[26]

Footage:
KENCOV1007-BBC000071[27]

38. I have seen the report completed by the PSU and the evidence provided is consistent with that provided to myself, with the exception of the staff interviews.

39. I note:

    6.11 staff colluding with the Nurse not to write up the incident as a UOF.

    6.24 DCO Paschali under interview gave an inaccurate description of the head support position when in the prone position. The head of the detainee is

[25] Use of Force Report for D1527, dated 25/04/2017
[26] Home Office Security Professional Standards Unit Investigation Report on D1527 by Investigating Officer Julie Galvin, 22 February 2018
[27] dated 25/04/2017

supported between the legs but the staff's hand is placed, not braced, on the forehead. This is to prevent the detainee banging their head against the floor. The chin is not touched when in this position as it would place the hands near the throat area.

6.25 DCO Paschali claims he was not digging his hands into the throat, they were static and if he was throttling someone the hands would move. This is incorrect, move strangles from above are performed with straightened arms and downward pressure. * Previously a defence from this type of attack was included within the personal safety training for staff.

6.38 The account of DCM Loughton is consistent with the footage and statements.

6.41 DCM Loughton left to write his report and had no knowledge of the events that followed, this would answer why he did not collate further UOF reports after completing his.

6.49 DCM Yates states he was unaware of force being used on D1527

7.52 A conversation between DCO Paschali and DCO Tulley regarding not completing UOF reports.

Good practice

40. The initial actions of DCM Loughton are commendable.

Areas of concern

41. The restraint was not managed and inappropriate and unlawful acts took place, both physically and verbally. The actions of Yan were dangerous and put D1527 at risk. The medical DVD[28] shown to all staff on UOF training includes information on not putting pressure on the throat, neck area during a restraint.

42. There is no reasonable reason for not completing UOF reports. All staff involved would be aware of their responsibilities and complete a statement even if a colleague tells them otherwise. It is a personal account and does not require authorisation from a senior member of staff.

43. If a BWVC was available, it must be activated. I would also ask why, considering the duration of the restraint, a handheld device was not considered and the DD not summoned to the scene.

[28] HMP000001 to HMP000004

44. I have previously provided an expert opinion on this matter to DC Stephen Trott of Sussex Police[29].

45. The three reports are dated: 06.02.18[30], 09.02.18[31] and 28.02.18[32].

46. Having reviewed these statements the only further evidence is the initial UOF report submitted by DCM Steve Loughton. This document describes the initial actions in removing a noose from **D1527** only. My first report dated the 6th February 2018 contains a more detailed account and summary of this incident. The two additional statements listed as Annex A and Annex B were prepared after reviewing footage and following the interview of DCO Paschali (Yan).

Summary

47. *Lawful under Detention Centre Rule(s)* - Rule 43 (1)

48. *Last resort* - The action to cut the ligature was correct and the only action available. I am unable to comment on the next phase where a restraint is initiated.

49. *Necessary, reasonable, proportionate* - The following restraint is not captured from the outset so I am unable to comment on how D1527 ended up in the supine position. The technique used by DCO Yan Paschali whilst controlling the head in the supine position does not meet any of the general principles, was disproportionate and potentially injurious.

50. *No more than was necessary*- as above, what is seen from the covert camera is more than was necessary.

51. Rule 41 (2) - provoke or punish a detainee - the language used by DCO Yan Paschali was provoking, disrespectful and unprofessional. In addition, they would cause further distress on D1527 who was clearly in a state of crisis and it could be

[29] SPX000133 – Full report of Jon Collier to Sussex Police (DC S Trott), 6 February 2018 (Annex A at SPX000130 and Annex B at SPX000134)
[30] CPS000002 – Report of Jon Collier, Head National Tactical Response Group on the use of force used on D1527 on 25 April 2017
[31] CPS000003 – Annex A to Jon Collier's report of 6 February 2018; 9 February 2018
[32] CPS000004 – Annex B to Jon Collier's report of 6 February 2018; 28 February 2018

interpreted that he was being punished by DCO Yan Paschali when you consider the language used.

52. This is the most concerning case based on the potential risk the technique used by Yan Paschali presented to D1527. Any pressure applied to the neck/throat area can result in serious injury and techniques of this type form no part of the restraint syllabus. In addition the professional standards expected of a DCO are not followed and the demeaning and insulting language heard bring the agency into disrepute. The failure of staff to provide documented evidence of their actions in a UOF statement does not comply with policy or their individual responsibility.

53. *References*

UOF training manual medical guidelines, section 1.4, pp. - 77 - 94
UOF training manual - Role of the Number 1, section 3.4, p.125
Detention Centre Rules 2001, rule 41 (1), (2)
PSO 1600

UOF incident log 135/17 – D149

Detainee concerned: D149

Date of incident: 31st May 2017

Reason for force as listed on the UOF report: maintain Good Order and Discipline, non-compliance, refusing to relocate to CSU

Staff involved: DCM Loughton, DCOs Webb, Edon, Tait & Freeburn.

Background

54. D149 was being moved to the CSU following an earlier incident where he took hold of DCO Tulley's keys. As an identified escape risk it was decided that he be relocated to the CSU. DCM Loughton had made an effort for him to walk to the CSU but received a negative response. Eventually a planned intervention was prepared with staff in full PPE and with a handheld and BWVC to record the incident. Healthcare staff were also in attendance but the initial briefing to staff was not recorded. After managing to encourage D149 out of the room it then became a stalemate with D149 refusing to move and was constantly asking 'for what reason'.

55. DCM Loughton then instructed the staff to forcibly move him. This proved to be an extremely difficult removal, with D149 constantly trying to drop his bodyweight and he made repeated attempts to kick, knee and trip staff. Handcuffs were applied and the despite their application the behaviour from D149 continued. Eventually he was located in the CSU using a full relocation technique. He continued to be verbally abusive and threatening toward staff, including the healthcare nurse.

Observations/Opinion

56. The incident was recorded on both a handheld device and BWVC. This footage demonstrated the difficulty staff encountered and the levels of resistance offered by D149. There was justification for locating him in the CSU following his attempt to take a member of staff's keys off them, especially when considering the security report of him being an escape risk.

57. It is clear from the UOF report and the footage that DCM Loughton made every effort to persuade D149 to walk to the CSU but eventually he was forced to summon staff for a planned intervention. There was a briefing to all involved but this was not

recorded. The planning covered all the necessary requirements, healthcare attendance, recording, and additional staff, although in this case only one extra member of staff was used.

58. The first part of the removal went well with D149 coming out of his room (D206) and moving to where he was instructed. After this he became non-compliant by refusing to move and kept repeating 'for what reason', DCM Loughton then instructed the staff to restrain him in order to facilitate the move.

59. The restraint proved extremely difficult and D149 continually struggled, he tried to hook his legs around the staff's legs and delivered knee strikes and attempted to kick out at staff. He then dropped his body weight, which made control even more difficult. When he was taken to the ground a fourth member of staff momentarily took control of his legs but even this was difficult. In my view the correct decision was made to apply handcuffs. DCO Fairburn struggled to apply the handcuffs and was assisted by DCM Loughton. Due to the constant struggle the handcuffs were not applied correctly and were put on in such a way that the effective control through wrist flexion on the right arm was not possible.

60. Throughout the restraint D149 made violent threats toward staff and was trying to intimidate them. He kept shouting 'get off, get off my hands' and intermittingly screamed as if in pain. This may be in some part to how the handcuffs had been applied. This was recognised by DCM Houghton at one stage but he was unable to adjust the handcuffs due to the struggle.

61. After several attempts at moving a discussion took place to adopt a carry position. This is an exceptional circumstance technique which is use for instances of this kind. Staff made a couple of unsuccessful efforts to get in a position to lift, but again due to the handcuff placement this was an impossible option. During their efforts D149 D149 screamed out in pain when his arms were trying to be manoeuvred for the lift.

62. Throughout this phase staff appeared unsure of what to do and lacked any direction, except when DCM Loughton intervened. From the UOF reports I note that DCOs Tait and Edon were only 5 months in service. At one point DCO Webb, who was on the left arm (although his report states the right arm, DCO Edon states he was right arm and Webb left arm) applies wrist flexion through the left arm. This caused a

reaction but the struggle continued once the application of pain had been applied. The correct procedure for applying pain was not evidenced on the footage or referenced in the UOF report.

63. As the move continues D149 says 'I will kill you' to staff and when the nurse tried to monitor him, he directed verbal abuse toward her.

64. The stair negotiation was particularly risky for staff and D149. They initially went down the first flight of stairs square on, which is potentially dangerous when dealing with a struggling person, they then adjusted their position to having D149 D149 with his back against the wall.

65. There is a point, and staff refer to D149 running out of energy, when the move flows freely and they arrive at the relocation room. The decision is then taken to allow D149 to stand upright. This is commendable given the earlier difficulties and evidence at the hope of de-escalation. Although the abuse continues it is only when a search of his pockets takes place that the struggle recommences. DCM Loughton rightly directs staff to a full relocation. This is a technique when the risk of releasing controlling holds is too great and the detainee offers significant threat to staff.

66. The relocation into the room in the CSU was poorly executed and the staff once again seemed lost and lacking in knowledge as to how to carry out the technique. Initially they manage to get D149 into the prone position but due to the inability of removing the handcuffs he is left in this position for a lengthy period. Considering the amount of energy he expended and the agitated state he was in this could have proved to be dangerous if constant monitoring did not take place. The positive aspect was healthcare on scene with emergency aid equipment. The nurse did enter the room but left after recognising she would be unable to measure his stats or examine any injuries.

67. 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

68. Almost immediately after the last member of staff left the room D149 was up on his feet and started shouting at staff through the observation panel.

Documents

CJS005650[33]

CJS000901[34]

69. Steve Webb reviewed the incident and I am shocked that he did not identify any training needs or lessons learnt. The staff involved clearly lacked experience in applying handcuffs and when carrying out a full relocation. No awareness of the medical risks with a prolonged restraint in the prone position have been identified and I can only conclude that this was a paper exercise that did not fully review all of the available evidence. If no additional training was provided a similar situation could have taken place at a later date that resulted in serious injury, or that unfortunately occurred in the past, a fatality. Prolonged restraint in the prone position has been identified by medical experts as a contributing factor in restraint related deaths. When used any prone restraint must be for the minimum period necessary and that constant medical observations are undertaken. At risk groups and those suffering from exhaustion (following a violent struggle) must be closely monitored, with an expectation staff communicate any concerns and act as described in the UOF training manual-medical emergencies. The incident supervisor would be aware of the risk, through UOF medical DVD, and made the necessary adaptations to the restraint and holds the responsibility for the welfare and safety of all involved. It was a necessary UOF to carry out a full relocation when considered against the threats presented by D149. If applied correctly it would have been proportionate but unfortunately the member of staff could not perform it as per the training received. Therefore it did increase a risk to D149 through incompetence rather than by being disproportionate.

Footage

CJS0073778[35]

70. This footage is from a BWVC, it also shows a handheld device in operation at the room door. The added benefit of audio confirms what staff state in their reports regarding the level of resistance and abuse/threats. It covers the whole incident up

[33] G4S Use of Force Report DC Rule 41 relating to D149 - 31/05/2017 at 17:16hrs

[34] Compilation of 'Use of Force review Meeting Forms' completed by Steve Webb on various dates ranging from 21/7/2017 - 31/7/2017

[35] Disk 52 UOF 135.17 BWC

to the relocation. At times the camera operator is poorly positioned and the footage misses what is actually happening. However, there is a handheld device also recording which does pick up the events.

CJS0073780[36]

71. This footage is from a handheld device and covers the start of the incident up to the relocation.

CJS0073781[37]

72. This footage from the same handheld device covers the last part of the relocation, where the staff exit the room.

KENCOV1027 BBC000359[38]

73. Mr Tulley reports that D149 took hold of his keys and tried to pull them. He asks about submitting an S.I.R and said that he should be located in the CSU.

KENCOV1027 BBC000362[39]

74. Discussing the restraint, Mr Tulley quotes 'he's only little', staff kitted up and he's not a nice bloke'. He again comments about the key incident and then says 'I thought they may have picked a bigger team'.

KENCOV1028 BBC000375[40]

75. Mr Tulley is again talking about the incident and mentions the behaviour of D149 D149 and that he 'flares up'. Mention of the Police in to look at the footage. Mr Tulley then asks a colleague 'did you get any digs in?' the reply was inaudible.

76. Yan then enters the office and a discussion around UOF takes place. They then discuss a restraint (not this case) and Yan says 'it was not C&R and not on camera'. They then discuss a colleague and his actions which Yan appeared to consider inappropriate and possibly resulting in dismissal.

KENCOV3042 BBC00617[41]

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[36] Disk 53 S2120002
[37] Disk 53 S2120003
[38] V2017053100010
[39] V2017053100016
[40] V2017060100017
[41] KENCOV3042

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

behaviour, including comments and personal viewpoints, regardless of where they are made.

Summary

91. *Lawful under Detention Centre Rule(s)* - Rule 40 (1), Rule 43(1).

92. *Last resort* - clear evidence of trying to conduct the removal without force by persuading D149 to walk from the room. Once outside he refuses to comply and verbally challenges staff. Force used after all reasonable efforts failed.

93. *Necessary, reasonable, proportionate* - the actual movement met all of the general principles and handcuffs were applied. The execution of the carry technique and the relocation were particularly poor but the decision to carry and use a full relocation were reasonable and proportionate to the threat presented by D149 toward staff.

94. *No more than was necessary* - the misapplication of the leg restraint and the difficulties in removing the handcuffs resulted in unnecessary pain and discomfort to D149, whilst not deliberate they amount to more force than was necessary due to the effect that they had on D149.

95. Rule 41 (2) provoke or punish a detainee - no evidence to support this.

96. The severity of this incident centres on the time D149 was positioned in the prone position during the relocation phase. There were problems removing the handcuffs and he is clearly in pain when staff attempt to apply the approved leg restraint in order to exit the room. The failure of the supervising officer to identify the misapplication of handcuffs, and the pain experienced due to this would also raise concerns over their suitability to manage incidents.

References

UOF training manual- use of pain inducing techniques (section 7), medical advice (1.4), relocation (section 11)

PSO 1600- medical advice (section 3)

UOF Incident log 134/17 – D1914

Detainee concerned: D1914

Date of incident: 27th May 2017

Reason for force as listed on the UOF report: failure to comply with removal, non-compliance, prevent self-harm

Staff involved: DCM Dix, DCOs Wragg, Paschali, Webb, Tulley, Bromley, Edon & Lake.

Background

97. D1914 was due to be transferred for a flight to Romania the next day and was required to be relocated onto Eden wing. D1914 refused to comply, and a letter signed by a medical professional confirmed he was 'fit to fly and fit for detention. He will need a medical escort due to the nature of his medical condition. I am happy for reasonable force to be used to facilitate the removal'.

98. Staff in full PPE carried out the removal, another team were assembled to assist with the temporary removal of his roommate. The footage shows DCM Dix open the door and the staff enter straight away. The roommate walks away with staff (no force used) and the staff then engage with D1914. D1914 refused to move and is forcibly placed in handcuffs then moved to the CSU.

Observation/opinions

99. The incident was recorded on a handheld device, with additional footage from CCTV. The original decision to move D1914 for his transfer from the centre was justified and there was a medical letter stating he was fit for travel and for reasonable force to be used. From the account of DCM Dix earlier attempts had been made for D1914 to comply. When the footage begins there is no communication or Instruction from the door and staff enter immediately.

100. Once the team enter they do not make contact with D1914, who is laying on a bed motionless. Attempts are made at persuading him to walk with the staff but he remains on the bed and eventually DCM Dix instructs the staff to sit him up. Healthcare staff then carry out some checks and confirm he is fit to be moved.

101. Whilst not considering myself a medical expert it did appear that D1914 was unwell and that at this point the requirement for staff to remain in full PPE should have been reconsidered. Although the intelligence reports may have presented a risk at the time he was only wearing a pair of shorts and did not appear capable of

presenting a significant threat to staff. PSO 1600- Role of a Supervisor (paras 4.34-4.34) - states the provision of PPE is optional. Each case should be judged individually and only when necessary should PPE be worn. Removing PPE as a de-escalation tool once the risk of injury to staff has been mitigated should follow the initial intervention.

102. After further attempts to persuade him to move DCM Dix instructs staff to restrain him so handcuffs can be applied. D1914 offers passive resistance only at this stage and drops his weight. He was of heavy build and was breathing heavy, which was a concerning escalation of events, and continued to shout/groan throughout the period where handcuffs are applied. D1914 and did not appear to have the energy to present a threat towards staff, he was more intent on avoiding being moved. He cries out 'please' on a couple of occasions before saying 'ok I'm good'.

103. Staff at one stage consider using a mobility chair to escort him to the CSU but this is rejected once he is stood up, although he does state 'I'm not feeling good'. At 11:39 into the footage the camera freezes and I could not observe any further footage of the relocation process form the handheld device.

104. I note on the UOF report front page that handcuffs were applied for 6 minutes. This is incorrect as the combined period in the room and the movement took longer and handcuffs remained until reaching the CSU room.

105. The CCTV footage shows the movement through a corridor and into the CSU. D1914 is in an upright position with staff still in full PPE. PPE should be removed at the earliest opportunity once it has been decided it is no longer necessary as a part of the de-escalation process. The locating into the CSU room also included a search and once staff exit the door is closed for a short period before healthcare enter.

Documents

CJS005651 [43]

[43] G4S Use of Force -DC Rule 41 relating to D1914 - date force used 27/05/2017 - 21:30pm

106. In addition to the standard UOF reports the document also includes a narrative of the briefing conducted before the intervention and the Doctor's letter that confirmed fit for travel and force being used if reasonable.

107. In their statements DCOs Webb and Paschali state that D1914 was abusive during the move and made racist comments. Nether DCM Dix or DCO Tulley mention this. DCO Paschali also mentions that he heard D1914 was going to obstruct staff and fight them. No other statements contain this information.

108. DCO Tulley mentions colleagues placing D1914 into the recovery position, no others mention this. DCO Webb does state that D1914 fell into the recovery position and healthcare were summoned into the room to carry out medical checks.

CJS000901[44]

109. Steve Webb review did not make any comment on lessons learnt and he found that the force used met the standard of being necessary, reasonable and proportionate.

Footage

CJS0073775[45] (Handheld device)

110. This footage was from the incident debrief conducted by DCM Dix with all staff who had been involved. No issues raised and no injuries reported. The description reflected that observed, namely D1914 dropping his weight, went to ground and handcuffs used.

CJS0073776[46] (handheld device)

111. The footage covered up until 11:39 on the camera recording when it then froze. This was as staff were removing D1914 from his room before relocating in the CSU.

[44] Compilation of 'Use of Force review Meeting Forms' completed by Steve Webb on various dates ranging from 21/7/2017 - 31/7/2017

[45] Disk 50 UOF 134.17 CAM 2

[46] Disk 50 UOF 134.17 CAM 3

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.

KENCOV1025 BBC000092[48]

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.

UOF Incident log 86/17 – D2159

Detainee concerned: D2159

Date of incident: 5th April 2017

Reason for force as listed on the UOF report: Prevent self-harm, medical observation, non-compliance

Staff involved: DCM Dix, DCOs Sayers, Murphy & Shadbolt

Background

125. D2159 had been refusing food and fluids and healthcare raised serious concerns over his condition. His room was unhygienic, with urine on the floor, and D2159 was not engaging with staff. He was to be moved so that a constant supervision could take place. Staff in PPE were instructed to restrain D2159 before handcuffs were applied. He was relocated with bouts of difficulty, mainly due to weakness from the lack of food or fluids.

CJS005529[49]

126. The decision to move to a location where constant supervision could be observed was justifiable considering his refusal to eat or drink, Detention Centre Rules 2001 R40 (1) for the safety of a detainee in particular circumstances.

127. I am concerned that despite the obvious physical condition of D2158 the DCM decided to put staff in full intervention PPE, including a shield. Given the health concerns and the unhygienic room my opinion is that staff should have been equipped with safety overalls and face masks rather than 'C&R kit'.

128. There is no evidence from the reports of healthcare engaging with D2159 or explaining what they planned to do in order to care for his wellbeing. If they did it should be recorded.

129. Once D2159 refused or failed to comply with the instruction, there is also the possibility that due to fatigue he may have been unable to engage, my opinion is that using a shield, even just to place against him, was not necessary, reasonable or proportionate to the risk at the time. Without being able to view any footage I cannot

[49] G4S Use of Force Form DCF2 DC Rule 41 - Detainee D2159 - dated 5.4.2017 timed at 1715

comment on the degree of force used with the shield, but I do not believe it was every necessary.

130. The restraints applied appear to be low-level but I do not agree that despite the route to be taken and the weakness of D2159 handcuffs were appropriate so that staff could support him. Moving along landings in a mobility chair and use of a lift, if available, would be more appropriate methods for moving a person suffering from weakness due to the lack of food/fluids. Alternately staff could simply support him without restraints.

131. F213 states he refused healthcare input and that no injuries were observed.

132. I have not been provided with any incident footage, despite the UoF form confirming that a camera was used.

133. Due to the physical condition of D2159 from a period of food refusal I am of the opinion that he presented very little, if any, threat to staff. I accept the unhygienic state of the room but using staff in full PPE, followed by the shield being placed upon him are completely disproportionate and unnecessary. A full assessment before the intervention would have identified the level of risk and the response should have been proportionate to that risk.

UOF Incident log 81/17 – D1234

Detainee concerned: D1234

Date of incident: 28th March 2017

Reason for force as listed on the UOF report: Failure to comply with removal, Non-compliance

Staff involved: DCM Dix, DCOs Sayers, Olayie, Rowley & Murphy- G4S

DCOs Winstanley, Haynes, Stevens, Lawson, Owen & Jones, Hann Driver, Maynard observer- Tascor

Background

134. D1234 was subject to a removal order on a charter flight and despite the attempts of DCM Dix for him to walk to the escort vehicle he refused. A team were assembled to carry out a planned removal and they were all issued PPE. After a further attempt failed the team were deployed into the room and D1234 stripped naked and started chanting. He resisted all attempts to control him and eventually handcuffs were applied. During the removal it was decided that the only method of moving D1234 was to carry him. He was carried by the staff and once they reached the discharge area he was handed over to Tascor staff. He was placed in a waist restraint belt and leg restraints were also used.

135. Tascor staff escorted D1234 to Stanstead airport but the flight was cancelled and he was returned to Brook House. D1234 complained of several injuries received during the restraint.

Observations/opinions

136. The initial decision to forcibly remove D1234 was to comply with the removal order and to have him escorted by Tascor staff to Stanstead Airport for a charter flight. All reasonable efforts were made and it is demonstrated through the footage when staff first enter the room that D1234 was not going to comply and resort to the extreme measure of removing his clothes to prevent his removal. This is all evidenced through the handheld camera use during the planned intervention.

137. Staff are then instructed to enter and control D1234 in order for the relocation to take place. At the time D1234 is sat on the bed shouting/chanting. DCM Dix then requested that the handheld camera move from the restraint to the

ceiling in order to preserve the decency and dignity of D1234. The last piece of footage is with the restraint taking place on the ground with staff controlling his head, arms and a fourth DCO controlling his legs. Attempts are made to wrap a sheet around him and once completed the camera returns to recording the actual incident.

138. There is no policy guidance for use of a handheld device but the policy, PSI 04-2017 BWVC[50] states that;

3.32 there may be occasions where a prisoner is either in a sensitive area such as the showers or is partially clothed but his/her behaviour is violent and aggressive and where the over-riding requirement is to record what took place. Such circumstances will be exceptional and in each case the accompanying paperwork must set out the justification for recording such images.

3.33 Where such footage contains intimate body parts, consideration must be given to pixilation of the footage where there is a need for copies to be made or for it to be made available for viewing as part of an adjudication. It is important that the master copy remains "un-changed" on the system.

139. The available footage presented did not comply with the above policy as there was not any pixilation.

140. Staff appear to be struggling to gain full control of the arms and the hand positioning of the head support officer is at times over the mouth and also making contact with the throat area. Wearing protective gauntlets can sometimes cause this impression and in this instance it did not prevent D1234 from communicating as he continued to shout, and the supervisor should have identified the risk and advised the member of staff of the correct hand positioning, and ask them to remove their gloves, or, have instructed the head support officer to re-position their hand as described in the UOF Training Manual 2015 v2.1- 'once you are satisfied that the prisoner is not going to ground and it is safe to do so, move your hand from the chin to the side/ top of the head'[51].

141. D1234 is in the supine position then sat upright to allow handcuffs to be applied. He struggles throughout and is intent on resisting any efforts to move him.

[50] PSI 04/17; issue date 20 March 2017
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/903462/
[51] Section 3.4: Teaching Points: Role of the Number 1, p.125

Once out of the room the staff pause and one DCO asks for his balaclava to be removed. It should not have been worn in this scenario as it is not within the authorised PPE listed in PSO 1600 for local interventions. Once removed the helmet was replaced. Under normal circumstances I would have expected all helmets to be removed, however if there is a risk of spitting the helmet full face visor offers protection against being spat at. None of the statements, or my observations, give evidence of the intention to spit. The removal of PPE after the initial restraint does not appear to be routine within Brook House as the footage for several incidents shows all PPE continually being worn throughout the removal.

142. The decision is taken to carry D1234 The UOF training manual contains guidance on how to carry a person in extreme circumstances, for instance when they continually drop their body-weight or hook their legs around fixtures such as railing/gates[52]. Carrying should only be used as a temporary manoeuvre and once it achieves its aim the detainee should be placed back on their feet. It is clear the staff have no understanding of how to follow this guidance and they end up in a carry technique that does not replicate the training delivered. Whilst all techniques have scope to be adapted to meet unusually difficult circumstances, there was no obvious knowledge of how to even prepare for the correct lift to take place. DCM Dix in his debrief states that there are lessons to be learnt from the incident.

143. Another concern is when going to ground staff appear to be pushing D1234 D1234 head down. This is not consistent with controlling the head and could present a risk of injuries to the neck area and possibly making contact with the floor. It is not necessary and is excessive use of force which should be identified by the supervisor and stopped immediately.

144. When the move reaches the discharge area Tascor staff are waiting to take over. The first action was to remove the handcuffs and move them to the front. The footage later shows that the handcuffs were wrongly applied and resulted in one wrist being almost fixed in a flexed position. This results in every movement from the handcuffs causing pain and potentially causing damage to the wrist. Once the handcuffs have been applied the waist restraint belt is applied. And conversations also mention the leg restraints. Throughout the application of the restraint devices D1234 struggles and shouts. The last piece of footage sees him being put onto

[52] Section 10.79 – Moving a prisoner against their will, pp. 232-234

the vehicle. At this point the footage ends. I am aware that all vehicles have recording facilities and at present I do not have any footage from inside the vehicle. The CCTV footage freezes as the escort staff take over.

145. The removal from the room to the discharge area was particularly difficult and made more so by D1234 removing his clothes. Staff did all that could be expected in preserving his decency and did try to make every effort for compliance by interacting with D1234 and trying to explain the process. There were several areas of concern over their ability in applying some techniques and this should have been addressed for their personal development and as a lessons learnt exercise.

146. I note from the report submitted by Rhiann Gilbert, HOM002495[53], that she viewed the briefing. This was not available of the footage I received. The post-incident debrief by DCM Dix was included, CJS0073731[54].

147. The Tascor staff reports all confirm that they received a verbally challenging detainee who resisted all restraints and attempts to move him. They applied a rigid bar handcuff (RBH), which at the time were not available to G4S staff, and then removed the G4S handcuffs before applying the waist restraint belt (WRB). The WRB has been developed specifically for escorts and is only provided to authorised detainee escort providers. During the move onto the vehicle the RBH was used to apply pain-compliance when D1234 spat at staff, knee struck staff and resisted the movement. There is no mention of pre-warning him that the pain-inducing technique would be used, as per training within the HOMES manual. Along with the WRB leg restraints were also applied. All of these restraint aids are approved through the Home Office for use by escort staff.

Documents

HOM002495[55]

HOM002486 [56]

HOM002496[57]

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[53] INQ000050 - Report on use of force incident involving D1234 on 28/03/2017, completed by Rhiann Gilbert, NTRG, dated 26/09/2017

[54] Disk 23 S1940004

[55] Report on use of force incident involving D1234 on 28/03/2017, completed by Rhiann Gilbert, NTRG, dated 26/09/2017

[56] Tascor Use of Force Report Forms for incident involving D1234 on 28/03/2017, dated 28/03/2017-30/03/2017

[57] Use of Force and Incident reports regarding incident involving D1234 on 28/03/2017

148. There is no incident review within the available documents. The lessons learnt mentioned by DCM Dix have not been recorded elsewhere or is there any detail on what they were and how they were addressed. I would expect to see individual staff development through training and mentoring for those identified through the review. Failure to address poor practice could lead to further failure when required to use force, resulting in a risk of injury to detainees, and to staff carrying out their responsibilities professionally and effectively.

CAP000519[58]

- Force justified after repeated attempts to comply with the move.
- Handcuffs applied whilst seated, which had been removed from the manual.
- The carry was justified due to not walking.
- There were proportionate staff deployed to manage the restraint.
- The injuries reported are consistent with resisting restraint.
- D1234 only complied with getting dressed after his flight was cancelled.
- The complaints are unsubstantiated.

CAP000521[59]

- Recommendations - 8.7.2 plus one other

CAP000529[60]

- Recommendations 8.6.1 & 8.6.2 correspondence on the application of head support technique.

Footage

CJS0073730[61] (handheld device)

Coverage of the initial entry, the restraint, movement and handing over to Tascor staff.

CJS0073731[62] (handheld device)

The debrief by DCM Dix

No footage available of the briefing.

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[58] D1234 - Home Office PSU letter sent to D1234 (served to file) in response to his complaint against officers at Brook House IRC and TASCOR about an incident that occurred on the 28/03/2017; letter dated 04/10/2017

[59] D1234 - Tascor email on the outcome and recommendations of the professional standards unit investigation on the allegation made by D1234 of use of excessive force during his removal From Brook House to Stansted airport on 28/03/2017; email dated 09/10/2017

[60] D1234 - Tascor email on the follow up on the recommendations from the PSU investigation into D1234 complaint of use of excessive force during removal from Brook House IRC on 28/03/2017; email dated 16/11/2017

[61] Disk 23 S1940003

[62] Disk 23 S1940004

CJS0073732[63]

Times the period between entry into the room to coming out at 06:53. The footage freezes at the handover point.

Good practice

149. The initial restraint is justified in order to remove under the removal orders. The staff faced a difficult and challenging detainee, made more difficult by him being naked.

150. Good attempts at de-escalation were made and DCM Dix gave clear and concise instructions and numerous opportunities to comply.

Areas of concern

151. There is a problem with applying the handcuffs and staff did not demonstrate a working knowledge of how to use handcuffs. A period was spent in the seated position. This should have been avoided in line with training advice in the medical section of the UOF Training Manual (section 1.4).

152. The carry technique was poorly managed and executed. The staff appeared unsure on what to do and they clearly could not recall the training delivered for this technique. If staff did not understand how to apply the lift the supervisor should have considered alternate options, including replacing team members if practicable. Before attempting a lift the supervisor must ensure all staff are confident and physically capable of carrying it out.

153. The wearing of a balaclava should not have been allowed, I do agree that maintaining full PPE was justifiable due to the threat of spitting. The supervisor is also responsible for monitoring the techniques applied and should have addressed the excessive pushing down on the head of **D1234**. This was disproportionate and not necessary or reasonable and could have caused an injury to the detainee.

154. The Tascor staff rightly applied the restraint devices available to them. They must carry out and document the correct protocol for applying pain-inducing techniques as directed in the UOF Training Manual (section 7), this includes giving a verbal instruction and warnings that PITs will be used.

[63] Disk 24 28March2017 2013

155. Handwritten reports are not ideal, and efforts should be made to have all completed electronically. The quality of writing make it difficult to read and electronic versions are easier to provide to investigations or reviews. It is not a policy requirement but an example of good practice.

156. Briefing should be recorded on a handheld device, such as video camera or BWVC, not available at this time.

157. No post-incident review is not acceptable and should be addressed.

Summary

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

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

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

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

162. Rule 41 (2) provoke or punish a detainee- no evidence to support this.

163. The PSU report supports my summary regarding the last resort and that handcuffs were a necessary and proportionate UOF. The carry was also justified as were the number of staff involved.

164. There is some confusion over the technical application of the head support position, however this is more a learning issue and does not impact on my assessment of force.

165. I note the PSU comment regarding Tascor staff not wearing BWVC and have addressed this within my recommendations.

166. The misapplication of handcuffs and the failure to properly carry out the approved carry technique lead this incident to be of concern. D1234 was placed in a seated position for a period of time in order to be handcuffed. This was removed from the 2015 Training Manual due to the risks of encountering breathing difficulties when bent forward.

References

UOF training manual- moving a person against their will (section 10.6) - head support position (section 3.4) - medical advice (section 1.4)

HOMES training manual- application of Pain-inducing technique

PSO 1600 medical advice – role of supervisor (section 4.34 – 4.35)

UOF Incident log 109/17 – D191

Detainee concerned D191

Date of incident: 27th April 2017

Reason for force as listed on the UOF report: Good Order and Discipline, protect a third party

Staff involved: DCM Webb, DCOs Bessaoud & Lainchbury

Background

167. Staff were alerted to sounds of shouting and screaming and found D191 acting bizarrely. They moved other detainees but D191 then struck a detainee on the head with a remote control. Force was used to prevent further risk of harm and they escorted D191 to the CSU. Healthcare attended and noted minor injuries.

Documents

CJS000902 [64]

168. Completed by Steve Webb, who was involved? If correct this is not good practice and opens up a conflict of interest and impartiality. A suitable alternate person should have been handed this incident to review.

CJS005549 [65]

The form is not signed by the orderly officer.

DCM Webb-left arm

DCO Bessaoud-right arm

DCO Lainchbury- head

169. All give similar accounts- responding to noise from room and observed D191 D191 acting bizarrely. They moved some detainees then D191 struck a detainee with a remote control. Force initiated to prevent further assault and to move D191 to the CSU.

Footage

170. CJS0073745 [66]

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[64] Compilation of 'Use of Force review Meeting Forms' completed by Steve Webb on various dates ranging from 17/7/2017 - 18/7/2017

[65] Use of Force - DCF 2 in relation to D191 dated 27/04/2017; Report Of Injury To Detainee dated 27/04/2017

[66] Disk 3 UOF 109 17 27Apr2017 1809-1821

171. The footage covers the residential landing and at 02:13 (footage time) DCM Webb and other staff arrive on scene and then enter the room. Other detainees appear to exit and at 03:17 DCM Webb appears at the door then re-enters shortly after. At 06:11 the staff are seen leaving the room with D191 restrained by two staff in a final lock position. This is a technique that used wrist flexion to control the arm and can be used for applying pain when necessary. The third DCO, Lainchbury, is opening doors and gates as they move from the landing and through toward the CSU. On reaching the CSU the locate D191 into a room and leave the scene.

Observations/opinions

172. I have several concerns regarding the management of this incident. When staff arrive at the room I would have expected DCM Webb to have activated his BWVC and also alerted other staff of the incident. At no time do other staff attend, even when moving from the wing. Healthcare are not in attendance and this would cause a risk if during the restraint a medical emergency, or injuries, occurred. I question why handcuffs were not used and that the continued use of wrist flexion was maintained, and importantly maintained when moving down stairs without adopting the correct procedure. When moving down stairs additional staff are required to act as 'anchors' against the base of the team when moving either up or down stairs. If staff lose their balance or if the detainee starts to struggle they would create an anchor to prevent falling.

173. The movement down the stairs did not replicate the technique delivered in training and should have been better managed. When relocating D191 into the CSU he is not seen straight away by healthcare and the staff simply walk away. At no time does the duty director attend and there is little in the way of supervision.

174. Based on the staff accounts the initial use of force was justified for the prevention of harm to a detainee and to remove D191 from possibly creating further problems. The staff identify his behaviour to that of someone under the influence of an illicit substance. I am aware that during this period the drug known as 'spice' was rife within the centre and several detainees demonstrated symptoms attributed to taking this substance.

175. The failure to activate a BWVC was not acceptable, especially when in the room during the initial restraint, and out of CCTV coverage.

CJS002741 PSU investigation[67]

176. The investigating officer highlights the similar issue I have regarding the activation of a BWVC, which would clarify the situation as described by the staff involved. The additional interview with a second detainee provides a valuable third-party perspective of the incident.

> 7.1.23 a second detainee confirms the staff statements that **D191** was acting bizarrely and struck him on the head with a remote control. This action made it necessary for staff to use force. The actions did not appear out of place to the other detainee.
>
> 7.1.27 confirms the restraint used and **D191** being walked whilst stood upright, not dragged as reported in his complaint.
>
> 7.1.34 No note of a complaint the following day about an injury to his wrist caused by excessive force when applying wrist flexion.
>
> 7.1.52 Unsubstantiated claim of excessive force and inappropriate segregation. The officers acted in accordance with training, policy and procedures.

177. I agree with the conclusions of the investigating officer, which are further justified when taking into consideration the third-party evidence.

Good practice

178. The initial UOF appeared justified by being reasonable and proportionate in the circumstances when based on the staff statements.

Areas of concern

179. There were several failings in managing the incident, specifically by not summoning assistance, having healthcare in attendance, activating a BWVC, the lack of support staff when moving on the stairs and a lack of senior managers. Whilst not altering my opinion on the UOF it failed to follow the procedures set out in PSO 1600 for an unplanned incident.

180. DCM Webb cannot review incidents where he is involved, this is a conflict of interest and should have been identified by managers.

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[67] Home Office investigation report for D191 dated 20/02/2018. Investigation into circumstances surrounding allegation that D191 was subjected to assault and ill treatment by DCOs and that he did not receive appropriate medical attention by A Hindmarch

181. The reports are brief and could contain more information. The injury to detainee form was completed approximately 15 minutes after the UOF concluded. Orderly Officer section not completed.

182. The technique used on the stairs was incorrect carried a considerable risk for all involved by either losing their footing or falling during the struggle. This would have been avoided by using additional staff, as directed in training, and using them as a brace for moving up/down stairs to secure the movement and to prevent falling.

183. DCM Webb failed to activate a BWVC when responding to the incident.

184. Healthcare attend and D191 was secured in a room within the CSU without being seen by healthcare as stated in PSO 1600.

Summary

185. *Lawful under Detention Centre Rule(s)* - Rule 43 (1)

186. *Last resort*- staff reacted to an incident and used force to prevent injury to a third party. Using force was the only option at the initial stage.

187. Necessary, reasonable, proportionate- force was necessary but I do not believe it was reasonable to maintain wrist flexion throughout when the use of handcuffs would have been a more suitable option, and that would present less risk of injury. Therefore, it was not proportionate to the risk, if as suspected the behaviour demonstrated was due to taking an illicit substance.

188. *No more than was necessary*- As above, in general no more than necessary but not necessary to continue with wrist flexion.

189. Rule 41 (2) provoke or punish a detainee- No evidence to support this.

190. The risk at this incident is around not applying the correct technique for moving on stairs. By not summoning assistance the staff are left with insufficient numbers to properly carry out the approved method for moving. This put D191 and staff at a risk of falling and should not have taken place until such time as additional staff were in attendance. Continuing with wrist flexion when the appropriate option of handcuffs was available resulted in unnecessary force used and a lack of de-escalation.

References

UOF training manual- role of a supervisor (section 3.1) negotiating stairs (section 10.3)

UOF Incident log 186/17 – D642

Detainee concerned: D642

Date of incident: 3rd August 2017

Reason for force as listed on the UOF report: Assault on staff

Staff involved: DCMs Yates &, Webb, DCO May

Background

191. Following an act of self-harm a group of detainees gathered around the scene when healthcare arrived to provide emergency treatment. As staff dispersed the group D642 became abusive and threatening toward staff and then threw water over DCO May and was restrained by staff. He continued to struggle and at one point managed to break free. Force was again used and D642 moved until he dropped his weight and stated 'he could not breathe'. Restraints were removed and D642 moved with staff to the CSU.

Documents

CJS005587[68]

192. No details have been recorded on the injury to detainee form, there is a healthcare input stating no injuries.

Footage

CJS0073719[69]

Observations/opinions

193. There is no available BWVC footage from the incident and although at least two DCMs were on the scene no activation of cameras appear to have been made. The wing CCTV shows two DCMs (white shirted staff) arrive on scene at 01:53 (footage time) and at 02:31 healthcare attend.

194. The incident attracted interest from other detainees and the scene quickly becomes crowded and based on the staff reports it was perfectly correct to disperse the group whilst medical attention was given to the detainee with injuries. A small

[68] Use of Force Report relating to D642 - 03.08.2017

[69] Disk 14 03Aug2017 CCTV

group appear to remain just outside one of the rooms, it is here that the restraint takes place at approximately 06:00 into the footage.

195. It is not clear on the CCTV if water was thrown but a DCO, who I assume is DCO May (blue shirt) then takes hold of a detainee in a white tee-shirt, who I now know to be D642 One of the DCMs, I assume DCM Yates, then assists DCO May and they are seen moving D642 from the landing towards a secure door that leads into a corridor. A group of detainees move along, following the staff, and they congregate around the end of the landing. The CCTV footage does not fully cover this area. Other staff, including who I assume to be DCM Webb, engage with the detainees and the situation appears chaotic and staff appear to be in danger of losing control.

196. Note* the evidence provided by CCTV moves from different period on the downloaded disk. Some of the timings do not correlate to the actual event times.

197. At 15:48 of the footage, staff come through a door at the end of the landing and into a corridor. As they come through they appear to have lost control of D642 and a further struggle takes place. DCM Webb then appears and takes control of the head whilst staff re-assert control of D642. As described in the statements D642 did go to ground and the restraints were removed. D642 then flicks between standing up and having face- face confrontations with staff, lying on the floor and sat in the corner of the corridor. This series of events, which also includes different staff attending and leaving, continues for approximately 11-12 minutes. After which they move from the corridor and eventually into the CSU (09:37 footage time) where D642 D642 is relocated.

198. There is no explanation within the UOF reports as to why the delay in the corridor took place and why there was a constant rotation of staff, it does not appear that all of the staff originally involved remained throughout the incident.

199. This incident seemed to escalate very quickly and the staff did well in removing D642 when faced with the challenges of a full wing of detainees. The force used initially appears reasonable and proportionate, if they assessed the behaviour of D642 D642 was a risk to staff and they had no other option of managing him. The restraint clearly fails when coming through the door into the corridor, hence losing control and having to re-engage with D642. It is not clear from the footage if any inappropriate

actions took place, based on what I could observe staff do appear to have used authorised techniques that were proportionate to the circumstances.

200. Healthcare did attend and staff followed the medical guidance when releasing the restraints on D642 after he complained of 'not breathing'. D642 complained of DCM Webb grabbing him around the neck, there is no visual evidence to support or deny this claim from any of the available footage.

HOM002694 PSU Investigation[70]

201. The investigation report confirms access to CCTV footage (5.10) of the incident that was reviewed following a number of complaints by D642

6.16 states that force was necessary to undertake the relocation and to maintain order. The force used was reasonable and proportionate to the resistance.

7.6 summarises the claims by D642 unsubstantiated.

202. Based on the evidence I reviewed I agree with the investigation report findings.

Good practice

203. It was re-assuring that the restraints were removed once the potential for a medical emergency became apparent.

Areas of concern

204. Any restraint used when a full landing of detainees being present carries the risk of escalating the situation. Consideration should always be given to the situation and how to avoid causing further issues by their staff actions. Carrying out a restraint in front of a wing full of detainees is highly emotive and has the potential to cause unrest within the detainee group. If the throwing of water was a potential start of further threats to staff then using force would be the appropriate. If it was a solitary action the risk of harm was no more than getting wet. DCM Webb states it was hot

[70] Home office investigation into the circumstances surrounding a complaint made by D642 that he was assaulted and verbally abused by detention custody staff at Brook House IRC, dated 24/10/2017

water, DCO May makes no comment over the water temperature. If it was hot I would have expected him to record the feeling of hot water on him.

205. Staff state they tried using guiding holds to remove D642. These are low level techniques and would possibly explain why D642 broke free when moving into the corridor. After this three staff, including DCM Webb apply correct restraints until D642 D642 went to the ground.

206. There is no obvious reason for the delay in the corridor. It seemed to take a long time to move D642, which could have heightened his anxieties and caused unnecessary stress. The lack of audio does not assist with evaluating what was happening, or the lack of information in the UOF reports.

207. Based on what can be observed on the footage there does not appear to be any use of techniques that were either inappropriate or disproportionate.

Summary

208. *Lawful under Detention Centre Rule(s)* - Rule 40 (1)

209. *Last resort*- Staff reacted to the throwing of water over a colleague. It is not evident from the reports if D642 continued to offer a threat.

210. Necessary, reasonable, proportionate- Necessary would depend on whether there was a further risk after the throwing of water. If so force would be necessary, if not then force would not be necessary. It was a proportionate response to use the techniques described to move from the wing.

211. *No more than was necessary*- All restraints were removed when D642 complained about not being able to breathe. After the restraints were removed no force was used.

212. Rule 41 (2) provoke or punish a detainee- No evidence to support this.

213. My concerns are for the initial justification for using force and the lack of evidence to support this decision. No BWVC activation from the DCM.

References

UOF training manual

PSO 1600 medical advice (section 1.4)

UOF incident log 120/17 – D687

Detainee concerned: D687

Date of incident: 13th May 2017

Reason for force as listed on the UOF report: Prevent self-harm and for refusal to transfer

Staff involved: DD Haughton, DCMs Donnelly & Farrell, DCOs Martin & Tulley.

Background

214. D687 was due to be transferred from the Centre and the escort staff from Tascor were ready and waiting for him to be handed over.

215. Staff observed D687 in the toilet of a holding room with a ligature around his neck that was tied to the fixture within the room. Staff were engaging with him but he was resisting any attempts to move from the Centre and stated that he would harm himself.

216. The Duty Director, Dan Haughton, attends and engages with D687 Seeing that D687 has an unlit cigarette he offers to light the cigarette and uses this as a ploy to move closer and initiate a restraint. After a short struggle staff gain control and handcuff D687, who is then moved in preparation for escort. DD Haughton states that he was in possession of a fish knife, therefore it is clear he had every intention of intervening and had the option of cutting the ligature.

Observations/Opinion

217. The only footage from within the toilet was from the covert camera operated by DCO Tulley. All other evidence is from CCTV and staff reports.

218. <u>CCTV footage - CJS0073760[71]– times from disc</u>

00:00 one member of staff at the door, which is ajar but when opens shows two staff in the room.

02:36 Two staff arrive, one in uniform the other in civilian clothes. I assume this is DD Haughton. DD Haughton enters the room and then comes out and moves out of shot and talks to another member of staff. He then re-enters. No healthcare are at the scene based on the footage reviewed.

[71] Disk 42 13May2017 1356

04:58 Force is initiated but the CCTV does not show inside the room. There are at least five staff in the room at this time.

05:50 DD Haughton leaves the cell and the holding room and returns at 07:00.

07:50 D687 is seen in handcuffs being escorted by staff with no additional force being used. The staff guide him for his own safety.

09:27 Healthcare staff arrive. The escort process then continues without force being used and the staff along with D687 exit the holding area.

BWVC footage from BBC000070[72]

01:59 footage begins at door

02:10 force initiated

02:11 'Ligature away' reported

02:12 D687 threatens to bite and spit at staff if they continue with force

02:13 Stood up in handcuffs and moved from room

219. The actual engagement with D687 meets the expectation of staff and they display a calm demeanour through this period whilst attempting to resolve the situation. Although he is clearly upset and frustrated by the whole situation D687 D687 is not offering any threat to staff but repeatedly mentions his intention to self-harm and tells them not to come near him. The actual drop from the ligature and the close proximity of staff would make an emergency rescue possible should it become life threatening by an act of self-harm. DD Haughton admits in his statement that he took a colleague's fish knife before entering the scene. As the most senior person present I would have expected that he would have taken a more strategic management overview of the situation as defined in the training manual as the incident scene manager. If DD Haughton is the member of staff in civilian clothes I would question why he left the scene whilst a restraint was ongoing.

220. The time period from entering engagement to intervention is approximately 11 minutes, although it must be taken into consideration that this is only the footage time and does not include the previous period where staff engaged with D687 before the BWVC operator arrived on scene. In order for force to be lawful it has to be when there is an imminent risk of harm and that all other options have been exhausted. The engagement should have continued with an aim for D687 to

[72] dated 13/05/2017; KENCOV 1016

remove the ligature and be escorted peacefully. It is accepted that the escort staff were waiting but negotiation and persuasion must always be the prime resolution option.

221. I am concerned at the actions of DD Haughton. Using subterfuge as a means to get closer can remove all trust that a detainee has in staff and will make future incidents more difficult to resolve. Additionally as the senior person he should not have become actively involved and should have taken a supervisory role, where he could monitor the staff and detainee. Due to the lack of immediate risk he could have ensured the incident was recorded on an official device and that healthcare were in attendance. This incident should have been managed as a planned incident.

222. The statements submitted by staff do not correspond to the actual events. DCO Tulley's view is that DD Haughton attempted to cut the noose with a fish knife, that D687 tried to prevent him from doing this and attempted to self-strangulate, was restrained to prevent self-harm and that DD Haughton then cut the noose from the hand rail. This is not evident from the available footage or within the statement of DD Haughton, who states 'the knot on the handrail came away, and I took the opportunity to remove the tee-shirt from around his neck, which came away without using the fish knife'. A few seconds after the force is initiated a voice is heard to say 'it's away'. Shortly after a further voice is heard to say 'ligature away'. During the footage from KENCOV1016 Mr Tulley describes the restraint and that DD Haughton tried to cut the ligature.

223. DCO Tulley also states that he controlled the legs of D687 A fourth officer to control the legs is only used when necessary and when the control is being compromised by excessive movement or resistance. It appears this was a routine application rather than for exceptional circumstances. The use of a 'leg officer' must only be when the situation requires additional control, for instance if staff are struggling to gain control of the upper body and the detainee is using their legs to prevent staff applying restraints. Any use beyond this is not necessary and more force than necessary. There is no evidence within the statements to suggest it was necessary on this occasion and therefore I conclude it was disproportionate to the threat at the time.

224. In the statement of DCO Farrell he states 'DCO Tulley was struggling with the right arm' as his reason for taking over control of the right arm.

225. Once under control handcuffs are applied and all restraints removed to allow D687 to be escorted in preparation for handing over to Tascor staff. The total duration for handcuff application was approximately 15 minutes. A positive aspect was the swift removal of restraints and allowing D687 to stand upright. This was captured by CCTV footage and is a good example of de-escalation, and an understanding of the medical risks of keeping a Detainee bent over when not necessary.

226. The reports submitted by staff could have given more detail, especially on how it was eventually de-escalated and the reasoning for their actions, for instance why DCO Tulley felt leg restraint was required, and did DD Haughton give an Instruction to use force, or did they simply respond to his actions. The use of handcuffs in situations of this nature is perfectly lawful in order to maintain control of a detainee whilst moving through the centre. All post incident documentation was completed by those involved and all state that they were in date with UOF training.

227. The review by Steve Webb, local UOF co-ordinator, did not highlight the actions of a DD to initiate a UOF, and in effect the incident was actually a planned intervention. Although D687 was making a threat of self-harm no immediate intervention was required. This would allow the correct planning and staffing resource to be assembled, including handheld camera, healthcare and support staff. The unplanned action demonstrated by the DD carries a risk of other staff being unaware of the intended restraint and acting instinctively, as opposed to a planned intervention where a briefing takes place and staff are identified for specific roles. Steve Webb did not mention the quality of the reports and ticked a box that they met expectations. In my view this area is concerning as there is room for improvement.

Documents-

CJS005652 [73]

CJS000901[74]

[73] G4S Use of Force DC Rule 41 relating to D687 force used on 13.05.17 at 13:54

[74] Compilation of 'Use of Force review Meeting Forms' completed by Steve Webb on various dates ranging from 21/7/2017 - 31/7/2017

Footage

CJS0073760[75] BBC000070 [76]

BBC000605 [77]

CJS001087[78]

228. The evidence available to the investigating officer, and the detainee for review, consisted of the covert camera operated by Mr Tulley and the CCTV footage from outside of the room, and the UOF statements from staff involved. The summary findings were that the force was necessary, reasonable and proportionate to the circumstances. There are comments during interview by DD Houghton that 'he didn't resist too much, moving around and moving his arms away from officers, not extreme violence'. DCO Martin states 'he was not a difficult man to restrain, he did not put up much of a fight'. I note these comments and the overall summary as they contradict the necessity to apply leg control as noted in my findings.

229. Two of the DCOs in attendance failed to activate their BWVC ref: 7.5.31-7.5.35 from the investigation report. The report then goes on to say the issues with BWVC carrying and activation have now been addressed. I have seen other footage where BWVC have not been activated and it would be interesting to see if the comment that 'non-use of a BWVC will now be challenged by security staff' has resulted in these failures being addressed.

Good practice

230. Staff were trying to negotiate from inside the cubicle and adopted a relaxed, non-threatening posture. They were ideally placed to respond if D687 carried out his threat.

Areas of concern

231. The incident was a planned incident, and should have been managed as described earlier, for the threat of self-harm, not to prevent an actual act of self-harm. The second reasoning for force was to facilitate a transfer. Whilst accepting the

[75] Disk 42 13May2017 1356

[76] dated 13/05/2017

[77] KENOV3025.docx

[78] Re D687 Home Office Professional Standards Unit investigation into the circumstances surrounding the complaint allegation by D687 that officers at Brook House used excessive force on 13 May 2017, were verbally and racially abusive during his detention and the mental healthcare was inadequate dated 20.2.18 (PSU investigation)

requirement to move D687 the attempts at a resolution through negotiation and persuasion should have been explored further.

232. I find the actions of DD Haughton inappropriate by offering to light a cigarette as a means to move closer and then initiate force. He did so without informing staff of his intentions, evidenced by their posture (arms folded, leaning against a wall) immediately prior to force being used.

233. It was unacceptable to not have healthcare in attendance from the time he was discovered with a ligature. They only arrive after force was used.

234. The review of report writing raises issues around the depth of review and the ability to highlight the concerns listed above.

235. The use of BWVCs do not appear to have been in operation at the time. This should be addressed in order to remain consistent with other custodial settings. The lack of a handheld camera for the incident is also not acceptable. G4S had protocols in place and they were not carried out by two DCOs -Ref PSU Investigation report.

236. Based on the evidence presented I have no concerns to raise with the application of restraint techniques, other than the unnecessary and more force than necessary leg restraint was applied by DCO Tulley. It is not explained in the UOF report why he made the decision to apply the leg restraint, although I do note he struggled to gain control of an arm and was replaced by a colleague. This may have resulted in trying to make amends for his inability in controlling an arm. I do question why a DD became involved in the actual application of force. With sufficient staff in attendance he should have taken a general management overview of the situation as described in PSO 1600 - Role of a Supervisor (section 3.1)

Summary

237. *Lawful under Detention Centre Rule(s)* - Rule 43 (1) to prevent a detainee injuring himself.

238. *Last resort*- I do not believe force was used as the last resort. My reasoning is that staff were engaging with D687 and it appears that once DD Haughton arrives he is intent on resolving the situation by any means possible, evidenced by him taking a colleagues fish knife and using a diversionary tactic to cut the noose. Staff

appeared surprised by his actions which lead me to assume there was no warning of his intentions. Negotiation and persuasion should have continued, especially as the incident was contained and not effecting the regime.

239. *Necessary, reasonable, proportionate*- Once the decision to end the incident was made the force used was proportionate in the main, with the exception of a leg restraint being used for no apparent reason. I do not believe the restraint was necessary in the first place as engagement was taking place and staff could react if the threat to D687 escalated.

240. *No more than was necessary*- The force used did not exceed that which was necessary, except the leg restraint. The application of handcuffs resulted in the restraints being removed.

241. Rule 41 (2) provoke or punish a detainee- No evidence to support this.

242. The means used to initiate force do not in my opinion represent the professional standards expected of staff, let alone a senior manager. The additional use of the leg restraint raises concerns as to why staff feel this is a default position when there is no evidence to suggest additional control was required. More time should have been given to address the needs of D687 and consideration for alternate ways of resolving the situation.

References

UOF training manual - role of supervisor (section 3.1)

UOF Incident log 400/17 or 137/17 – D390

Detainee concerned: D390

Date of incident: 5th June 2017

Reason for force as listed on the UOF report: Good Order and Discipline, Move to another centre, non-compliance

Staff involved: DCM Povey-Meier, DCOs Sayers, Bromley & Shadbolt DCM London- camera

Background

243. D390 was due to be moved to another centre and a team of escort staff were waiting to move him. Following a conversation with DCM Povey-Meier D390 stated he was not prepared to move as there were ongoing legal matter outstanding. A team were assembled and despite repeated instructions D390 refused to comply and was forcibly moved from the room.

Documents

CJS005624 [79]

CJS000903[80]

Footage

BBC000407[81] (Covert camera Mr Tulley)

CJS0073856[82]

244. Briefing by DCM Povey-Meier. Stated that all efforts at a compliant resolution had been made and that D390 refused to walk. Highlighted that there were suspicions that D390 had an escape plan. Staff introduced themselves and all stated they were in date with UOF training.

CJS0073857[83]

245. DCM Povey-Meier is at the door and appears to be talking to a second detainee (confirmed during briefing that a second detainee was located in the room) and

[79] G4S Use of Force record - D390 - 05/06/2017

[80] Compilation of 'Use of Force review Meeting Forms' completed by Steve Webb on various dates ranging from 9/8/2017 - 31/8/2017.- highlighted no injury report completed

[81] V2017060500013.docx

[82] Recorded Briefing: ACTIVE_33225385_1.mp4

[83] Recorded footage: UOF 137.17 (2).mp4

asking him to come to the door and follow the officers. Confirmed to staff that D390 was boiling a kettle, one of the team told him to be aware and asked to turn off the power. The door is then opened by DCOM Povey-Meier and the staff enter and arrest D390 by pinning him with the shield. The shield is quickly removed and D390 is walked from the room with staff applying guiding holds. D390 is saying 'why did you not speak to me', and when they move to the stairs he says 'I'm happy to walk'. The holds are maintained and one DCO says 'this is how it has to be done'. The removal continues until they are met by Tascor staff who then engage with D390.

CJS0073858[84]

246. Debrief check for injuries to staff.

247. The statements and the above footage confirm that a handheld device was used by DCM London. DCM Povey-Meier also has a BWVC on his utility vest.

Observations/opinions

248. A briefing is carried out that sets the scene and gives some of the background information on why D390 was refusing to move. These all surround legal challenges and the build-up conversations that resulted in a planned removal being authorised by the Director (name not clear). In his statement DCO Sayers states D390 D390 was 'willing to fight', this is also not heard from the footage but the sound is slightly distorted. Based on the information available there was justification to move D390 and he was given ample opportunity to comply with the Instruction. Staff from Tascor were on-site in preparation for the escort.

249. Once at the door there is no clear conversation between DCM Povey-Meier and D390. Instead he tries to persuade the second detainee to come to the door and follow the staff. He should have followed this with a further, and last, opportunity for D390 to walk from the room. No effort was made to open the room door and give D390 a chance to speak with DCM Povey-Meier face to face, instead he opened the door and sent the team in. They immediately pin D390 and then remove the shield. The events that followed show D390 to be calm and explaining his reasons for not complying with the removal order. Although the staff used minimum force, guiding

[84] Video recorded debrief; - UOF 137.17.MP4

holds, I believe it was not necessary and based on his demeanour he should have been released from holds and allowed to walk without force being used.

250. The entry into the cell was done with haste following the discovery of water outside the room and observations that D390 was boiling his kettle. There is mention from DCO Shadbolt of steam in the room, but the covert camera is not positioned to confirm this. The shield is quickly removed from the room and the staff exit shortly after with D390 held in back hammers, with his wrist inverted.

251. D390 is taken from the wing into a stairwell and staff are engaging with him. He appears upset with the circumstances and the number of staff in attendance but at no time does he sound or act violently or demonstrate non-compliance with the movement. The covert camera then moves from the relocation back onto the landing.

252. All of the staff statements are consistent that once controlling holds had been applied the assessment resulted in them being de-escalated into guiding holds only. The movement into the stairwell confirms this, and that the head support position was not adopted.

Good practice

253. The decision to use force to remove D390 was justified based on the circumstances and confirmation from the relevant departments for him to be moved. D390 was given the opportunity earlier to comply with the instructions but insisted he would not walk.

254. There was quick de-escalation once staff had entered the room and D390 was removed shortly after the staff intervened in an upright position.

Areas of concern

255. The concerns over why D390 was boiling a kettle could be contentious. On one hand he could have been simply making a hot drink, or he could have been carrying out an act of indiscipline. The presence of a puddle around the cell door and one account that mentions steam in the room would raise the concerns for staff safety.

256. There is no attempt from outside the door to persuade D390 to walk compliantly. All efforts are aimed at the roommate. The deployment of the team

without opening the door and engaging in the first instance is not good practice and does nothing to demonstrate all reasonable efforts had been made, or that force was the last resort.

257. The behaviour and compliance shown by D390 following the removal did not justify continuing with restraints and he should have been allowed to walk to the discharge area.

258. The staff reports could contain more information and cover the handover to Tascor staff.

Summary

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

260. *Last resort* - All reasonable efforts had not been made for D390 to comply with the instructions given. Further engagement should have been made before resorting to using force. Force was not used as the last resort.

261. *Necessary, reasonable, proportionate* - The force used was not necessary or proportionate in the first instance. Restraints were limited to guiding holds but even they were not necessary.

262. *No more than was necessary* - initial use of a shield was more than necessary as communication should have taken place first. The shield was removed shortly after once control was gained.

263. Rule 41 (2) provoke or punish a detainee - no evidence to support this.

264. This incident did not use force as a last resort and the team were deployed without any attempts at persuasion. My opinion is that once it became clear D390 was fully compliant and calm all restraints should have been removed.

References

UOF training manual

[No UOF incident log] – D275

Detainee concerned: D275

Date of Incident: 17th May 2017

Background

265. D275 was involved in a protest on the netting and national resources had been deployed to provide an intervention option for the silver commander. Local staff had been identified to either take a surrender or assist national staff once D275 was removed from the netting. The local staff were in PPE whilst located in a stairway when covert footage captured a number of comments.

266. The audio varies from clear to indescribable and I can only comment on what I picked up during my review.

KENCOV1019

V2017051700009[85]

01:51 – 05.22 Nothing

V2017051700010

00.00 – 01.31 Nothing

V2017051700012

03.35-04.27 DCO Tulley 'it was good to see Yan and Derrick at work, wrapped him up, under restraint'.

14.04-15.37 Nothing

V2017051700013

02.27-04.27 'full search under restraint, no guiding holds straight to finals, if not walk carry the cunt'.

06.52-08.47 Nothing

18.44-25.22 'will fuckin spray him, not Taser, tagged him, dirty protest, off in finals or figure fours as the nationals will be watching, if he fucks about face down'.

[85] TRN0000009

25.33-30.00 'went in at 0630 in morning, bashed the door down flash bangs went in then battered the fuck out of them-fuckin brilliant, Dogs went in, they squilled all the way up the staircase'.

V2017051700014
01.34-02.16 Nothing
02.17-08.07 'shit themselves, 3 left including the Director and Deputy Director'
08.33-08.49 'just banging a bin to be honest'.
09.12-09.41 'hear stories about people dying during restraint'.
10.09-15.25 'behind doors, they did last time'
19.04-20.25 'we have some real knob ends in at the moment, especially on A wing', 'black fellas think they're it',
21.23-21.31 'nationals gonna give em a beating'
29.36-30.00 'he's a prick, hopefully…'

V2017051700015
00.00-02.40 'didn't put up a fight, said I'm not coming, wrapped up, kept in locks, got off lightly'
03.05-04.40 'do we fill in UOF statements, guiding holds not recorded, no guiding holds will be figure fours'.
07.10-30.00 'spray em all, and drop em all', 'shouldn't get away with it', (regarding search and relocation) 'drop him, trousers and shoes off with figure four'.

V2017051700016
02.15-03.34 'slap some…'
07.55-17.09 'scrap the cunt, cant fuck about', 'that's our justification for throwing him in that corner, just got to grab him, that's my justification can't fight him on top of the stairs, can't see any cameras, fucking pussyholes'.
21.16-30.00 'Christian country and we got a Muslim as a manager'

V2017051700017
00.35-02.55 'they will do him if he got blades in his hands'
04.53-09.00 '...dicks on that wing', 'women at 4ft 6, what good are they, might be pretty, good at making tea, scrapping the barrel'
12.47-15.05 nothing
17.42-18.55 nothing

18.56-23.00 'can't say you got to snitch on your colleagues, do you think it was one of your lot who grassed on Babs, stick up for your colleagues, member of staff put a report in against ginge, yoga teacher put a report against me (DCO Tulley),
24.05-24.16 'bunch of cunts'
24.50-25.41 'Albanians watching porn (during Muslim prayers)'.

V20170517000018[86],[87]
00.15-17.04 'rag him, straight to floor and cuff him' (manager)-'if you try guiding holds or figure four he will pull his arms away and that's your excuse'. 'If his fist is clenched crack it (demos action), Mr Mandib (Mandibular Angle Technique) will work'. 'Got to go in hard, if you pussyfoot around you get hurt'. 'If he fucks bout head down and bang on the locks, it's Christmas time if he does'.
20.33-30.00 'I'm still fucking the cunt, the full you know'. 'Hurt him as well, he won't do it again'.

V20170517000019[88]
14.20-14.40 nothing
17.30-17.50 nothing

267. My concerns are over the obvious plan to use force, regardless of it being necessary, and the suggestion from a manager of how to justify using force as a result of non-compliance. The language and attitudes demonstrated by some staff are not within the professional standards expected.

[86] BBC000662 – KENCOV1019 - V2017051700018 – redacted.mp4, British Broadcasting Corporation
[87] TRN0000010

[88] TRN0000011

UOF incident Log 114/17 – D1527

Detainee concerned: D1527

Date of Incident: 4th May 2017

Reason for force as listed on the UOF report: Non-compliance, prevent self-harm, prevent injury to third party, prevent injury to oneself

Staff involved: DCM Dix, DCOs Bromley, Shauket & Yates

Background

268. D1527 was to be relocated to Eden wing (CSU) and when informed by staff he refused and tried to retrieve something from his pocket. Some reports state that he tried to swallow his phone, but was unsuccessful, and he raised his voice and had his fists clenched. Given his history of self-harm staff initiated force to prevent harm to himself and others. Earlier D1527 had staged a protest on the safety netting within a residential landing. Due to his actions he was to be relocated under Detention Centre Rule 40.

269. Once inside the room DCM Dix was met with an act of non-compliance and D1527 D1527 refused to relocate, despite it being explained to him why this was necessary. DCM Dix then reacted to what he perceived as a potential threat of self-harm or of harm to others.

Observations/Opinion

270. There is no footage available from within the room where the restraint took place. I find it unacceptable that although DCM Dix had considered this would be a problematic engagement with D1527, based on him taking three additional staff with him and following the events earlier on that day, that DCM Dix did not activate a BWVC. Potentially challenging conversations are a normal situation where pre-planned activation of a BWVC should be a routine procedure for staff.

271. Once confronted by the potential threat DCM Dix, after trying to explain the reasons for the move, initiated force and then removed himself whilst the three other staff applied the control. DCM Dix then applied handcuffs to D1527

272. This all appears to be consistent with training and force being applied lawfully and only when necessary. The application of handcuffs helped with the de-escalation process and D1527 was then stood upright and escorted to the CSU.

273. In his statement DCO Yates states that due to D1527 pushing against staff during the relocation he applied a thumb lock. If so, he should have applied the correct procedure for the application of a pain inducing technique as described within the UOF training manual (section 7).

274. In his review Steve Webb ticked the evidence from CCTV. This is only partial and from when staff exit the room and relocate D1527

Documents

CJS005530[89]

CJS000901[90]

Footage

CJS0073759[91]

275. The footage as downloaded appears to be formatted in reverse order. It is only late into the footage that the actual recording from outside of the cell on D wing appears. Earlier footage shows the movement through the centre and notably on the staircase.

276. The initial restraint takes place in a cell covered externally on CCTV. As with most CCTV footage no audio is available. Staff are seen entering the room and after a short period they come out with D1527 stood upright with handcuffs applied. He appears to be shouting whilst being supported by staff on either arm. Throughout this a male member of staff in a white shirt is making every effort to engage and explain what is happening.

277. 03:03 As they reach the stairway D1527 appears to be focussing his anger toward the DCO who is supporting his right arm. According to the statements this is DCO Yates. The white shirted DCM talks with him and eventually takes over control

[89] Use of Force Report form for D1527, dated 4/5/17 G4S Report of Injury to Detainee, by K. Churcher dated 4/5/17

[90] Compilation of 'Use of Force review Meeting Forms' completed by Steve Webb on various dates ranging from 21/7/2017 - 31/7/2017

[91] Disk 41 05May2017 1727

of the right arm. If this is DCM Dix he did not cover this in his UOF statement. In my view this an excellent example of removing a trigger from an already frustrated and angry young man. If D1527 did have an issue with DCO Yates the decision to remove him would be a sign of co-operation and that all attempts at de-escalation are being explored. The movement down the stairs involved several staff acting as 'anchors', which is a term for supporting staff who are deployed to avoid any trips or falls whilst negotiating stairs.

278. The later section of footage shows the staff around the relocation room door whilst a full search takes place.

279. Throughout the whole process staff in white shirts with shoulder holsters are seen close to the situation. No BWVC footage is available, and it would be interesting to know if they do in fact have issued BWVC as part of their duty operations equipment.

KENCOV 1012 V201705040002

280. This footage was recorded on a covert camera by Mr Tulley.

281. At 18:15 into the recording D1527 is seen on the safety netting above the ground level landing. Initially he moves freely along the netting but eventually he settles just above the gap in the netting by the stairs that access the ground level.

282. The control of this incident scene was very poor. Detainees were allowed to remain on their landings and are at times shouting and making the situation almost impossible to manage. Staff are also stood around or leaning over the railings. They appear uncertain of what to do and from the footage available there does not seem to be any incident control or thoughts on how to resolve the matter. By allowing the detainees to remain unlocked it made communication very difficult and provided numerous distractions to D1527 There is no clear negotiation strategy in place and no planning for how to facilitate a surrender if D1527 decided to end his protest. From my personal experience I know Brook House have had similar incidents at height on the netting previously **(see note)** where detainees access the safety netting in an act of protest. It is expected that all custodial sites should have a set procedure for managing incidents at height and specifically netting incidents given the escalation experienced over the past few years. This would involve setting up a dedicated negotiation strategy and removing all detainees from the scene. Only

staff actively involved need to stay and planning for a surrender and possibly an intervention should start. Although staff should not access safety netting, if there was a genuine risk to life they could access it as part of a planned and authorised intervention. Considering the history of D1527 I would have expected this to be in place. It would also be interesting to see if the local command suite opened.

21:47 Mr Tulley asks a colleague 'are we locking the landing up' and again at 24:12 when he receives the response-no.

34:12 D1527 is stood directly above the stairs and tells staff to move.

283. The footage then moves form the scene and Mr Tulley is starting to lock detainees in their cells.

284. Considering the duration and location I am concerned that no official footage is available for this incident. At the very least BWVC or a handheld recording device should have been in operation.

Good practice

285. The initial restraint does not raise any major concerns and appears to meet the lawful application of necessary and proportionate, other than no BWVC being activated. Good de-escalation once handcuffs are applied and allowing D1527 to stand upright.

286. Really good decision to remove a trigger from the restraint and replace with another member of staff.

Areas of concern

287. No official evidence from the incident on the netting, which is concerning.

288. The management of the incident on the netting was poor and could have extended the duration of the incident by not applying basic incident scene management procedures.

Summary

289. *Lawful under Detention Centre Rule(s)* - Rule 40(1).

290. *Last resort*- all reasonable efforts through persuasion and negotiation failed and force was the last option available to facilitate the move.

291. *Necessary, reasonable, proportionate*- The level of force used, and the necessity are all justified and there is no evidence that anything other than reasonable force was used. Handcuffs were applied and when D1527 emerges from the room he is stood upright, indicating that after the initial force was used the restraints were removed once handcuffs had been applied.

292. *No more than was necessary* - Only handcuffs.

293. Rule 41 (2) provoke or punish a detainee - Good example by removing a DCO from the restraint who was being targeted by D1527. No evidence to support provocation or punishment.

294. No concerns.

References

UOF training manual

Incidents at height Brook House

26.06.16- 1 x Detainee on the netting surrender following NTRG recee – Myself as team lead

30.11.16- 2 x Detainees on the netting, 1 surrendered, 1 restrained by NTRG PAVA used

07.03.17- 1 x Detainee on the netting to NTRG staff

28.04.17- 1 x Detainee on the netting restrained by NTRG PAVA used

UOF Incident log 162/17 – D2054

Detainee concerned: D2054

Date of incident: 28th June 2017

Reason for force as listed on the UOF report: Failure to comply with removal, Non-compliance prevent self-harm, prevent injury to third party.

Staff involved: DCM Aldis, DCOs Murphy, Martin, Shadbolt, Di-Tella, Simmons

Background

295. D2054 was informed that he was being moved for a charter flight to Nigeria. He refused all instructions from DCM Aldis to walk to the discharge area, where staff from Tascor were waiting to escort him to RAF Brize Norton. A planned intervention was then executed and when staff entered D2054 was lying in his bed and before had removed his clothes. He resisted the attempts by staff to take control of him and he was eventually placed in handcuffs and moved under restraint to be handed over to Tascor staff. Staff used a towel to preserve his decency. Throughout the movement D2054 was shouting and continued to resist staff. The head support remained throughout the entire movement until handed over to the Tascor staff.

Observation/opinions

296. There is footage from BWVC, CCTV and a handheld device. The briefing conducted by DCM Aldis is recorded and it covered all of the necessary information. One recurring factor during some of the briefings observed so far that is staff not having any identification, either on their helmets or overalls. This helps identify the individuals involved and their role in the restraint. Details of staff identification are within the Incident Management PSI 09-2014. When in full PPE staff have some method of identity that are announced during the recorded briefing. I did not observe a senior manager in attendance but at various stages there are numerous people around the incident scene.

297. DCM Aldis makes every reasonable effort for D2054 to walk without the need for force being used. He explained the situation and the fact that escort staff from Tascor were waiting to move him to Brize Norton for a flight to Nigeria/Ghana. At the time D2054 is lying in his bed and after all attempts fail DCM Aldis deploys the staff. As they enter D2054 moves from his bed and it becomes

known that he is in a state of undress. BWVC from DCM Aldis, which was attached to his person, does intermittently cover his naked state but for most of the time the camera focuses away from the restraint.

298. There is no policy guidance for use of a handheld device but the policy, PSI 04-2017 BWVC[92] states that;

> 3.32 there may be occasions where a prisoner is either in a sensitive area such as the showers or is partially clothed but his/her behaviour is violent and aggressive and where the over-riding requirement is to record what took place. *Such circumstances will be exceptional and in each case the accompanying paperwork must set out the justification for recording such images.*
>
> *3.33 Where such footage contains intimate body parts, consideration must be given to pixilation of the footage where there is a need for copies to be made or for it to be made available for viewing as part of an adjudication*. It is important that the master copy remains "un-changed" on the system.

299. The available footage presented did not comply with the above policy as there was not any pixilation.

300. The staff end up restraining **D2054** in the supine position and for a short time leg control is also used. It is quickly released and the female member of staff leaves the room. **D2054** continually shouts 'Jesus' and is agitated by having to be escorted from the centre. The decision is made to handcuff if non-compliance is demonstrated, this was covered during the briefing. The handcuffs are applied with **D2054** in the seated position. This is a method that has been removed from the training syllabus due to the risks from compressing the chest and experiencing breathing difficulties associated with being bent forward for prolonged periods of time. If handcuffs are required to a detainee in the supine position staff should firstly stand them up and apply the handcuffs whilst standing upright. Once stood up a towel is provided to cover **D2054** before they exit the room.

[92] PSI 04/17; issue date 20 March 2017 - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/903462/

301. Staff then move D2054 from the wing and through the centre, toward the discharge area where Tascor staff are waiting. D2054 continues to shout but he is not seen to be offering any immediate risk of harm to staff. I do feel that in order to de-escalate the situation consideration should have been given to removing the helmets and protective gloves once the initial control had been achieved. Although not clear there are times when the hand position of the head support officer appears close to the neck area. This is normally an inadvertent result of wearing protective gloves that are quite bulky. Another effort at de-escalation would have ben to remove the head support position. Staff had control over the arms and if the result was for an escalation the head support can be re-applied. In my opinion staff should have used all or at least some of these examples during this restraint once the initial threat to staff had been reduced. It appears that during restraints where PPE is used there is a reluctance to remove it, or that staff simply do not consider removing it. Even when justified in the first instance all efforts must be made to enhance the de-escalation and improve communication with the detainee. Full restraints continued to be applied and should have been de-escalated prior to this point and the continued force demonstrated was not necessary or proportionate at the time. Even when force is used as a last resort it must either cease or be reduced when no longer necessary.

302. There was a lengthy pause in the movement as DCM Aldis went to discuss the handover with Tascor staff. The final footage available at present is of D2054 being handed over to Tascor staff who have prepared the WRB and take over once the handcuffs are removed. They then take him into a room (covered from the outside only by CCTV). When he appears from the room D2054 is dressed and walks to the escort vehicle for the removal to continue.

303. All BWVC and hand held device footage ends when D2054 is handed over. There are different contractors involved but I feel the recording should continue until at least the point where a detainee is located onto a vehicle. They are still in custody and held under Home Office Rules so I see no compromise by continuing any evidence gathering. If G4S staff could not record the handover I see no reason why the contractor staff could not have BWVC or similar recording devices.

Documents

CJS005574

No UOF documents are available from Tascor staff

No UOF review is provided at present

Footage

CJS0073733[93]

Footage time of 02:47 entry to room and exit at 05:26

CJS0073734[94]

Covers the briefing from DCM Aldis. Mentions an earlier act of self-harm.

CJS0073735[95]

CJS0073736[96]

304. This footage does at times cover D2054 in a state of undress, due to it being attached to the person of DCM Aldis.

CJS001627 PSU Investigation[97]

305. The complaint made by D2054 consisted of several different issues that he encountered whilst at Brook House. The UOF matter was reviewed within the scope of the investigation and did not find any evidence to support the claims. The investigating officer had access to the footage and makes note at 5.9 that the CCTV from the escort vehicle was not available.

306. D2054 's claim that he was not given the opportunity to comply with the instruction was addressed in 7.5.6 where it states a 2 minute conversation took place with DCM Aldis. 7.5.9 states the force was reasonable and necessary in removing him from the room for escort, 7.5.11 that the force used was proportionate and in 7.6.6 the claims made are unsubstantiated regarding hitting his head on the floor and losing consciousness.

307. I can confirm that DCM Aldis explains the situation and give several opportunities for D2054 to comply with the instruction. I am satisfied that he

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[93] Disk 25 28June2017 2319 CCTV

[94] Disk 26 20170628221925_E2047N_0006 - Handheld device or BWVC?

[95] Disk 26 20170628222251_E2047N_0007 - Handheld device or BWVC?

[96] Disk 27 28June2017 2221BWVC DCM Aldis

[97] Professional Standards Unit (PSU) investigation report dated 15/09/2017, investigating a complaint made by D2054 regarding an assault alleged to have taken place at Brook House on 28/06/2017. There is an email chain between Stephanie Benson (PSU), Karen Goulder (G4S), and Helen Wilkinson, dated 13/07/2017. Also attached are interviews of Derek Murphy, Jonathan Martin, Dave Alvis, and Ben Shadbolt.

made all reasonable efforts to manage the incident without using force and as a last resort deployed staff to forcibly remove D2054.

308. The team do enter at pace and make contact on the bed. This would replicate training and is reasonable in order to prevent harm to themselves or an act of self-harm. The shield is removed after a few seconds. I can confirm that the head is supported, and the member of staff is protecting the head from hitting the floor. Throughout this D2054 is screaming and shouting. The handcuffs are applied effectively and without any undue problem. At no time did I observe any indication that D2054 could have become unconscious.

Good practice

309. There were good attempts at engaging with D2054 and for staff taking the action of covering him when he was removed from the room.

Areas of concern

310. The UOF for the removal was lawful and only used once repeated attempts at persuading D2054 to walk to the discharge area. Issuing staff PPE was reasonable in the first instance but once control had been gained the helmets and gloves could have been removed. Removing PPE assists with de-escalation, although the continued wearing is not disproportionate it is not effective for communication or for when in view of other detainees who may observe the restraint.

311. The head support position was maintained throughout the move and it should have been removed as a further attempt at de-escalation. At the very least the gloves of the head support officer could have been removed. The continued use was not necessary as the risk to staff had been reduced and D2054 did not offer any significant threat. The head support can always be re-applied if there is an escalation of a risk to staff or adapted to avoid contact with the throat area.

312. The practice of handcuffing in the seated position should be withdrawn.

313. Evidence gathering once a detainee is handed over to the escort contractor should continue, as should recording from the vehicle once located. No UOF reports available from Tascor staff.

314. I can confirm that the head is supported, and the member of staff is protecting the head from hitting the floor. Throughout this D2054 is screaming and shouting. The handcuffs are applied effectively and without any undue problem. At no time did I observe any indication that D2054 could have become unconscious.

315. There is no evidence of any excessive force and based on the footage observed staff applied all techniques correctly and when necessary in order to avoid any potential injury to D2054.

Summary

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

317. *Last resort*- All attempts for D2054 to comply with the instruction to move and due to his failure to comply the last resort was force being used.

318. *Necessary, reasonable, proportionate*- In the first instance force was necessary to carry out the removal and the techniques used reasonable in the circumstance. Once handcuffs were applied the continued use of the head support position was not necessary and not proportionate to the risk. The same applies with staff wearing PPE, items of PPE should have been removed when moving through the centre. Full restraints continued to be applied and should have been de-escalated prior to this point and the continued force demonstrated was not necessary or proportionate at the time. Even when force is used as a last resort it must either cease or be reduced when no longer necessary.

319. *No more than was necessary*- As above- either remove or adapt the head support position and arm restraints.

320. Rule 41 (2) provoke or punish a detainee- No evidence to support this.

321. The concerns are that continued force was used when no longer necessary and the lack of attempts to remove PPE. No effort was made to remove or adapt the head support position, resulting in D2054 remaining in the bent over position for longer than was necessary.

References

UOF training manual

PSO 1600 - medical advice (section 1.4)

UOF Incident log 164/17 & 165/17 – D87

Detainee concerned: D87

Date of incident: 30th June 2017

Reason for force as listed on the UOF report: Relocate under Rule 40

Staff involved in incident 1 (164/17): DCM Trott, DCOs Parpoworthy, Moshiri, Stokes, Bromley & Sayers

Staff involved in incident 2 (165/17): DCM Shadbolt, DCOs Murphy, Bryant, Tomsett, Brown, Fiddy, Brewster

Background

322. The two incidents happened in quick succession and were both related to the decision to remove D87 under Rule 40 to the CSU. This was approved at Duty Director level and followed earlier threats made by D87 which included hostage taking.

323. The first incident starts in a room on the residential wing and results in a restraint being used to move D87 to the CSU. The second incident is approved after the observation panel to the room was blocked and staff were unable to communicate with D87. Force is used only to control D87 whilst items that could be used to self-harm are removed.

324. Two members of staff were injured during the first restraint and required outside medical attention.

Documents

[TBC]CJS005592[98],[99]

Incident 2 165/17

[98] G4S Use of Force Form DCF2 DC Rule 41 - Detainee D87 - dated 30.6.2017 Use of force used at 1730 approx.

[99] The staff named on the spreadsheet of documents that I have been sent do not match those identified on Disk 29 SH3-briefing before intervening in the room occupied by D87. This was after the initial incident where two staff required hospital treatment.

CJS005566 - G4S Use of Force Form - DCF2 - Detainee D87 - dated 30.6.2017 Use of force used at 1945

Footage incident 1

CJS0073737 [100]– (handheld)

Briefing conducted by DCM Brackenbridge. Duty Director authority to removal of D87 under Rule 40 to the CSU following threats made against staff, including hostage taking.

CJS0073738 [101]– (handheld)

This covered the removal from the room and escort to the CSU.

CJS0073739 [102]– (handheld)

Debrief which was not proceeded with due to two staff requiring hospital treatment. D87 now only to be unlocked by a minimum of four officers, known as a multiple staff unlock.

CJS0073746[103] (CCTV)

Full intervention from outside the door and the move to the CSU.

Footage incident 2

CJS0073743 [104](handheld)

Briefing prior to staff entering the CSU room in order to check on the condition of D87 and to remove items in order to prevent self-harm. Observation panel was covered and no response from D87, Duty Director authorise the intervention.

CJS0073744 [105](handheld)

This covered the removal of a ligature and the removal of items.

CJS0073741[106] (handheld)

Debrief of incident

CJS0073740 [107] (–handheld)

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[100] Disk 28 D87 (2
[101] Disk 28 D87 (3)
[102] Disk 28 D87
[103] Disk 30 30June2017 1733 (CCTV)

[104] Disk 29 D87 SH (3)
[105] Disk 29 D87 SH
[106] Disk 29 D87 SH (1)
[107] Disk 29 D87 (1)

Healthcare statement
CJS0073742 [108](handheld)
Healthcare statement

Observation/opinions

325. The initial authority to remove D87 was lawful and in my view correct when considering the serious threats he had made. In order to prevent a serious risk the option of using Rule 40 allows a closer level of control to be maintained and for higher supervision of the individual.

326. The briefing to staff was recorded and covered the situation and background. It is clear that DCM Brackenbridge tried to persuade D87 to comply and after some discussion D87 agreed to move and started to put on his socks and shoes. He continually asked the same questions, such as 'what threats' and seemed to deny making them. The situation changes when he becomes aware of the presence of a team (staff in PPE) at the door. His demeanour and body language then change and he becomes confrontational and asks 'come and fight me'. DCM Brackenbridge does ask 'is there anything I can reasonable do or say for you to comply'. These attempts fail and the staff are deployed into the room. The shield officer makes contact with D87 and forced him against the rear wall, a struggle then commences. D87 is actively resisting any efforts to control him, however he is not trying to cause harm to staff by striking or attacking them, despite having many opportunities to do so. His actions are entirely avoiding force being used on him and he continually asks 'why are you attacking me'. Due to D87 refusing to comply with the lawful Instruction to move from his room the staff were justified in using force once all other reasonable efforts had been exhausted. The staff only attempted approved techniques but struggled to gain control due to D87 actively resisting their attempts. The force used was reasonable and proportionate in the circumstances, but proved ineffective as times due in some part to the physical stature of D87 and by staff being unable to gain any sort of control of his arms.

327. At one point he steps up onto his bed and staff then manage to bring him back down and apply the head support position, along with controlling the arms. The struggle continues and they end up outside the room. Other staff become involved and they end up on the ground with D87 on his back in the supine position. Up

[108] Disk 29 D87 SH (2)

until this point staff have failed to gain full control, or apply controlling techniques as taught in the UOF syllabus. When on the ground staff still struggle to apply the correct techniques and when trying to stand D87 up it is clear they will struggle because of this. D87 asks 'why are you trying to kill me' when he is on the ground.

328. Staff do manage, with some co-operation from D87, to stand up and they move him toward the CSU. He continues to struggle and at one point pushes staff into a wall. Throughout this staff do not apply the head support position and are only controlling him by his arms, no handcuffs are applied.

329. When they reach the CSU room they force D87 through the door and at one point a call is made for a full relocation. This is where the detainee is laid flat and staff exit after applying a figure of four leg hold. The staff almost release all holds as they go through the door and decide to simply direct D87 away and then they exit the room.

330. When applying hindsight and viewing in a sterile environment it could have been an option to release the restraints earlier when considering that D87 was not intentionally harming staff, he tried to avoid being restrained and was almost fending them off as opposed to lashing out. Considering all of the risk and the levels of strength and potential violence it was correct to maintain control and it was unfortunate that two staff were injured during what was a particularly difficult situation to manage. The force used was appropriate, but I would question why handcuffs were not applied and why the head support position was not use during the move to the CSU. I acknowledge the attempt to de-escalate but that could have been applied as a mark of good will if D87 started to comply and stop struggling.

331. Whilst appreciating the potential medical risks to a detainee during a restraint there is also a responsibility to protect staff. The training syllabus covers options based on the risk and it is important to follow the guidelines when faced with a significant risk of injury to staff as well as to the detainee. Which is why I question not applying handcuffs or using the head support position for staff safety during the struggle when moving to the CSU.

Incident 2

332. The second incident which followed later in the day as a result of D87 covering the observation panel in his room and not communicating with Staff. There were concerns over his well-being and Duty Directors approval was given for staff to enter the room and remove any potential items that could be used to harm himself.

333. DCM Robinson briefs the staff and outlines what their objective is. DCM Robinson explains what is required from outside of the room and there is no response from D87 The door is opened and staff enter with a shield and make contact at the rear of the room. D87 asks 'why are you attacking me' and 'leave me alone'. Items are then removed before one of the team removes a ligature with a cut down knife. D87 starts shouting whilst staff remove bedding and other items of risk. Throughout DCM Robinson tries to calm the situation and demonstrates good control of the situation. Once all of the items are removed staff are instructed to leave the room.

334. The management and control of this situation were excellently performed by DCM Robinson. He demonstrated a calming but assertive presence and spoke politely and with clear explanation to D87 Considering the difficulties that staff encountered earlier it was the correct decision to equip staff with PPE and to take all reasonable precautions. Staff exited the room without using unnecessary force and the only force used was reasonable in order to eliminate the risk of self-harm by using the items in the room.

HOM003157 PSU Investigation[109]

335. The evidence considered by the investigating officer is consistent with what I have been provided, with the exception of interviews with the claimant and staff.

> 7.3 After considering all of D87 concerns and based on the balance of probability found that all staff acted in a professional manner and followed all Home Office guidelines and procedures.
>
> 7.4 Taking account of the evidence gathered there is insufficient evidence to substantiate that D87 was assaulted or mistreated during either incident.
>
> 7.46 makes reference to PPE being standard practice for planned removals. JC comment- Each incident should be assessed on its own unique circumstances and whilst most will require PPE for staff safety there must be a

[109] Report of investigation into complaints made by D87 alleging gross misconduct and medical negligence, completed by Kim Shipp, PSU Investigating Officer, undated.

justifiable reason for it. In this case I agree with the provision of PPE due to the potential for a threat to staff but it should not be an automatic decision for every incident.

7.47 The account by D87 of the events are somewhat similar to my observations- he was resistant not aggressive. Despite this common acknowledgement staff still had a lawful justification to move D87 based on the security and risk assessment and authorisation of a senior manager.

7.48 'Once he saw the team he (D87) changed tack'. This is confirmed in the footage as his demeanour changes once he realises a team are prepared outside.

7.101 the claims by D87 are found to be incorrect in that only one shield was used, not the 4-5 claimed, along with 13 officers running at him and beat and attacked him.

336. I can confirm the facts and agree with the conclusion of the investigating officer that no inappropriate action was evidenced by the staff and that there was a lawful right to move D87.

Good practice

337. Two parts to this incident, in the first a very difficult restraint against a strong resistant detainee. Staff struggled to gain control and due to the level of resistance and inability to fully control D87 two staff received injuries that required outside medical attention.

338. The force used was not always as per the UOF training manual, but staff did adapt where they could. I never felt D87 was in danger of sustaining any injuries, or was he put in a restrictive position that could compromise his safety, but when he started thrashing around the likelihood of staff getting injured increased. This is not a criticism of staff but for instances of this nature careful selection of personnel is important. Ideally experienced staff whose physical stature matched the detainee may have been a consideration but is not always possible within the staffing compliment on duty at the time.

339. Staff constantly spoke with D87 and explained what was happening. His behaviour was erratic, at times appearing compliant then exploding into shouting. The staff maintained total professionalism throughout and should be commended on their efforts.

340. The decision to remove items after D87 covered his observation panel and refused to engage with staff was justifiable. The risk of self-harm or acts of disorder, for instance barricade, required staff to enter the room.

341. It was correct to take all reasonable precautions, providing staff with PPE, and controlling the scene. DCM Robinson was excellent throughout in managing the incident.

342. The force used was necessary to affect the removal of items and to ensure the safety of staff.

Areas of concern

343. Future training needs to include specific areas of weakness highlighted from the footage, including restraint in the supine position, correct head support position, applying handcuffs when it reasonable to assess staff may struggle with restraint techniques alone against a strong powerful individual. All of the techniques were applied incorrectly which prevented control being gained. When on the floor the staff appeared unsure what to do and ended up with the arms wrongly placed to facilitate getting up. Handcuffs would have been a suitable and reasonable option, even if they had to double-link two sets of handcuffs to compensate for the size and flexibility of D87

344. I note the Duty Director approved the two interventions though there is no evidence of them attending the incidents or at the debriefs. There appears to be a total focus on DCMs taking complete charge of incidents and there is clear guidance in PSO 1600 of the two roles. One supervises the actual UOF, focussing on the monitoring of the detainee and staff, continuing assessing the techniques used and attempting to de-escalate the situation; the incident manager takes overall incident scene management, including utilising all of the resources available at the time, attendance of support staff, for instance healthcare and most importantly making any executive decisions regarding the incident.

Summary

345. *Lawful under Detention Centre Rule(s)* - Rule 40 (1)

346. *Last resort*- During both incidents staff made numerous requests for D87 to comply with their instructions. As a last resort staff were deployed to enforce the instruction.

347. *Necessary, reasonable, proportionate*- Force was necessary to move D87 and all techniques were reasonable and proportionate to the threat, although not applied correctly. This was due to the struggle and resistance offered by D87. The second incident justified force to enable items of potential harm were removed from his room.

348. *No more than was necessary*- All force observed was necessary, and even when additional staff become involved it can be justified due to the problems encountered trying to gain control of D87.

349. Rule 41 (2) provoke or punish a detainee- No evidence to support this.

350. Concerns over staff ability and competence and the decision making from the DCM when selecting appropriate staff.

References

UOF Training manual and PSO 1600 -role of a supervisor (section 3.1)

UOF Incident log 129/17 – D52

Detainee concerned: D52

Date of incident: 22nd May 2017

Reason for force as listed on the UOF report: To facilitate a move to another wing

Staff involved: DCM Breckenridge, DCOs Murphy, Marshall, Hedge, Wright & DCM Aldis supervising officer

Background

351. D52 refused to move from an interview room in the visits area. He had made previous threats against staff and was therefore being relocated to Eden Wing. After attempts at persuading him to move DCM Aldis instructed staff to restrain D52 D52 in order for the move to Eden wing.

352. During the restraint a member of staff was bitten and needs medical attention. Once control was gained handcuffs were applied and restraints were released and D52 was relocated in the CSU.

Observations/Opinion

353. There is no footage available from the actual incident scene. A recording number BBC000310 [110] contains a conversation in an office with DCO Tulley (recording covertly), a member of staff who I assume to be DCO Marshall, and another unknown member of staff.

354. Most of the conversation centres on the incident where DCO Marshall was bitten by D52. He gives a graphic account of the difficulties in gaining control, especially considering the level of resistance by D52 and the tight confines in the room. The room had fixed furniture and the staff were trying to apply controlling holds underneath the table.

355. DCO Marshall does admit to using his knee on the arm of D52 to assist with control, this is an approved technique for use in circumstances where full control cannot be gained and is applied to the upper arm in order to avoid any direct and

[110] V2017052400004.docx

potentially injurious effect on the elbow or shoulder area. It is only used temporarily whilst attempting to gain control and should be removed once control has been gained. At one point his keys come free and are grabbed by D52 . He then describes applying a thumb lock, which again is an authorised technique for prizing the hand from an object, for instance situations like this when a detainee attempts to grab security keys. The guidance in the UOF Training Manual (section 7) states it is only applied as long as is necessary and once its aim achieved it must be removed. Before use an instruction must be given and repeated before applying what is a Pain Inducing technique (PIT). This is the procedure that must be used when applying any PIT. I am unable to find any evidence that it was followed during this incident. Although justified staff are still required to follow the guidance from the training they receive.

356. Of concern is the mention that one member of staffs BWVC becomes dislodged. There is no BWVC footage available at this time but DCO Marshall states it would have captured the initial restraint.

357. A great deal of the conversation makes inappropriate and unprofessional dialogue between them, including DCO Marshall referencing how he starts laughing during restraints when he hears detainees screaming, as was the case in this incident. He demonstrates an unprofessional level of behaviour. The conversation with DCO Fiddy includes disrespectful comments about a colleague, examples include 'who's that cunt, an Asian guy with a stupid haircut, he an absolute dick head', I hope he gets slapped in the face'. Other comments, regrading detainees, include 'you know what their like' and mocking the dialogue used.

358. The UOF report submitted by DM Aldis states that attempts were made to resolve the situation by negotiation and that D52 became more aggressive and was demonstrating violent behaviour by thumping the table. Given the earlier threats it was correct that he assembled sufficient staff to manage the situation.

359. Due to the lack of immediate action being required and DCM Aldis attending as the senior person this incident was not unplanned. There was time to prepare and plan as a planned removal and for evidence gathering to take place, either by BWVC or a handheld device. I would also question why the DD was not informed or why they did not attend.

360. All of the reports paint a similar picture; a difficult restraint with a resistant detainee in a confined area that made things more difficult. Once control was gained handcuffs were applied and D52 started to co-operate with staff. Restraints were removed and he was relocated to the CSU. The depth of information was limited on some reports and the overall quality was adequate but with room for improvement.

361. The review by Steve Webb listed an investigation due to the bite injury sustained. He was satisfied with the quality of reports, which is concerning given the lack of detail in some. The lesson learnt box is ticked but no further information provided on what, or how it will be cascaded to staff.

Documents

CJS005620 [111]

CJS000901 [112]

Footage

BBC000310 [113]

Good practice

362. The de-escalation once handcuffs were applied is a positive response by staff.

363. Based on the documented evidence there are no concerns over the actual application of force by staff, or the techniques used.

Areas of concern

364. The lack of footage from either BWVC or a handheld device is not acceptable given the time to prepare for intervening. There was no immediate necessity to initiate force and the correct procedures for a planned removal should have been applied.

365. The unprofessional conversation captured on the covert camera should be addressed and all staff reminded of their professional responsibilities.

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[111] Use of Force form re: D52, dated 22 May 2017

[112] Compilation of 'Use of Force review Meeting Forms' completed by Steve Webb on various dates ranging from 21/7/2017 - 31/7/2017

[113] V2017052400004.docx

Summary

366. *Lawful under Detention Centre Rule(s)* - Rule 40 (1)

367. *Last resort*- All efforts appear to have been made for a peaceful resolution, so I am satisfied the decision to use force was the last option available.

368. *Necessary, reasonable, proportionate*- No footage to assist with an opinion but the reports point to it being necessary to use force and that once used they were proportionate to the threat. Handcuffs were applied and restraints removed once under control. Description of using a knee to pin the arm would be a reasonable UOF as long as it was only for the required time and removed once control was achieved.

369. *No more than was necessary*- No footage to test how long the PIT were applied, I am unable to make any further opinion.

370. Rule 41 (2) provoke or punish a detainee- No evidence to support this.

371. Unprofessional comments by staff and no activation of BWVC are the main concerns.

References

UOF training manual - role of supervisor (section 3.1)

Home Office professional standards

UOF Incident log 133/17 – D1978

Detainee concerned: D1978

Date of incident: 23rd May 2017

Reason for force as listed on the UOF report: non-compliant, refused to move to CSU

Staff involved: DCM Dix, DCOs Sayers, Akhtar, Matchett & Fielding

Background

372. D1978 had made threats to staff earlier in the day and it was decided that he be moved to the CSU under Detention Centre Rule 40. He had spat at a DCO and pushed another detainee down a flight of stairs during the day.

373. The staff involved were from the night shift. They were informed to equip themselves with PPE for a planned intervention in cell D115 and received a briefing from DCM Dix. There is no available recording of the briefing and as good practice prior to any planned intervention the briefing to staff should be recorded. Healthcare were in attendance and the intervention was recorded on a BWVC. There is also CCTV footage of the relocation route.

374. DCM Dix attempted to resolve the incident at the room door but was met with a negative response. The team were deployed using PPE, including a shield, and restrained D1978 in the room before escorting him to the CSU. On route he continued with the verbal abuse and after being allowed to stand upright he spat at DCM Dix. He made racist comments toward member of healthcare and continued with threats to staff.

375. At present I do not have the incident review within the documents.

Observations/Opinion

376. The review of this incident has been enhanced by the activation of a BWVC, this sets out good practice and I am concerned why they have not been used for other incidents. There may be a misunderstanding that only when staff are in full PPE that this is a planned removal. This is not the case and any incident where there is no requirement to use force straight away is a planned intervention, regardless of whether PPE is issued to staff.

377. In their statement all of the staff confirm that they received a briefing from DCM Dix and that he made a final attempt to persuade D1978 to move to the CSU

without force being required. The accounts given by staff of the intervention are confirmed through the BWVC footage and after the initial contact is made by DCO Sayers the shield is removed and staff applying controlling techniques as described in the UOF training manual. All of the procedures carried out were in fact textbook examples of a planned intervention, including use of BWVC, healthcare in attendance and de-escalation used. There was a swift move out of the room and after moving off the wing into a corridor D1978 is allowed to stand upright. I am slightly surprised that handcuffs were not applied given the risk D1978 posed and there is no explanation as to the reason for this.

378. During the movement to the CSU the staff accounts and the BWVC footage evidence the level of abuse and threats made by D1978. He uses foul language and insults staff throughout the relocation process. At one point he spits at DCM Dix, which he then laughs at. Throughout the relocation members of the healthcare are in attendance. Once in the CSU D1978 calls one of the healthcare staff 'a black witch'. The relocation into the CSU room was again a good example of using only the necessary level of force, staff released the controlling holds and allowed D1978 D1978 to walk into the room. An alternate higher-level technique would have been to place him in the prone position to allow a safer exit for staff, however the decision was made to opt for a less intrusive option.

379. Throughout this removal all of the staff demonstrated the utmost professionalism and self-control when faced with a very challenging individual. The constant verbal abuse and personal threats did not generate a response and the staff carried on with their duties without responding to the attempts at intimidating them. The racist abuse should have been reported as part of the zero-tolerance agenda employed within the Home Office.

380. I do question why this removal took place so late in the day and why night staff were used. There are less staff available at night and if any were injured it would have left the establishment short of staff for the shift.

Documents

CJS005646[114]

[114] Use of Force form re: D1978, dated 23 May 2017

Footage

Disc 48 BWVC

CJS0073770[115]

CJS0073771 [116]

CJS0073772[117]

381. The footage benefits from the audio evidence it provides. The team assemble outside of the room, D115, and DCM Dix gives final Instruction for D1978 to move. As D1978 walks toward the door DCM Dix steps to the side as if to allow him to come out as directed. At this point the staff move in and restrain D1978 DCM Dix makes a belated move to stop them and can be heard uttering quietly no on more than one occasion. If D1978 was compliant and following the Instruction given to him using force would be unlawful in the circumstances. The correct procedure for a resolution would have been for DCM Dix to direct the shield officer to the door and to instruct D1978 to show his hands and walk toward the shield. He would then be moved from the room and face the wall before proceeding with moving to the CSU without force being used, unless handcuffs had been agreed for use.

382. The footage shows staff enter the room whilst wearing full PPE and the shield is used to pin D1978 until control of the arm is gained. The shield is then passed out of the room and the shield officer then adopts the head support position. The movement and relocation then continue with restraints maintained but with the head support removed. D1978 does not appear to be in any pain and the restraint holds are consistent with the approved method. He directs a comment to one of the arm officers 'go on then break my wrist' but shows no sign of being in distress from the application of pain. When pain is deliberately and lawfully applied (PIT) it generally causes a reaction, such as twitching, sudden jolt or an outcry of pain.

383. The footage provides evidence of the level of abuse and threats continually made by D1978, when he spat at DCM Dix and the racist comment toward a female nurse.

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[115] Disk 48 20170523205517_E1606N_0012

[116] Disk 48 20170523210142_E1606N_0013

[117] Disk 48 20170523211507_E1606N_0015

384. The footage from the debrief provides a different version of events when described by DCM Dix as compared to what actually happened. During the debrief he states D1978 started to encroach toward him and he had no option but to deploy the team. The scene footage clearly shows DCM Dix stand aside to allow D1978 to leave the room and then the team move in and restrain D1978. DCM Dix makes a half-hearted attempt to stop staff but only after the first DCO has entered the room. DCM Dix utters quietly to himself 'no, no, no'.

CJS0073773[118] (CCTV)

385. Even with no audio it is evident from the footage that D1978 is shouting and acting aggressively. The footage follows the whole process up to the point where staff locate him into the CSU room. A constant watch is place outside of the room after the relocation is complete.

BBC000299 [119]

386. This is footage form the covert camera operated by Mr Tulley. It captures D1978 D1978 earlier in the day arguing with staff, including a female DCO. His behaviour was intimidating and he continued to argue even when staff tried to calm the situation down. Mr Tulley continues the recording in a staff office at some point after the altercation with the female DCO.

387. The female involved and another female DCO speak of D1978 spitting toward the second female DCO and the threats he was making. The first female is speaking to a DCM and asking for D1978 to be located in the CSU.

388. The first female then states that because D1978 was in close proximity to her she pushed him away. Colleagues then explain that she would need to submit a UOF report following the use of a personal safety technique. She agrees and appears to be looking for a document. She then goes on to speak of what she would do if this behaviour was repeated, her comments included, elbow him in the face, punch him and other similar themed comments. Whilst language and comments of this nature are unacceptable and unprofessional I do think consideration should be given to the situation. She had just encountered a very difficult and challenging man

[118] Disk 49 26May2017 2158
[119] V2017052300026.docx

who was abusive and threatening, and was responding by venting her anger, frustrations or even fears as a result of the obvious stress this put upon her.

BBC000300 [120]

389. This footage again shows D1978 being confrontational with staff, which along with other footage provides give full justification for the ultimate decision to locate him in the CSU. His disruptive behaviour could cause unrest within the confines of a custodial residential area and staff would be constantly dealing with him at the expense of others.

Good practice

390. The planned removal was carried out professionally and fully justified based on the events earlier in the day. Although the force used was proportionate to the threat and quickly de-escalated by staff there is confusion between the DCM and the team. As DCM Dix steps aside the team obviously take it as a que for them to enter the room. If DCM Dix had remained at the door and given Instructions for D1978 to raise his hands the staff would have been aware he intended to walk to the CSU as instructed and waited for further instruction from DCM Dix.

391. In the face of excessive intimidation the staff all remained professional and should be complemented on their actions.

392. D1978 was a challenging individual who constantly made threats toward staff and used racist and insulting foul language. Staff did not react and continued in silence.

393. Staff were correct in advising that a UOF report must be submitted for any level of force used. It is reassuring that they all communicated this to the female DCO.

Areas of concern

394. The racist comment toward the female nurse must be reported and investigated.

[120] V2017052300028-1.docx

395. The female DCO who used unprofessional language and comments in the office should be challenged. Consideration should also be given to the mitigating circumstances following the confrontation that took place.

396. The incident supervisor, in this case DCM Dix, should have been more assertive when negotiating a surrender and ought to have informed staff that D1978 was walking toward the door and for the team to remain outside but ready for when D1978 emerged from the room door onto the landing. He could have then instructed D1978 to present himself to the team ready for moving to the CSU. The recorded debrief should have addressed this issue and not changed the description to 'encroaching toward me, so no other option but to deploy the team'.

Summary

397. *Lawful under Detention Centre Rule(s)* - Rule 40(1) Rule 43 (1)

398. *Last resort*- There was some confusion as to if D1978 was actually complying by walking out of his room. In my view he was but DCM Dix mismanaged the situation and allowed staff to enter and restrain D1978.

399. *Necessary, reasonable, proportionate*- As D1978 was walking toward DCM Dix it was not necessary to use force and using force on a person who is complying is disproportionate. When force was used it was reasonable and proportionate, with D1978 being allowed to walk upright and no additional force used when he became threatening and insulting toward staff.

400. *No more than was necessary*- No techniques were used above those necessary.

401. Rule 41 (2) provoke or punish a detainee - no evidence to support this

402. The poor scene control by the DCM that resulted in staff restraining D1978 when he was showing compliance are the main concern. The force used was minimal but would have been avoided if correctly managed.

References

UOF training manual- role of a supervisor (section 3.1) planned intervention (section 3), resolution process

UOF Incident log 142/17 – D1538

Detainee concerned: D1538

Date of incident: 6th June 2017

Reason for force as listed on the UOF report: Good Order and Discipline, fight with another detainee

Staff involved: DCMs London & Farrell, DCO Bromley

Background

403. D1538 was involved in a fight with another detainee in the art room. Staff intervened and force was used to control him and prevent further indiscipline. He was allowed to walk back to the residential wing.

Observations/Opinions

404. The footage comes from a CCTV camera which has a slight time delay. At 07(00) (footage time) a detainee enters the art room and walks around to where D1538 D1538 is and starts a fight. In the first instance it appears that the first strike was delivered by the detainee. Other detainees then move in and break the fight up. D1538 is trying to re-engage with the other detainee and the detainees do a good job in keeping them apart. Staff then start to appear and what looks like a restraint is applied and then moves to the far bottom right of the footage. I am unable to see what was happening as the camera view did not cover this area.

405. Support staff then move the other detainees from the room and at 11:36 staff release D1538 from the restraints and allow him to be treated by healthcare staff. Although gesturing D1538 is walked without restraints to Eden wing. Considering the number of DCMs who were in attendance it is disappointing that none of them activated a BWVC. Once again the activation of cameras for unplanned incidents seems to have been neglected. In the staff UOF reports there is mention of injuries to the face of D1538 but the injury report is left blank.

406. DCM London reports that D1538 was stood in an aggressive stance with his fist clenched and with a sharpened pencil in his hand. Staff intervened and the pencil is dropped. Restraints are applied by guiding holds, followed by the head

support position as D1538 started to struggle and could have caused injury to head.

407. It is reassuring that staff only applied a guiding hold when the head support was adopted. It demonstrates using the appropriate force even when there is resistance by the detainee.

408. Based on the limited footage and taking into consideration the UOF reports submitted it appears that force was necessary and when applied only with the proportionate amount, and for no longer than necessary.

Documents

CJS005615[121]

Staff UOF statements

Footage

CJS0073784 [122](CCTV)

KENCOV000073

409. The footage from a covert camera operated by Mr Tulley shows footage once he enters the classroom at a point after the initial fight. D1538 is being held by two staff and is clearly angry and upset over the incident and continues to struggle with staff. A third officer comes in and applies the head support position momentarily before allowing D1538 to come upright before re-applying the head support position for a longer period until the restraints are released. The technique applied is consistent with training and is necessary due to the continued struggle and potential risk of staff being thrown off balance in an area full of furniture. All restraints were removed once they were no longer necessary and D1538 was allowed to sit down and be assessed by healthcare.

Summary

410. A lawful application of force to stop an incident continuing and possibly escalating. Staff only used low level techniques and head support was for the safety of D1538

[121] G4S Use of Force DC Rule 41 relating to D1538 on 06/06/2017 at 15:19pm

[122] Disk 55 06June2017 1526

411. The other detainees deserve recognition for stopping the initial fight. It was an apparent unprovoked attack and came with little warning.

412. The failure of any of the DCMs to activate BWVC is unacceptable. They were alerted by a general alarm (according to the UOF statements) and this in itself should be a prompt to turn cameras on.

413. Injury reports do need to record any injuries observed or reported. The disparity between staff statements and the medical report is concerning.

414. No incident review is available at this time.

Summary

415. *Lawful under Detention Centre Rule(s)* - Rule 43 (1)

416. *Last resort*- Staff reacted to a spontaneous incident and based on the actions of D1538 using force at the time was the only option available to prevent an escalation of the incident and potential injury to others.

417. *Necessary, reasonable, proportionate*- Force was necessary to prevent further violence, the techniques were reasonable in that they utilised three staff as specified in the UOF training manual. It was a proportionate response to apply the head support position when D1538 was struggling with staff.

418. *No more than was necessary*- Once the head support was no longer required it was removed, and then re-applied when the situation escalated. I am content that constant evaluation took place and that staff responded appropriately withy the level of force used.

419. Rule 41 (2) provoke or punish a detainee- No evidence to support this.

420. No concerns.

References

UOF Training manual

UOF Incident log 088/17 – D2416

Detainee concerned: D2416

Date of incident: 11th April 2017

Reason for force as listed on the UOF report: To facilitate removal directions-failure to comply with removal

Staff involved: DCM Farrell, DCOs Shadbolt, Timms, Wright & Shauket

Background

421. D2416 refused to walk to the discharge area, where Tascor staff were waiting to remove him for a charter flight to Germany. He was restrained by staff after all attempts to persuade him to walk failed and he was handcuffed and walked to the discharge area under restraint. For much of the move he was naked and he refused to dress.

Documents

CJS005630[123]

DCM Farrell- Supervisor

DCO Shadbolt- Shield officer then took control of right arm

DCO Timms- Left arm

DCO Wright- Head support

DCO Shauket- Handcuffs

CJS000902 - Compilation of 'Use of Force review Meeting Forms' completed by Steve Webb on various dates ranging from 17/7/2017 - 18/7/2017.

- All ticked except no injury report. I note the orderly officer has not signed the document.
- No footage available for my review although the UOF front cover ticked 'yes' for use. Use of a BWVC noted on the UOF form.
- UOF form not signed by the Orderly Officer.

Observations/opinions

422. My opinion can only be based on the written statements from staff due to the lack of footage. All statements confirm DCM Farrell tried reasoning with D2416 and gave him ample opportunity to comply with the lawful Instruction to move from his room for escort. After all attempts failed and as a last resort staff were deployed

[123] Use of Force - DCF 2 DC Rule 41 for D2416 dated 11/04/2017

and in full PPE to remove D2416. D2416 was initially in his bed and when force commenced staff became aware that he was in a state of undress. Attempts were made to cover him in order to preserve his dignity. Handcuffs were applied and the restraint was maintained, although the head support position was removed in order for D2416 to stand upright. It was re-applied when on the stairs as D2416 tried to place his feet on the railings and disrupt the movement. Once in the discharge area D2416 was handed over to Tascor staff. The handcuffs were removed and the waist restraint belt (WRB) applied. D2416 was provided with clothing for the journey to the airport.

423. The descriptions would indicate that the force used was reasonable and proportionate. Attempts at de-escalation were used and the application of a WRB was necessary and reasonable under the circumstances at the time.

References

UOF Training manual 2015 v2.1

HOMES Training Manual

Summary

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

425. *Last resort*- all reasonable efforts made to comply with the Instruction. Force only used when all failed to get a level of compliance.

426. *Necessary, reasonable, proportionate*- the descriptions lead me to state force met all the general principles.

427. *No more than was necessary*- Examples of removing parts of the restraint when appropriate, I conclude that only necessary force was used.

428. Rule 41 (2) provoke or punish a detainee- No evidence to support this.

429. No concerns other than this being another incident involving a detainee undressed.

UOF Incident log 153/17 – D1853

Detainee concerned: D1853

Date of incident: 15th June 2017

Reason for force as listed on the UOF report: Facilitate removal, serving of removal directions

Staff involved: DCM Lyden, DCOs Mrishri, Harness & Jones

Background

430. A no notice flight as the detainee had disrupted a previous flight by having razor blades in his mouth. He became non-compliant when outside of his room and force used to move to the discharge area.

Documents

CJS000903[124]

Comments: Left arm not adjusted when complaining of pain, stairway negotiation needs addressing in training.

CJS005648[125] UOF reports

431. There are a number of inconsistencies within the reports. DCM Lyden states Healthcare where not in attendance but included them in the briefing script. His report heads grade as DCM, but the narrative says DCO. The overall quality of his report is poor, with little information and no mention of the movement after force was used, or of DCO Harkness being head-butted. With five years' experience as a DCM I would expect a better report. It is concerning that the review stated all documents to an accepted standard. DCO Moshiri mentions D1853 ran down the landing and he was the first one to gain a headlock. This is incorrect terminology and raises concern over how the restraint was actually applied.

432. No footage available to review despite a BWVC noted on UOF form.

Observations/opinions

[124] Compilation of 'Use of Force review Meeting Forms' completed by Steve Webb on various dates ranging from 9/8/2017 - 31/8/2017

[125] - 070520-Bix-0086 - Use of Force - DCF 2 DC Rule 41 for D1583 dated 15.06.2017.

433. This was a planned incident and therefore I am concerned that healthcare staff were not in attendance in line with PSO 1600. The absence of footage from a planned incident is another concern based on the guidance in PSO 1600 and PSI 04-2017.

434. The report of DCM Lyden mentions concerns at being in an open space and D1853 climbing onto the safety netting. The initial engagement is in the room of D1853 where he was in bed and informed that he was being removed from the centre. The report mentions D1853 becoming irate and throwing his arms around when being escorted from the wing and at one stage his waving arm came toward DCM Lyden. With no available footage it is difficult to establish if this was a gesture of frustration, or an act of aggression directed toward DCM Lyden. Whichever version it was, it did result in force being used.

435. The restraint was taken to the ground due to the problem in gaining control and once control was gained the move to the discharge area continued. De-escalation took place with the head support being removed but after D1853 became disruptive and then head-butted DCO Harkness the head support was re-applied. This would have been a proportionate response in order to avoid the risk to staff and to prevent further acts of violence.

436. DCO Jones states that D1853 became verbally threatening and DCM Lyden instructed staff to restrain him, with no mention of the waving arm coming close to DCM Lyden. DCO Jones also mentions being head-butted, but no other staff note this. PIT techniques were applied by DCO Jones but there is no mention of the prior warnings given before they were used, although the description of the situation lead me to conclude that they were justifiable and proportionate when taking into consideration the threat presented.

437. All accounts end when D1853 is handed over to the escort staff from Tascor.

438. The briefing transcript states the camera operator as DCM Warrilow and healthcare in attendance.

439. The initial UOF is difficult to assess due to conflicting statements and no footage of the actual event. Initially compliance is observed but it changes when on

the landing, and this results in force being used. A consideration to avoid the risk of going onto the netting would have been to apply handcuffs in the room and carry out a controlled move to the discharge area.

440. Based on the accounts the force used appears proportionate, even the PIT, but the correct procedure for use was not followed- give instruction, explain PIT will be applied, re-instruct, further warning, apply pain for no more than 5 seconds. If staff were at risk and the continued threat of climbing onto the netting would justify using force, even at a low level, for instance a guiding hold.

Summary

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

442. *Last resort*- No force used initially and only applied as a last resort when D1853 became disruptive and attempted to move away from the staff when on the landing.

443. *Necessary, reasonable, proportionate*- all descriptions lead me to state all force met the general principles. I am unable to comment if the PIT was applied for the correct period.

444. *No more than was necessary*- the head support was initially removed and then re-applied when attempting to head-butt staff. The force used was no more than necessary in the circumstance.

445. Rule 41 (2) provoke or punish a detainee - no evidence to support this.

446. No concerns.

UOF Incident log 130/17 – D2034

Detainee concerned: D2034

Date of incident: 22nd May 2017

Reason for force as listed on the UOF report: Non-compliance, prevent self-harm, prevent damage to property, other- climbing onto netting

Staff involved: DCOs Murphy, Clarke & Brackenbridge

Background

447. D2034 climbed onto the safety netting and on occasions jumped back over before returning to the netting. Staff engaged with him without success. After jumping back over DCO Clarke initiated force and prevented D2034 climbing back onto the netting. After gaining control D2034 was relocated to the CSU.

Documents

CJS000901[126]

Ticked for further investigation, lessons learnt, not proportionate, not reasonable, not necessary

No tick for UOF documents being correct or to standard

CJS005618[127]

CJS005927 - Accident Report checklist dated 22/05/2017 - injured person DCO Murphy. D2034

Footage

CJS0073762[128]

CJS0073768[129]

Observations/opinions

448. Working at height incidents, and in particular access onto netting, are the most common type of incident that requires specialist national resources assistance. Brook House will have encountered many of these incidents, which are problematic and give little means for a resolution, other than requesting support and continued

[126] Compilation of 'Use of Force review Meeting Forms' completed by Steve Webb on various dates ranging from 21/7/2017 - 31/7/2017

[127] Use of Force - DCF 2, used on D2034, dated 22/05/2017; Annex A, Use of Force dated 22/05/2017; Report of Injury to Detainee dated 22/05/2017

[128] Disk 44 22May2017 1728

[129] Disk 47 22May2017 1729

negotiation. In 2015 HMPPS issued a Senior Leaders Bulletin for managing incidents at height. I am unsure if privately managed facilities such as Brook House would have been included within the distribution list.

449. In this instance D2034 is seen on the netting and then jumping back over onto the landing. I am surprised that there were no staff positioned to react for this and there does not appear to be any strategy in place to manage the incident, or an incident scene commander. These actions are a basic fundamental for incident scene control and assist in resolving the incident by denying the detainee to freely move on/off the netting and allowing a negotiation strategy to be put in place.

450. When on the landing DCO Murphy starts to engage with D2034 from a few metres away and the mood seems relaxed, leaning on rails and engaging. As D2034 jumps back over DCO Murphy and another DCO attempt to grab him and pull him back over, however this fails and D2034 evades their attempt and is back on the netting. The guidance mentioned earlier contained information for this type of scenario and that staff could, if appropriate and not putting themselves or the detained person at risk, attempt to pull them back over if they were positioned close enough to the railings.

451. I am now aware that DCO Murphy sustained an injury to his torso whilst attempting to pull D2034 from the netting. As part of the G4S investigation into the injury I note a centre manager, B Saunders, comment that DCO Murphy acted lawfully under the circumstances and that his actions were in line with policy.

452. The next section of footage shows a DCO, who I now know to be DCO Clarke, behind a door to the stairway and looking through onto the landing. He is within close range to where D2034 is stood. It is not evidenced through the UOF reports if this was planned, or if DCO Clarke had been instructed to position himself there. He is seen to remove his utility belt, which would include security keys, radio, emergency aid kit and other essential items. Staff are expected to only remove the utility belt in sterile areas and not within the residential or other areas of detainee access. It is as though he is preparing to intervene when D2034 is at a suitable position. At the time another detainee is the only person on the landing and is talking to D2034

453. Eventually DCO Clarke appears from the door, leaving it unlocked, and swiftly moves over and takes D2034 by surprise and wrestles him to the ground, in what can be described as a rear takedown technique. There is not any training for this technique within the UOF syllabus. He controls D2034 on the ground until colleagues arrive. They then stand D2034 upright and use guiding holds to move him from the wing. DCO Clarke's utility belt is left in the stairway until later when a colleague collects it.

454. If this method of intervening and resolving the situation was planned and authorised by the duty director I would state it was well executed and achieved its aim with no recorded injuries. The intervention did prevent the incident becoming protracted and prevented any self-harm or damage to the structure of the netting. There is no evidence that either were actually highlighted as being a concern or that D2034 intended to carry them out.

455. I am of the opinion that this was a personal act by DCO Clarke, and although he used his initiative, he is not authorised to carry out an intervention without approval during an operational incident. If I was to comment on the actual force used I would disagree with the review of DCM Webb. It was necessary to prevent D2034 D2034 going on the netting, the force was reasonable, in that he applied a takedown technique that did not put D2034 at risk, and was proportionate due to once he made contact he quickly removed his control and used the lowest level restraint, guiding holds to move and prevent D2034 from jumping back on the netting. It could be questioned why DCO Clarke did not simply take hold of D2034, this would not have guaranteed success and led to him jumping back on the netting. The method DCO Clarke used allowed him to totally control D2034 D2034 by wrapping himself around him and preventing him from escaping, as evidenced earlier when staff tried to grab him on the netting. It did not involve anything that could have initiated pain and isolated him until colleagues arrived when the control was removed.

456. Other options for a resolution would have been to have staff situated nearby and to use a three-officer team to control D2034 in order to prevent him going back on the netting. As stated previously there is no evidence of the correct incident scene management being in place at the time.

457. This incident should have been managed within the guidelines of PSI 09-2014 Incident management. There was no scene control and it appeared that DCO Clarke acted independently.

458. The attempts by DCO Murphy and another DCO to pull D2034 back over the railings were in line with guidance, but I am unsure if Brook House received this.

459. The removal of his utility belt and then leaving it unattended is unacceptable. It is a security breach and unprofessional to disregard his responsibilities.

460. The actual force used meets all of the general principles and DCO Clarke and Brackenbridge used low level guiding holds after the initial restraint.

461. Although the technique used by DCO Clarke was not an approved technique, or was it covered within the UOF syllabus, it does not necessarily mean it was unlawful. He used reasonable force in a controlled manner to manage a threat to good order and to prevent the incident escalating. The failings are that he was not given authority to intervene, or had his intentions been approved within a structured resolution strategy.

Summary

462. *Lawful* - Not an authorised UOF based on the circumstances.

463. *Last resort*- Not a last resort as negotiation and persuasion could have continued.

464. *Necessary, reasonable, proportionate*- Due to the above any UOF would not be within the general principles. When assessing the actual techniques used they were proportionate and reasonable, but not necessary at the time.

465. *No more than was necessary*- As above

466. Rule 41 (2) provoke or punish a detainee- No evidence to support this.

467. No concerns with the force used, but concerns over the incident scene management.

References

UOF training - manual-unplanned incidents (section 9), planned incidents (section 3)

PSI 09-2014 Incident Management

Senior Leaders Bulletin- managing incident at height, issued 2015

*Note**

468. Since completing my initial review of this incident I have now received document SXP000039- Report from Sussex Police. The Police report concluded that the force used was minimal, necessary and justifiable. DCO Clarke did operate outside of policy and did not use an approved Home Office technique.

469. The UOF Training manual 2015 v2.1 contains the following extract from the Introduction to physical techniques (section 2.0.4);

470. The description of UoF techniques in the basic manual reflect their use in an ideal controlled environment where the techniques represent the optimum solution for resolving the incident. Operational experience will not always mirror tutorial contrived situations. The unpredictable behaviour of the prisoner requires the officer to have an open-minded approach when applying to a live incident those aspects of training experienced in a controlled environment. In the daily operation of these techniques, the local geography of the establishment or physical inability of staff to perform the techniques as described in this manual, may require staff to adapt those techniques to enable them to gain effective control of the prisoner.

UOF Incident log 136/17 – D1538

Detainee concerned: D1538

Date of incident: 3rd June 2017

Reason for force as listed on the UOF report: Protect yourself and protect a third party

Staff involved: DCO Fiddy

Background

471. A number of detainees are in an IT room using the computer system. DCO Fiddy enters and shortly after D1538 walks over and to DCO Fiddy and another DCO who comes into camera view. D1538 moves close to the staff before being moved away by another detainee. Soon after he again goes up close to DCO Fiddy, who then pushes him back resulting D1538 coming back up close, resulting in a second push, then the right arm of D1538 goes around the neck of DCO Fiddy. His response is to grab and push by the neck to move D1538 away. Other detainees then prevent D1538 from going back.

472. A DCM enters and eventually D1538 leaves the room.

Observation/Opinion

473. The evidence is provided by CCTV[130], therefore lacking any audio of the dialogue. D1538 is obviously unhappy with something and he seems to be targeting DCO Fiddy. The first instance where he goes close to DCO Fiddy and another DCO (00:24 from footage time) resulting in another detainee ushering him away. At 01:28 he again goes up close to DCO Fiddy who pushes him away. This is followed by a second push away when D1538 gets close again. On both occasions the level of force used is a push to the torso area. Within the UOF continuum this is classed as a personal safety technique used when faced by an immediate threat. It is clear from the visual footage that D1538 is targeting DCO Fiddy and moves within his personal space. His body language and actions would cause concern for staff and without the benefit of the audio I believe that the two pushes were necessary, if all other attempts at resolving where not effective, and the level of force was proportionate to the threat at that time.

[130] Disk 4 UOF136 17 03June2017

474. After the second push D1538 's right arm ends up around the neck of DCO Fiddy. Unfortunately the delay from the CCTV does not give a clear view of whether this was a swing of the arm or an attempted grab. From the footage the hand is open when around the neck area. At this point DCO Fiddy places both of his hands around the neck of D1538 and pushed him backwards. This created distance between them and other detainees then usher D1538 away from DCO Fiddy. Although the grabbing by the neck is not a preferred option, I hold a view that DCO Fiddy may have raised his hands in response to the right arm and automatically grabbed the nearest point to push at. In times of confrontation staff can use the whole body as potential targets for defensive techniques. Training does highlight the extreme vulnerable areas, with the neck being among these. As a reactive motion the grab was momentarily and followed by a push away, as opposed to a grab and a 'strangling' type action. DCO Fiddy had every right under Common Law to protect himself and use reasonable force.

475. At 04:50 a DCM arrives and at 05:05 he takes the other DCO out of the room. At 05:30 and 05:55 D1538 again goes over to confront DCO Fiddy and they both point at one and other, before he returns to the computer he was sat at.

476. At 06:07 D1538 is called out from the room and does not return. At 08:05 DCO Fiddy is called outside and returns at 09:05. In his UOF report DCO Fiddy states that initially there were threats and abuse directed to a colleague, he did confirm the initial two pushes and then that D1538 tried to grab him and pull him forward. This was when the last push as a defensive action was made. There is no mention of where he pushed but his account has been considered within my opinions.

477. DCO Instone-Brewer submitted a witness statement and alleges threatening and abusive behaviour by D1538 toward him in the IT room. He also confirms when DCO Fiddy arrived he moved between the two of them and that the threat then moved toward DCO Fiddy. He also confirms the pushes and the attempt by D1538 to grab DCO Fiddy around the neck.

478. No UOF review available at present.

Summary

479. The actions and behaviour described resulted in a necessary UOF. The last push, when the hands were around the neck, are because of the threat and actions demonstrated by D1538 and no more force than was necessary were used.

480. Even without audio the incident is clear to establish that D1538 is showing signs of anger and venting this towards staff. The conversations are not available but he does move in close to staff in what could be described as a threatening manner.

481. Once distance had been achieved DCO Fiddy did not make any further attempts at restraining D1538 and allowed him to continue with his activity.

482. The intervention of other detainees assisted with calming the situation. It has to be considered that they accepted the staff were acting professionally and not being the aggressors in this instance.

Summary

483. *Lawful* - Immigration and Asylum Act 2 (4).

484. *Last resort*- due to necessity to take immediate action the use of a push was the last resort when other options such as withdraw, or retreat, were not a viable option.

485. *Necessary, reasonable, proportionate*- The push was a reasonable option under the circumstance and was proportionate to the threat at the time. It was necessary as no other option available.

486. *No more than was necessary*- A low level response to the threat that was appropriate at the time.

487. Rule 41 (2) provoke or punish a detainee- No evidence to support this.

488. No concerns.

References

UOF training manual - personal safety (section 16)

PSO 1600 - medical considerations (section 1.4)

UOF Incident log 158/17 – D1747

Detainee concerned: D1747

Date of incident: 20th June 2017 (listed as 26th on spreadsheet)

Reason for force as listed on the UOF report: Non-compliance, prevent injury to oneself

Staff involved: DCO Murphy

Background

489. DCO Murphy was supervising detainees in the medical waiting room when he challenged D1747 over not taking his medication and trying to leave with it in his possession. D1747 moved toward DCO Murphy, and they ended up face to face. DCO Murphy used a push to create distance between them and then a second push once they became face to face again.

Documents

CJS005621[131]

No UOF review report available at present

Footage

CJS0073712[132]

Observations/opinions

490. The footage shows a group of 6 detainees, including D1747, in a medical waiting room along with three staff and DCO Murphy.

491. At 02:56 (footage time) DCO Murphy moves just out of camera view and then D1747 appears in view walking toward the door. There is obvious some communication between them and D1747 then turns and moves toward DCO Murphy, ending up with the pair in close proximity, generally termed as 'nose to nose'. DCO Murphy then uses both hands to push D1747 away, after which the pair come together again and a second push is used. After this a detainee intervenes and positions himself between them and DCO Brown removed D1747 from the room.

[131] Use of Force Report - DCF 2 relating to D1747 dated 20/06/2017.

[132] Disk 08 20june2018 (should be 2017) 2180813

492. The mood in the waiting area appears relaxed with no obvious sign of tension, it is only when DCO Murphy moves over (slightly out of camera) and D1747 appears in focus that the situation changes. DCO Murphy has his back to the camera, but his stance does not change and his arms remain at his side. It is not until the push takes place that others in the room react.

493. The facial expression and body language of D1747 could be described as aggressive, he was stood square on within the personal space of DCO Murphy. DCO Murphy then uses a pushing action toward the torso to move D1747 away. The only concern I have is that the push is executed with clenched fists. Whilst there is no definition of how to execute a push the action of using a clenched fist may give the impression that a punch was delivered. It did not resemble a punch and was used exactly as you would describe a push, other than with clenched fists. The second coming together resulted in another push by DCO Murphy.

494. The account given by DCO Murphy of D1747 not taking his medication and concealing it in his hand would give rightful cause to challenge him and explain the requirement to take the medication in the medical area, rather than take it back into his room. The reaction observed and the follow up action justify using a low level technique, push, to prevent any threat of harm and to create distance for effective resolution strategies to be used. Trying to hold a conversation with someone in close proximity is not effective and can cause extra tension to the person being confronted, therefore creating distance by either stepping away or using low level force or tactile distancing are reasonable options. In some cases the suddenness and unexpected actions can result in a verbal interaction within close range. This is not effective communication and can antagonise a situation. I believe DCO Murphy used reasonable and proportionate force to create a safe distance between them.

495. I believe that DCO Murphy was justified in using a push in the first instance, even though it was delivered with clenched fists. The push moved D1747 slightly, just enough to achieve the aim of distance, and considering the size difference it would confirm only reasonable and proportionate force was used. The second push followed after the two ended up in close proximity again. As with the first phase, D1747 demonstrated aggressive body language, and the push was justified and proportionate to the threat as D1747 only moved back slightly.

496. The intervention of a detainee and DCO Brown in removing D1747 prevented the incident escalating and allowed the administration of medication for the other detainees to continue. It was clear D1747 was aggrieved at DCO Murphy and the intervention of others helped resolve the matter which had the potential to escalate further.

Summary

497. DCO Murphy was right to challenge D1747 over taking his medication in the medical room rather that to his room.

498. The coming together of DCO Murphy and D1747 was instigated by D1747 D1747 and DCO Murphy used justifiable force to prevent the risk of harm.

499. The incident continued and a second push was justified for the same reasons after they came back together.

500. The actions of the other detainee are commendable in preventing the escalation of the incident, as was the swift action of DCO Brown in removing D1747 D1747

501. No UOF review was completed for this incident, as a lessons learnt it should be clarified with staff that if they use a push it should be with open hands to avoid any confusion or interpretation of a punch.

502. The use of a push was justified under the circumstances and regardless of it being with open hands or a clenched fist I believe D1747 would have reacted in the same way.

Summary

503. *Lawful* - Immigration and Asylum Act 2 (4)

504. *Last resort*- DCO Murphy reacted to threat and had no opportunity to use other options, such as withdraw, or retreat.

505. *Necessary, reasonable, proportionate*- It was a necessary UOF to move D1747 and the two pushes, delivered at separate times, amount to a proportionate response to the threat at the time.

506. *No more than was necessary*- Low level technique that no more than necessary at the time.

507. Rule 41 (2) provoke or punish a detainee- no evidence to support this.

508. No concerns.

References

UOF Training manual- personal safety (section 16)

UOF Incident log 174/17 – D2830

Detainee concerned: **D2830**

Date of incident: 10th July 2017

Reason for force as listed on the UOF report: Maintain Good Order and Discipline, non-compliance

Staff involved: DCM Webb, DCO Francis, in attendance Sarah Edwards

Background

509. D2830 took a drink from the office desk after requesting food. When instructed to take him to the CSU D2830 ran down the landing and went under the pool table. DCM Webb and DCO Francis tried to remove him and he slid out and was placed in guiding holds for removal to the CSU. On arrival at the CSU D2830 started to struggle and was taken into the room. When the holds were released he tried to come out of the room and DCM Webb pushed him back and secured the door.

CJS005612[133]

510. The UOF form lists nationality as Gambia, is not signed by the Orderly Officer and no F213 completed.

511. The decision of Sarah Edwards to place D2830 on Rule 40 for the act of taking a can of drink from the office was disproportionate and does not meet the general principles for using force. When measured against the justifiable reasons for removal from association the action demonstrated would not be a lawful removal within the criteria set in Rule 40, Rule 42 or Rule 43. Alternate measures should have included being advised of his actions and warned reference future conduct. I do not feel relocation to the CSU for this part of the incident alone was justifiable, or lawful. It would not in my opinion met the threshold for maintaining Good Order and Discipline.

512. Staff used low level guiding holds after removing D2830 from under the pool table, which were reasonable and proportionate following his previous actions.

513. The difficulties relocating into the room raise the question of why CSU staff did not attend when aware of a new arrival on the unit. Normal protocol would be for the CSU staff to be contacted via radio transmission of movements onto the unit.

[133] - 070520-Bix-0107 Use of Force - DCF 2 DC Rule 41 for D2830 dated 10/07/2017

514. The push used would be proportionate to prevent access back onto the unit and are justified to avoid a further incident.

515. The lack of an F213, activation of BWVC by DCM Webb, or availability of wing/unit CCTV is concerning.

516. The concern is the decision to remove to the CSU and the justification listed.

Part 2

517. I was instructed to review the priority incidents of interest first, then conduct a reduced response to other incidents, which have no footage. Following this review incidents 86 and 174 have been added to the incidents presented as a concern. There are a number of incidents within the original list that I have no concerns over, which are at the end of the summary reports. The remainder of the secondary incidents have been reviewed and are detailed in the following section.

UOF Incident log 104/17 – D1527

Detainee concerned: D1527

Date of incident: 24th April 2017

Reason for force as listed on the UOF report: To prevent self-harm

Staff involved: DCMs Brown & Ring, DCO Croucher

Background

518. D1527 was checked on by staff and did not respond when observed in bed under the covers. When staff removed the covers they discovered he had a ligature around his neck. He was controlled to allow the ligature to be removed.

CJS005538[134]

519. In this circumstance staff are lawfully authorised to use for force to prevent self-harm. The necessity to preserve life is paramount and all efforts should be made to verbally gain compliance unless immediate action is required (see Detention Centre Rules 2001, Rule43 (1)).

520. Based on the staff statements it appears as a reaction to seeing the ligature DCO Croucher controlled the right arm of D1527 in order to allow the ligature to be removed. DCM Brown assisted by holding the legs of D1527 to prevent him kicking out and putting staff at risk of harm, or to prevent the removal of the ligature.

521. D1527 refused to be assessed by healthcare staff following the incident.

522. The incident was reviewed by Steve Webb on the 18th July 2017, nearly three months after the incident. This is unacceptable and reviews should be completed much sooner. Although PSI 30-2015, 2.38[135] states 'quarterly' reviews this is specifically a formal multi-agency review panel meeting with a view to monitoring UOF in general[136]. The light touch reviews by Steve Webb must be within a shorter timeframe.

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[134] Use of Force Report for D1527, dated 24/04/17
Report of Injury to Detainee D1527, written by Nathan Ring and Medical Staff Melissa Morley, dated 24/04/17

[135] PSI 30/2015; Effective date: 04 November 2015;pp.12-13;
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/904544/PSI-302015-Amendments-to-use-of-force-policy.pdf

[136] Amendments to the use of force policy: PSI 30/2015,

523. D1527 made a number of complaints around his detention and a PSU investigation was completed.

524. In summary I am satisfied that the force used was necessary and proportionate to the risk at the time.

UOF Incident log 169/17 – D812

Detainee concerned: D812
Date of incident: 6th July 2017
Reason for force as listed on the UOF report: To prevent self-harm
Staff involved: DCM London DCOs McMillan, Murphy & Martin

Background

525. Whilst on a constant watch D812 was observed trying to make a ligature. Staff entered the room and D812 attempted to strike out and then spat at DCO McMillan. Force was used by three staff to prevent them being harmed and to retrieve the ligature, which fell to the floor after the restraint. The restraints were removed immediately after and staff left the room.

CJS005590[137]

526. In this circumstance staff are lawfully authorised to use for force to prevent self-harm. The necessity to preserve life is paramount and all efforts should be made to verbally gain compliance unless immediate action is required *(see* Detention Centre Rules 2001, Rule 43 (1)).

527. Staff initially dealt with the reaction by D812 by using approved techniques to control him in order to prevent harming himself or others.

[137] Use of Force for D812, dated 06/07/2017 - Report of Injury to Detainee, including Detainee: De Brief dated 07/07/17

528. Once the ligature was retrieved staff removed the restraints and left the room. The debrief carried out by DCM Loughton states D812 was frustrated and angry with himself.

529. The medical section on the UOF report has not been completed but a F213 has recorded the incident. This type of omission should be identified when collating and reviewing incidents.

530. As a constant watch it was essential that staff removed any risk to D812 and they acted in response to a serious potential risk of self-harm. Once they faced a risk to their own safety it was reasonable and necessary to use force. I am of the opinion that the force used was proportionate, especially when he spat at DCO McMillan. The force was not used for any longer than necessary and removed once the threat had been eliminated.

UOF Incident log 157/17 – D149

Detainee concerned: D149

Date of incident: 19th June 2017

Reason for force as listed on the UOF report: Failure to comply with removal, non-compliance, prevent self-harm, prevent injury to third person

Staff involved: DCOs Williams & Brewster, DCM Aldis

Background

531. D149 was to be transferred from Brook House to HMP Wormwood Scrubs. He had a history of violence and non-compliance therefore a team in PPE were assembled to remove him to the discharge area. He complied with instructions and handcuffs applied for the removal. Handed over to Tascor staff on arrival.

CJS005561[138]

532. Staff are authorised to use force in order for a removal under Detention Centre Rule 43 (10). The history of D149 suggest he may refuse to comply but there is no evidence of any prior conversation with him or that he was refusing to move, self-harm or pose a risk to others. I am confused at the reasons for force listed.

[138] - G4S Use of Force-DCF 2 Form DC Rule 41 re D149 dated 19.6.2017

533. The staff accounts are that when instructed to place his hands behind his back he did so. Handcuffs were applied and he was removed to the discharge area and handed over to Tascor staff.

534. It is correct that the application of handcuffs is listed as a UOF and that statements were completed. It is also acceptable that handcuffs be used after a risk assessment of the detainee had been completed and authorised by a manager.

535. My opinion is that the use of force (handcuffs) was necessary and reasonable in the circumstances. The details for use do not reflect this actual incident and they should be re-worded to reflect the justification for use on this occasion.

UOF Incident log 119/17 – D1020

Detainee concerned: D1020
Date of incident: 10th May 2017
Reason for force as listed on the UOF report: prevent injury to third person
Staff involved: DCO Paschali

Background

536. DCO Paschali observed D1020 entering another detainee's room and followed him. D1020 attempted to stab another detainee with a pen. PCO Paschali grabbed his arm and walked him back to his own room.

CJS005545[139]

537. Using force to prevent injury to another person is authorised under Detention Centre Rules 2001 43 (1).

538. In this instance the quick thinking and alertness of DCO Paschali prevented a potentially serious injury. He used a low level use of force by simply taking control of the arm and removing D1020 from the room.

539. The incident was reported and documents completed, including a F213 medical assessment which recorded no injuries observed or reported.

540. This was justified UOF which was necessary and proportionate to the threat at the time.

[139] G4S Use of Force DCF2 Form DC Rule 41 re D1020 dated 10.5.2017 timed at 2045

UOF Incident log 122/17 – D243

Detainee concerned: D243

Date of incident: 17th May 2017

Reason for force as listed on the UOF report: prevent self-harm, prevent injury to third person

Staff involved: DCOs Olyale & Randall

Background

D243 was upset that his flight did not go ahead, he threatened self-harm and had a razor blade in his clenched fist. Refused to give up the blade and staff intervened.

CJS005543[140]

541. Using force to prevent injury to self is authorised under Detention Centre Rules 2001 43 (1).

542. Staff tried to resolve the situation by engaging with D243 but he refused to comply. DCM Aldis instructed two staff to control his arms, this indicates a low-level threat to staff and was the minimal force that could have been applied once all reasonable efforts for compliance had been exhausted.

543. DCO Olyale states that there was no resistance once he took control of the arm and the razor blade dropped to the floor.

544. DCO Randall states that once the razor blade was dropped DCM Aldis asked D243 if he would comply. This was agreed and the restraints were removed and D243 walked back to his room.

545. This is an excellent example of managing a low level risk presented by a detainee in distress. Force was necessary but it was proportionate to the threat and removed once the blade had been dropped and full compliance given.

[140] Use of Force Record - 17/05/2017 - D243 Record of use of force by Detainee Custody Officer to prevent self-harm and to prevent injury to a third party.

UOF Incident log 095/17 – D489

Detainee concerned: D489

Date of incident: 20th April 2017

Reason for force as listed on the UOF report: maintain Good Order and Discipline

Staff involved: DCMs Ring & London

Background

546. The Home Office had requested a thumb print from D489 in order to produce an emergency travel document. Initially D489 refused and then complied with staff. Once at the point of presenting his hand he became resistant, and staff used force to obtain the thumb print.

CJS005551[141]

547. Under Section 141(5) of the immigration and Asylum Act 1999 those authorised to take fingerprints are: a constable; an Immigration Officer; a prison officer; an officer of the Secretary of State authorised for the purpose; or a person who is employed by detention centre contractors.

548. After initially agreeing to have his thumb print taken D489 changed his mind at the last moment. Due to staff having all the equipment in place low-level force was used on the left hand to control the hand and place the thumb onto the ink pad.

549. Throughout the day staff had engaged with D489 and explained why this was required. After the thumb print was taken DCM Ring recorded D489 was in a low mood and ordered supervision monitoring over 24 hours.

550. The F213 records pain to the left hand, which was used for the thumb print.

551. DSO 15-2012[142] sets out the procedure for using force to take fingerprints. I note that it should be a planned incident but due to the circumstances in this instance

[141] - Use of Force Report relating to D489 - 20.04.2017

[142] Home Office Detention Services Order about mandatory instructions for fingerprinting detainees in Immigration Detention Centres: Detention Services Order 15/2012 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/257739/fingerprinting.pdf

it was justified to take as in the way described as planning had taken place for taking fingerprints and healthcare were in attendance.

552. The force used on this occasion was minimal and proportionate to achieve the objective. Staff demonstrated engagement and rightfully raised concerns after observing a change in mood.

UOF Incident log 110/17 – D2559

Detainee concerned: D2559
Date of incident: 28th April 2017
Reason for force as listed on the UOF report: Protect self
Staff involved: DCO Paschali

Background
DCO Paschali attended the room of D2559 after hearing banging. He struggled to open the door and when entering the room D2559 was shouting and tried to punch DCO Paschali. A push was use that forced D2559 to the floor. When seen by the nurse he complained that Mr Paschali tried to kill him and hit him many times for no reason.

CJS005532[143]

553. DCO Paschali responded to the noise from the room and after finding the door difficult to open it would have been normal practice to alert colleagues. The incident took place at approx. 14:45 so other staff would have been available.

554. The events described in the room vary between both parties and they have different viewpoints. If as described by DCO Paschali he could rightfully use force to prevent harm to himself, and a push would amount to necessary and proportionate.

555. The F213 lists complaints made by D2559 of pain and redness to the right side of his neck, and pain when swallowing. This would not be consistent with a push and would more likely be of a grab or strike to the neck area. DCO Paschali makes no reference as to what part of the body he pushed or how he applied the push, therefore it is impossible to state if the injury was as a result of the push.

[143] G4S Use of Force Form DCF2 DC Rule 41 - Detainee D2559 - dated 28.4.2017

556. D2559 was located in the CSU.

557. Steve Webb review lists a different incident under 110/17.

UOF Incident log 092/17 – D523

Detainee concerned: D523

Date of incident: 14th April 2017

Reason for force as listed on the UOF report: inciting disorder, non-compliance, preventing injury to a third party

Staff involved: DCM Dix, DCOs Sayers, Murphy & Shadbolt

Background

558. D523 was identified as being a principal inciter during the concerted indiscipline that took place on the exercise yard. His behaviour was deemed threatening and abusive, therefore once back in his room it was decide that he be placed on R40 in the CSU. DCM Dix explained the situation and asked D523 to comply. He failed to comply and sat on his bed. Staff used a three officer team to restrain him before handcuffs were applied and he was then relocated to the CSU.

559. Detention Centre Rules 2001 R40 (1) state that in the interests of security removal from association is permitted. Following an act of concerted indiscipline, and the behaviour by D523 in inciting others, the decision to remove to the CSU was justified and lawful.

560. All documents refer to an unplanned incident. This is incorrect; this was a planned incident as D523 was in his own room and staff were assembled to remove him. DCO Sayers UOF statement confirms this.

561. As a planned incident healthcare should have been in attendance and evidence gathering through the activation of BWVC, or a handheld device should have taken place.

562. Once D523 refused to comply with the instruction to move staff could justifiably use force. The description from the statements all appear to confirm that approved

techniques were used and the application of handcuffs was necessary due to the risk of further disorder.

563. D523 was released from restraint and allowed to stand upright, whilst being supported by staff for the move to the CSU and the relocation.

564. An F213 was completed and reported no injuries or concerns.

UOF Incident log 108/17 – D1199

Detainee concerned: D1199

Date of incident: 24th April 2017

Reason for force as listed on the UOF report: Prevent self-harm, Good Order and Discipline

Staff involved: DCOs Bromley, Fallbrown, Mishiri & Instone-Brewer

Background

565. D1199 was to be removed from the centre to HMP Wandsworth. Previous removals had been stopped due to the possession of blades and disruptive behaviour. Instructed to leave his room and failed to comply which resulted in staff restraining him before moving to the discharge area and handed over to Tascor staff. CJS005067[144]

566. Staff are authorised to use force in order for a removal under Detention Centre Rule 43 (10).

567. The decision to have a team prepared can be justified when based upon previous unsuccessful removal attempts. The threat of razor blades would be sufficient to issue staff PPE.

568. The UOF report confirms BWVC and handheld device used. The form is not signed by the supervisor and the healthcare section left blank.

569. DCM Roffey gave D1199 an instruction from the door and when D1199 failed to comply the staff were deployed to carry out the removal.

[144] Home Office Detention Services Security information report re D119, updated 10 June 2017.

570. The threat posed by D1199 was not significant and it is therefore reassuring that the shield was not used and two DCOs controlled the arms in order to move D1199.

571. The removal ended with a search of D1199 before handing over to Tascor staff.

572. Based on the documents the UOF on this occasion appears to be justified and necessary, with only minimal proportionate force used.

UOF Incident log 097/17 – D2636

Detainee concerned: **D2636**

Date of incident: 21st April 2017

Reason for force as listed on the UOF report: Prevent harm

Staff involved: DCMs Bannister & Roffey

Background

573. D2636 had been placed in the CSU following four/five assaults on staff. DCMs Roffey and Bannister went to his room in the CSU to issue the paperwork stating the reasons for his removal from association. After reading it he then punched DCM Roffey before he was restrained on the bed until he calmed down. Staff left the room and a nurse attended to complete the examination.

CJS005539[145]

574. The initial reason for removing to the CSU are justified if multiple staff had been assaulted earlier. Detention Centre Rules 2001 R40 (1) for the safety and security of the centre.

575. Considering the number of staff assaults I am surprised that only two staff went to issue the paperwork. Although not trying to antagonise the situation by taking multiple staff I would have thought having staff in close attendance would have been a sensible precaution.

[145] Use of Force - DCF 2 in relation to D2636 dated 21/04/2017; Report Of Injury To Detainee dated 21/04/2017

576. The assault on DCM Roffey appears to have been unexpected and with no prior warning. In these instances staff will rely on personal safety techniques, which have to be reasonable and proportionate to the threat. It is commonplace for staff to react instinctively and defend themselves using their primal skills as opposed to any taught techniques.

577. The description of events from both statements demonstrate that reasonable force was used by pushing D2636 to the bed before controlling him until such point as the staff could exit.

578. I am confused that there is no mention of other staff responding, especially in the CSU. The 'melee' would have alerted other staff, especially in a confined area where large numbers of detainees are not routinely unlocked.

579. The F213 states no injuries observed or reported.

580. No reports of BWVC being activated which they ought to have been considering the potential for a difficult conversation.

UOF Incident log 098/17 – D2636

Detainee concerned: D2636

Date of incident: 21st April 2017

Reason for force as listed on the UOF report: Good Order and Discipline, injury to third party, damage to property.

Staff involved: DCM Webb DCOs Lainchbury, Camara, Olyaie, Bromley, Clarke & Hoque

Background

581. D2636 attacked staff with a broken pool cue and when challenged by responding staff he refused to take his hands from his pockets and attempted to strike another member of staff. Force was used to prevent injury to others and to control him in order to relocate to the CSU. One statement mentions damage to two TVs in addition to the assaults.

CJS005623[146]

[146] Use of Force - DCF 2 in relation to D2636 dated 21.04.17

582. The use of force was necessary to prevent injury to staff and others and to prevent damage to property. There was justification to intervene in order to prevent an escalation of events. Detention Centre Rules 2001 42 (1) *'the manager may order a refractory or violent detained person to be detained temporarily in special accommodation'.*

583. The initial attack was on DCO Clarke when D2636 struck him with a broken pool cue, he then threw the pool cue at DCO Hoque.

584. When other staff responded the area was secured and D2636 was asked to remove his hands from his pockets. He then tried to assault DCO Lainchbury, which resulted in force being used.

585. The staff statements provide detail that three staff controlled D2636 but had to take him to the ground in order to gain full control of him. Once under control he was removed to the CSU and seen by healthcare, no injuries observed or reported.

586. The UOF form has not been signed by the Orderly Officer and the BWVC section has been ticked. In addition I assume CCTV would have captured all of the incident and should be provided for review.

587. Due to the risks presented staff had no option but to use force and based on the statements my opinion is that force was necessary and proportionate (three officer team) in the circumstances.

UOF Incident log 091/17 – D2497

Detainee concerned: **D2497**
Date of incident: 14th April 2017
Reason for force as listed on the UOF report: Assault staff, non-compliance
Staff involved: DCOs Sawyers, Murphy & Shadbolt
Background

588. Following a protest on an external yard it was reported that D2497 had assaulted a member of staff and as a result would be relocated to the CSU. DCM Dix informed D2497 that he would be relocated and for him to comply with his instruction. D2497 refused to comply and turned away from staff. Staff were

instructed to use force to remove him and three DCOs carried out the instruction and used approved techniques to facilitate the removal.

589. It was justified and lawful to remove D2497 to the CSU under Detention Centre Rules 2001 40 (1) and 42 (1) following an assault on a staff member.

590. The UOF form states unplanned. This is incorrect- three staff were in attendance and the necessity to use force was for removal to the CSU, not, as in an unplanned incident, where force is used immediately due to the risk of harm and the necessity to utilise protective strategies. DCM Dix gave an order to D2497 and after failing to comply he deployed the staff, this is a planned action.

591. Once force was applied all three staff used appropriate techniques to enforce the removal, although I note handcuffs were not used and BWVC were not activated. No details of CCTV coverage of the initial incident.

592. D2497 refused to see healthcare and the F213 states no visible injuries. D2497 later banged his head on a window but again refused to be seen by healthcare.

UOF Incident log 143/17 – D720

Detainee concerned: D720

Date of incident: 6th June 2017

Reason for force as listed on the UOF report: Good Order and Discipline

Staff involved: DCO Matchett

Background

593. DCO Matchett put his arm out to prevent D720 from entering Aren wing. As a resident on Clyde wing he was not allowed to go onto other wings. A similar incident had occurred the previous day. D720 tried to manoeuvre past him and DCO Matchett grabbed his right arm before D720 sat down. D720 then verbally threatened DCO Matchett, saying 'get out of my fucking way, don't touch me, and get out of my way otherwise you'll have a broken nose'. DCO Opoku intervened and took D720 away.

CJS005580[147]

594. DCO Matchett was quite entitled to prevent DCO720 from entering the wing. He used a physical barrier with his arm which resulted in a reaction from D720 who appeared intent on going onto Aren wing.

595. DCO Matchett reacted by grabbing an arm in order to prevent D720 entering the wing. This is reasonable and proportionate in the circumstances. The following threats are not acceptable, and it appears only the intervention of DCO Opoku resolved the incident.

596. The F213 stated that there was some redding on the arm, which would be consistent with the action taken by DCO Matchett.

CJS001526[148]

597. CCTV footage observed which showed another DCO (Brown) present. After reviewing the evidence, including CCTV, the investigating officer found the complaint unsubstantiated and no further recommendations.

UOF Incident log 143/17 – D672

Detainee concerned: **D672**

Date of incident: 7th May 2017

Reason for force as listed on the UOF report: Non-compliance

Staff involved: DCMs Webb, Harris & Roffey, DCO Harris

Background

598. D672 was to be relocated to the CSU in preparation for a flight to Afghanistan under the orders of the Home Office. The reasons being previous failed moves due to the presence of blades and disruption. DCMs Webb, Harris and Roffey explained the situation to D672, who initially complied then became non-compliant and resistant to any attempts to move him. Force was initiated and D672 relocated into a room within the CSU for a search to take place. Due to non-compliance one of the statements reference the removal of his jogging bottoms by staff as part of the search.

[147] Use of Force Record - 06/06/2017 - D720 Records use of force by a Detainee Custody Officer to maintain good order and discipline

[148] Use of Force complaint made by D720 on 6 June 2017. Physical Environment Complaint Withdrawal by D2169.

CJS005552[149]

599. The removal of D672 under the Home Office instruction is lawful and justified as outlined in Detention Centre Rules 2001 Rule 43(10).

600. It appears that staff expected some difficulties in removing D672, hence the three DCMs in attendance and follow -up inclusion of an extra DCO. Once it was evident D672 would not comply the incident became planned, not unplanned as listed within the UOF documents. CCTV should be available in the areas of the incident.

601. The description of techniques used are consistent with authorised techniques taught during training and based on the risk/threat they appear necessary and proportionate.

D672 continued to resist against the removal and staff were forced to maintain controlling techniques until in the CSU room. In this room the search was to take place. One account mentions staff removing the jogging bottoms before D672 gave assurance of compliance and the search under restraint was replaced by a compliant search.

602. There is a section within the 2015 v2.1 UOF Training Manual for carrying out a full search under restraint (section 12). This is only to be used when all other options have failed and in the interests of safety or security and search is required, even when in restraint. In this case it appears only the jogging bottoms were removed, and whilst D672 was stood up. The F213 reports no injuries but D672 was requesting tubi-grip for his wrist.

[149] - Use of Force Form - Detainee D672 - 07/05/2017
Record of use of force by Detainee Custody Manager to facilitate removal

UOF Incident log 084/17 – D1774

Detainee concerned: **D1774**

Date of incident: 2nd April 2017

Reason for force as listed on the UOF report: Fight with other detainee, protect a third party

Staff involved: DCM Dix, DCOs Edon & Purnell

Background

603. Staff were alerted to an incident on C wing where they found a large number of detainees at the scene of a fight. D1774 was talking to staff when a second assault occurred, the accounts of staff differ on who instigated the fight but it resulted in D1774 being restrained by staff to prevent escalation.

CJS005635 [150]

604. The incident involved many detainees but one of the main protagonists was D1774. He was talking with staff when a further incident took place and staff rightfully used restraints to prevent assault and escalation of the incident.

605. The statements of DCM Purnell and DCO Edon differ as to who initiated the fight but it resulted in D1774 being restrained. I am concerned that EDCO Edon states at the end of his report that *'at no point were control and restraint techniques used'*, but in his report he mentions restraining the arms and holding the legs.

606. The description of techniques appears to evidence that reasonable force was used once it was necessary and only proportional force used until they were no longer required. The quality of reports does not include sufficient detail to make further assessment of the incident. DCM Dix only completes the mandatory sections of the UOF form and does not include any narrative of the incident, despite being present.

607. The F213 lists some injuries, which all appear to be from the initial fight.

608. Due to being on a residential wing CCTV footage should be available for this incident.

[150] Use of Force [Stop detainees fighting] report - D1774 - dated 02/04/2017

609. The removal to the CSU is authorised under Detention Centre Rules 2001 Rule 40(1), 42(1) and 43(1) and was justified in this instance based on the events that had taken place.

UOF Incident log 152/17 – D368

Detainee concerned: D368

Date of incident: 13th June 2017

Reason for force as listed on the UOF report: Stop detainee leaving the wing

Staff involved: DCOs Lainchbury & Sandhar

Background

610. D368 tried to push past a member of healthcare in order to leave the wing. Staff used force to prevent him doing so and relocated him back to his room, where the restraints were removed and the incident concluded.

CJS005628[151]

611. No F213 or supervisors report included within the statements.

612. The force appears to be necessary to prevent leaving the wing after what appeared some confusion over being seen by healthcare.

613. Staff only applied low-level guiding holds and de-escalated the incident by sitting D368 on his bed before releasing all restraints.

614. As healthcare were on the wing it is confusing why they did not complete the F213. First response was called so the supervisors report should have been completed by the Orderly Officer.

[151] Use of Force report - D368 - 13/06/2017

UOF Incident log 171/17 – D68

Detainee concerned: D68

Date of incident: 7th July 2017

Reason for force as listed on the UOF report: Good Order and Discipline, prevent injury to third party

Staff involved: DCM Dix, DCO Stokes

Background

615. DCM Dix was approached by another detainee when D68 came toward them and delivered a strike in their direction (unsure who it was aimed at). DCM Dix restrained D68 along with DCO Stokes who responded to the incident. Once control was gained D68 was relocated to the CSU. D68 made threats to assault other detainees for fun.

CJS005560[152]

616. An unplanned incident where staff reacted to an act of violence against another detainee. There was little build up other than observing D68 approaching DCM Dix and the other detainee.

617. Once the assault was initiated it was lawful and justifiable for DCM Dix and other staff to use force to prevent harm to a third party. The description of restraints used are consistent with those taught during training and were proportionate to the threat/risk.

618. De-escalation resulted in restraints being removed before D68 was located in the CSU. Removal to the CSU was lawful under Detention Centre Rules 2001 Rule42 (1) and Rule 43(1).

619. The F213 reports no injuries observed or reported.

[152] Use of Force Report relating to D68 - 07.07.2017

UOF Incident log 112/17 – D68

Detainee concerned: D68
Date of incident: 29th April 2017
Reason for force as listed on the UOF report: Protect oneself
Staff involved: DCO Sayers

Background

620. D68 was at the wing office asking for a mobile phone. He was told that he would be on a waiting list he became abusive toward DCO Wright. DCO Sayers arrived at the scene and D68 became threatening by saying *'what are you going to do about it, I will slap you'*. D68 then stepped toward DCO Sayers who repeated several times for him to move back, eventually after ignoring the request DCO Sayers pushed D68 in the torso area with open palms. Another detainee came and spoke with D68, who then went back to his room.

CJS005599[153]

621. DCO Sayers used verbal reasoning to try and encourage D68 to move from within his personal space. He eventually used a low-level push to the torso to create space.

622. The above description is consistent with the UOF Training Manual 2015 v2.1, personal safety. When all reasonable efforts have been unsuccessful staff may use personals safety techniques, for instance a push, that are reasonable and proportionate to the threat of imminent harm.

623. The actions of D68 as described were aggressive and intimidating and would have put DCO Sayers under pressure. He reacted to the threat with lawful force under the circumstances.

624. No F213 completed and CCTV footage from the wing should be available.

[153] Use of Force - DCF 2 in relation to D68 29.04.17

UOF Incident log 163/17 – D2953

Detainee concerned: D2953

Date of incident: 29th June 2017

Reason for force as listed on the UOF report: Disruptive behaviour, non-compliance

Staff involved: DCM Page DCO Williams

Background

625. D2953 had been demonstrating poor behaviour and when collecting his meal form the servery he started asking for more food. When told he would have to wait for a change of meal he became abusive and threw his food to the floor and in the direction of DCM Page. Staff took control of D2953 and removed him to the CSU as he was disrupting the centre and causing other detainees to become irate.

CJS005593[154]

626. The removal to the CSU was authorised under Detention Centre Rules 2001 Rule 40(1) and Rule 42(1).

627. There appeared to be an escalation of negative behaviour by D2953 which resulted in the servery incident. DCM Page provides a well written detailed catalogue of events concerning D2953.

628. The force used to remove away from the servery was a combination of low-level guiding holds, arm control and figure four holds. At one stage DCO Williams escalates to wrist flexion but once no longer necessary he reverted to lower-level techniques. Eventually all restraints were removed and D2953 was located in the CSU. A good example of de-escalation.

629. The F213 reports several previous injury signs but no new injuries.

630. All force used in this instance were in my opinion justified and necessary.

[154] Use of Force Report relating to D2953 - 29.06.2017

CJS001506 PSU Investigation[155]

631. No reference to this incident within the list of complaints submitted.

[155] - Allegation of physical assaults on 10/11/12 June 2017 made by D2953 investigated, including HO Investigation dated 15 February 2018.

Findings and recommendations

Use of Force (UOF) techniques

632. The Home Office are an approved user of the HMPPS system of restraint known as UOF. Previous terminology included Control and Restraint (C&R) and breakaway techniques.

633. The system of restraint was first introduced in the mid-1980s as a structured method for dealing with violent or recalcitrant prisoners within custodial settings. Since then it has developed through several reviews into the version in use at the time of the incidents at Brook House, UOF Training Manual 2015 v2.1.

634. I am satisfied that the practical system of restraints currently employed, when carried out appropriately, meets the requirement for instances when force is the last resort. The techniques have been medically evaluated and with the correct supervision, training and governance provide as safe a system as is reasonably possible. I will refer to the behaviour management training later. A review of both policy and the training manual is currently being undertaken by HMPPS with a view to go live from April 2022 - included will be a section on neurodiversity and other generic mental health management.

635. The techniques contained within the manual are designed to reflect the type of restraints encountered within a custodial setting and allow a degree of flexibility based on the individual circumstances of each incident. It would be impossible to design a manual that covered every possible scenario and there are too many impact factors to specify how to respond to each situation. What is consistent are the general principles and lawful application of force, along with the use of prescribed techniques as taught during training. Adequate supervision and management of UOF incidents are covered in the syllabus and full details are in the UOF training manual and PSO 1600.

636. My observations when reviewing incident footage raised concerns over the current level of training and the understanding, primarily within the DCM group, of the lawful application of force, how to de-escalate and exploring all other reasonable options before using force as the last resort. Simple measures such as removing

PPE, as evidenced during planned removals on incidents 134, 81,162, 86 and 108 where PPE remained despite the situation being de-escalated and the risk to staff reduced, once the initial force has been initiated are good examples of acknowledging the behaviour of a detainee. It is evident from the footage that after the initial engagement teams are sent in to use force. Good practice may include, leave and allow the detainee time to reflect, use another detainee or suitable non-uniformed person to engage and help to explain the situation, and continue for longer with persuasion before resorting to forcibly removing the detainee.

637. There are also concerns over the technical ability of the DCO ranks This is evident during incidents 135, 81, 164 and 162 when all or some of the following are seen, handcuffs are incorrectly applied, inability to perform the full relocation, how to apply restraints in the supine position or effectively carry a detainee as prescribed in the training manual. The conversations prior to the removal of D275 from the netting including conversations between the staff identified to support the intervention on how to apply the most basic of techniques, including a guiding hold, figure of four hold an the leg restraint. At one point the correct technique was demonstrated to assist the staff member. On many occasions they appear unsure of what to do and require guidance from colleagues. To a degree this is all part of the learning curve when staff are new into post, however the lack of knowledge does not help in providing a safe environment and as evidenced can be potentially injurious during difficult restraints.

Recommendation 1 (use of force techniques)

All DCMs should in future receive incident scene management training before taking up post. This can be adapted from the current syllabus by local instructors, or preferably designed by HMPPS as a bespoke package. It will focus on scene control and defensible decision making using the model within the UOF Training Manual, negotiation skills and staff management.

New staff should have an additional one-day refresher after six months in post. This will support learning and allow extra training within the techniques that they have struggled with, or cannot remember from their initial course.

638. The process for the development and approval of techniques would normally follow a general route:

- Identify the training needs based on operational knowledge and experience
- Design a range of techniques that are not reliant on physical strength and which can be used by staff of varying abilities.
- Medical approval of proposed techniques based on the application as delivered in training. Any physical restraint will carry a degree of risk and a risk matrix will assess each individual technique against the potential risk of harm/injury.
- Internal approval by a multi-disciplinary group.
- Inclusion within a revised training syllabus to be cascaded to local staff in approved sites.

639. In addition to the approved techniques the training manual also contains sections on; The Law, communication strategies, medical advice and report writing. All four topics are mandatory elements to be covered on all UOF training sessions before practical skills are introduced. The medical advice section is supported by a DVD produced by Dr Ian Maconochie FRCPCH, FCEM, FRCPI, PhD[156].

640. Local training is delivered by accredited instructors. In order to qualify they must attend a course designed by the Learning & Development Group of HMPPS and delivered by the National Tactical Response Group (NTRG). Once qualified they must attend an annual revalidation to remain authorised to deliver UOF training.

641. Local staff do attend an Initial Training Course of 32 hours (as described in PSO 1600) during their foundation training course, known as an ITC, and a further 8 hours refresher every 12 months (as described in PSI 30-2015[157]). They are assessed as competent, or not, and signed off to authorise them for operational duties. In the event that a member of staff does not complete a fresher course within the 12 month period they can continue in an operational role, however they are not permitted to be deployed during a planned incident, and only used for unplanned incidents where there is an imminent risk of harm, until such time as currently accredited staff attend.

[156] HMP000001 to HMP000004

[157] PSI 30/2015, Effective date: 04 November 2015; https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/904544/PSI-302015-Amendments-to-use-of-force-policy.pdf

Recommendation 2 (use of force techniques)

Consider a bespoke communication package for staff working directly with foreign nationals held in detention centres. It should be more behaviour management and therapeutic based and cover detailed information specifically on the legal aspect of detention, rather than focussing on when situations have escalated or when dealing with confrontational situations. Training in managing difficult conversations is essential for all roles within a Detention Centre and should be included, however a greater asset would be for better staff training that utilises preventive strategies by recognising and managing potential risks (understanding of preventive strategies) as opposed to reactive strategies when a situation has escalated.

Internal and external quality assurance of locally delivered training in the UOF, including peer observations and independent external bodies observations of training must be introduced. As a minimum I would expect at least two observations per year, this would be in addition to the mandatory Instructor revalidation through NTRG.

Assurance and Governance

642. Whenever force has been used a review should be completed by a UOF review committee. The full details are covered in PSI 30-2015, 2.38-2.40, which are an amendment to PSO 1600, 8.14-8.15. Full details are in Annex A (replacing Annex G from PSO 1600) of PSI 30-2015[158].

643. The key points are:

All establishments must have in place a "Use of Force Committee" in order to monitor and review the use of force within the establishment and identify any issues and problems that may be arising from any aspect of use of force. The Governor/Director must agree the structure and remit of the Committee (which could be an extension of the role of an existing committee) and must agree this with the Deputy Director of Custody. Meetings must be held at least quarterly.

[158] See page 15 of PSI 30/2015; Effective date: 04 November 2015; https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/904544/PSI-302015-Amendments-to-use-of-force-policy.pdf

644. I have had access to the reviews of UOF conducted by DCM Steve Webb. These reviews do not meet the expectations as stated within the PSI and can only be described as a 'tick box' exercise. I appreciate that the documentation promotes this methodology but it fails to provide any reassurance over the scrutiny of force used and identifying trends, hot spots, themes or importantly misuse and local culture issues when managing detainees. For example, I reviewed a number of incidents, 81, 162 and 88, where the detainee involved was undressed. This appears to be a more regular situation in a Detention Centre when compared to a Prison. It may be as a result of staff moving detainees during the night when there are known risks to a forced removal under Home Office orders, or detainees using this to prevent removals due to being in public view. Staff made all reasonable efforts at preserving the dignity of the individual but a committee may have also identified these occurrences and sought to find a solution. Examples could include, source or design a smock that could be simply placed over the head of the detainee which allowed the control of the arms to be maintained and the head supported if required.

Recommendation 3 (assurance and governance)

A multi-agency UOF review committee, as directed within PSI 30-2015, chaired by the Director, is appointed and to meet quarterly. Inclusion of Detainee representatives held within the centre is encouraged.

As soon as possible after every incident a review should be conducted by a suitable manager, with a view to taking emergency actions in instances of unlawful or inappropriate force. They should ensure that all documentation has been collated correctly and is then preserved, including footage from CCTV and/or BWVC, within an evidence pack. These should be safely secured in a suitable location and only accessible by nominated personnel.

Management for removal

645. Through the review of the incidents that I have been asked to comment on a number of themes and local practices have been identified that raise concern. Pleasingly they have also highlighted examples of good practice by staff during what is acknowledged as difficult situations involving detainees in a heightened level of stress.

646. Many of the incidents are as a direct result of a removal from the unit under Rule 40 (1) safety or security, or to enforce a Home Officer removal from the centre, which normally includes the removal to the CSU in advance. The issuing of information is carried out by the DCM and in my view this can sometimes lead to an escalation of events due to their limited knowledge of the circumstances for the removal. A preferable option would be for a Home Office representative to inform the detainee of the requirement and removal order. They can explain in detail the removal process and can assist with any follow-up investigation based on any questions or appeals that the detainee may raise. In many cases the DCM is accompanied by a team (3 or more staff) in full PPE. I understand the precaution taken when based on previous incidents where detainees have either carried out an act of self-harm or caused disorder in various forms. I appreciate that at times the conversations have taken place prior to the recorded footage made available, but there is an almost calculated process that after any refusal to comply staff immediately resort to using force. Rule 43 (10) provides authority for force to be used in these circumstances but, as with all force, should be a last resort when all other options have been unsuccessful.

Recommendation 4 (management of removal)

Home Office staff to inform detainees of removal orders. DCMs attend in support and to familiarise themselves with the individual case. Produce a standard operating procedure to reflect this change.

Evidence gathering

647. Many of the incidents logged as unplanned are in fact planned. It appears that unless staff are deployed when in full PPE to a room any other incident is classified as unplanned. I observed incidents where several staff are in attendance and there is no imminent risk of harm, yet when they apply force it is recorded as unplanned. During the build up to incidents; 120-threat of self-harm, 129-passive protest, 92 and 91- both non-compliance with order to relocate; there were three or more staff in attendance to carry out a planned intervention. Unless immediate action is required, for instance a fight, or an assault on a person, staff should treat as planned. This will include informing healthcare to attend, summoning a manager and recording the events.

648. Unless immediate action is required, for instance a fight, or an assault on a person, staff should treat as planned. This will include informing healthcare to attend, summoning a manager and recording the events.

649. The use of BWVC did not appear to be utilised during many incidents. The main culprits seem to be the DCM group, who all appear to be in possession of a camera but fail to activate them. The BWVC policy was only introduced in 2017, therefore it acceptable that during many of the incidents there was a degree of confusion as to their use. I would hope that there are now adequate measures in place to utilise the benefits that BWVC provide in terms of transparency, openness and as a safety improvement tool.

Recommendation 5 (evidence gathering)

Produce a policy/operating procedures document on BWVC use and activation, alongside use of handheld device guidance if PSI 04-2017 is not adopted, otherwise enforce the PSI.

This will include nominated roles where the carrying of BWVC is mandatory and definitive information on when they must be activated. Often staff not involved in an incident may be able to provide clearer evidence when recorded away from the scene. DCMs receive guidance on recording incidents during the bespoke training package aimed at incident scene management.

Staff from approved escort providers are also to wear BWVC when moving detainees. This is in addition to the vehicle CCTV and the policy be amended to include use in public areas. Current policy does not include them but an amendment is recommended for their inclusion using the same guidelines as custodial staff.

Training scenarios

650. In certain incidents staff are initially deployed into a room when equipped with full PPE. This is within policy and ensures the safety of staff during the period where they are at most risk. What appears to be less obvious is an understanding of when PPE actually needs to be used. Not every planned intervention I observed required staff to wear PPE as the detainee offered little threat of violence and was simply not complying. Once the risk has been reduced there is little evidence of PPE being

removed. Incidents 133, 134, 81, 162, 137 and 86 are in my opinion times when PPE could have been removed to aid the de-escalation and when the initial risk to staff has been mitigated by taking control of the detainee. As an absolute minimum the helmet and gloves could be removed when moving through the centre. The de-escalation demonstrated by removing the head support officer and allowing the detainee to stand upright is praiseworthy. The interaction with detainees before and during restraints were professionally delivered, and even when subject to intimidating and threatening behaviour staff remained disciplined and did not react. By removing helmets at the very least, it gives reassurance that de-escalation is taking place and if observed by other detainees paints a different picture of events.

Recommendation 6 (training scenarios)

Local UOF training includes a scenario based element that is regularly reviewed and focuses on real incidents and is designed to cascade good practice, and identify potential issues. DCMs are advised about providing justification for PPE during scenario based training.

Report writing

651. When reviewing the staff post-incident statements the overall standard is poor in most cases due to a lack of detail of the events prior to, during and after the UOF was applied. Simple comments like 'refused an order' are not sufficient detail and do not 'paint the picture' for independent reviewing purposes. Staff may rely on their statements alone in later years so it is important that they include as much detail as possible. Things to be included are, emotional responses (both detainee and staff), verbal interaction(even in recollection form), what the risk of harm was to justify force being used, attempts at de-escalation, reaction of the detainee, consideration through the restraint for continued use, how the relocation was performed, how was the detainee when relocated, debrief information.

Recommendation 7 (report writing)

Line managers, assisted by UOF Instructor, carry out random quality assurance checks on completed UOF statements submitted by their direct reports. Additional training be provided where necessary and to enhance understanding issue all staff a pocket guide on how to effectively structure a report, including essential content before, during and after the incident, and any personal emotions experienced throughout the incident.

Complaints and Investigations

652. When complaints from detainees are received there is an official process to follow that has been implemented by the Home Office. During the subsequent investigation there are many allegations and perception of the events that could be mitigated by viewing the available footage. It is understandable that during periods of confrontation, when the body's natural adrenaline and chemical reaction are activated, individuals may experience auditory exclusion, time distortion and other perceptions which when viewed do not replicate what actually happened. This can also be experienced by staff when they are involved in a UOF or threatening situation.

PSI 04-2017[159] section 2.11:

Any senior member of staff, with express permission from the Governor may access the footage for professional standards or related purposes where there is a clear and justifiable need to do so, including for:

- *Quality assurance purposes*
- *Conducting supervision or assisting with training and professional development*
- *Identifying establishment-wide or individual training needs*
- *Investigating specific allegations, specific patterns of complaints and conducting disciplinary investigations*
- *Where specific intelligence has been received that would indicate that viewing of BWVC footage is proportionate and necessary*

Recommendation 8 (complaints and investigations)

BWVC, handheld or CCTV evidence be available during investigations or complaints for the purpose of evidential clarity of events.

Wrongdoing

653. The covert camera evidence obtained by Mr Tulley included staff conversations when in communal staff areas away from detainees. There are examples of unprofessional conduct and attitudes by staff when talking within these areas.

[159] PSI 04/17; issue date 20 March 2017 - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/903462/

References are made to previous UOF incidents where staff demonstrate an enthusiasm for applying force and mock the reaction of detainees. Other examples include discussions around colleagues and detrimental remarks that are personally based and disrespectful.

654. Evidence exists from the incident involving D275, whereby staff discuss and pre-meditate and concoct a situation that would result in more force than is necessary being used. This goes against all ethical UOF and amounts to a breach of Detention Centre Rule 41(1) & (2).

Recommendation 9 (wrongdoing)

To promote reporting wrongdoing by posters, staff leaflets and included within all staff yearly performance review. Publicise outcomes from investigations into wrongdoing and highlight inappropriate behaviour will be dealt with through formal proceedings.

Serious Incidents

655. The centre did experience a number of planned incidents, included within them are situations of disorder. Those observed included a detainee, D275, accessing the netting as a protest. The management of this incident does cause concern. The first issue is that the wing remained unlocked and the detainee on the netting could freely speak with others and be provided essential items that would allow him to remain there for a long period. If the management choice is to continue with this procedure they must anticipate long drawn out scenarios and possibly request national assistance, which, as demonstrated, resulted in an intervention using PAVA irritant spray.

656. Other options would be to secure the landing and deploy trained negotiators to attempt a peaceful resolution. Negotiator training is available through the HMPPS catalogue of training and is a hugely beneficial resource to have locally. Whenever these incidents occur the local command suite should open, and in the most serious type of incident the national Gold command suite would also be opened. They would then offer support, resources and approval for any surrender or intervention.

Recommendation 10 (serious incidents):

Brook House have trained negotiators to assist with the resolution of serious incidents and who are available 24/7 on a rota basis. They should be deployed before resorting to using force, unless there is an imminent risk that requires immediate action.

Conclusion

657. My conclusions are based on all of the evidence that I reviewed and when measured against the relevant policies and legislation in place at Brook House at the time and the professional standards expected of Detention Centre staff. I can confirm that I had previous knowledge of some incidents after watching the BBC documentary, and that I have visited the site previously within my role within NTRG and know the former Director Ben Saunders from my time as the restraint lead within Secure Training Centres, where Ben held the role of Director at Medway. Similarly, I know Jerry Petherick, the former Executive Director of G4S, from our time at HMYOI Reading where he was the Deputy then Governor, and from when he was the area manager for South West England Prisons. I may have unknowingly had contact with other staff from Brook House during the period when I was at NTRG and delivering UOF Advanced Training at the National Centre.

658. With the exception of the incidents that I will comment on further all of the other key incidents came as a last resort and when other methods of gaining compliance had failed. I hold a concern that there is a cultural process of automatically resorting to staff in full PPE being assembled for situations where the detainee has indicated that they will not comply with either a removal order, or to be relocated to the CSU, for either a removal or on GOAD. There does not appear to be a consideration for exploring all other options, or even deploying staff without PPE, and when PPE is worn it remains on until the relocation. This is area are that must be addressed as it is not conducive for a stable environment to have 'officers in riot kit' regularly 'lifting' detainees and 'taking them away'. These perceptions can cause fear and anxiety within the detainee group and in at least one instance (164/165) it caused an escalation as the detainee (D87) resorted to taking preventive action as he feared what was going to happen to him.

659. The over reliance for removal to the CSU or GOAD can in the main provide a temporary solution to a problem, when in fact longer term solutions should be in place due to the recurring theme evidenced from the footage. In at least one case (174/17) the decision to remove was completely disproportionate to the offence by the detainee (D2830). There are times when the relocation is fully justified but they

should follow the same process as any UOF, the last resort when all other methods have been exhausted.

660. It is understandable why the relocation to the CSU prior to removal on a flight has been adopted, especially when previous attempts had failed due to disruptive behaviour, possession of potentially high-risk items (secreted blades for instance), and even acts of self-harm. When doing so staff should be sensitive to the situation, especially when waking the detainee up in the early hours and they should be prepared to adopt preventive methods in the first place to avoid the detainee acquiring items that have the potential to disrupt the removal. In the situations I observed staff do act appropriately and the DCM communicates effectively during the initial dialogue. It is only after this fails that force is used and in some instances the detainee is undressed. Using force in these circumstances is difficult but I feel the staff made all reasonable efforts to preserve the dignity of the detainee, even after restraints were applied. I am surprised that they have not looked at options for wrapping around a naked detainee, especially considering it is a frequent occurrence.

661. The force used on most occasions followed all of the training guidelines as outlined within the UOF Training manual, unfortunately on some occasions staff demonstrate incompetence during the restraint. With the exception of incident 105 (D1527) all other footage shows staff using, or attempting to use, appropriate authorised techniques. I am particularly pleased to note the quick transfer when the head support has been adopted to an upright position, although on a few occasions it remained applied when not necessary. I did not observe any adapting of the technique so the hand position could avoid inadvertently covering the mouth or throat in situations where the head support needed to be maintained. Staff appear well versed in using the full range of restraints on the arms, and not relying fully on wrist flexion or pain inducing techniques. De-escalation of techniques is commonplace and demonstrates an awareness of only using necessary force and trying to avoid deliberately inflicting pain on a detainee.

662. There are a number of occasions when staff apply techniques incorrectly and there seems little guidance given by colleagues, other than the DCMs. I appreciate that many staff are relatively junior in service but there must be adequate training provided before they are accredited for operational duties. Examples are the wrong placement of handcuffs which caused undue pain during incident 135 (D149), trying

to force the head to the floor in the supine position when it should remain in a neutral position, and whenever staff end up in the supine position they struggle to apply the correct process for standing up. The procedure for handcuffing whilst seated was removed in the 2015 training manual. I am also concerned at the poor practice when trying to carry a detainee and the lack of summoning additional staff when situations become problematic.

663. My previous report to Sussex Police reference incident 105 remains unaltered as there is nothing to support or justify the actions observed by the member of staff or the dialogue which was completely inappropriate and unprofessional. Furthermore, it could be contrary to Article 3 as degrading and inhumane treatment.

664. However during difficult restraints staff act in a professional manner and do not react to threats or imitation by the detainee, two key examples are incidents 133 and 135, where the staff remained focussed on the task, which is commendable when considering the level of abuse/threat that was directed at them. Throughout all of the incidents it is the DCM who engages with the detainee throughout the restraint and into the relocation phase. This is correct practice and a good example of leadership and supervision.

665. I have placed incidents 86 and 134 together as there is a theme between two which is concerning. On both occasions the detainee who had been authorised to be moved was not in good health and certainly in 134 offered no physical threat to staff. The reports from 86 indicate a man who was very weak from being on food refusal for some time. My conclusion is that there was no lawful reason to enter the room with a team in full PPE and use a shield against him, even if it was, as described, placed on him. The footage from 134 also shows little threat to staff, with a man who despite the Doctor confirming he was fit for removal, demonstrated only reluctance to move. Incidents of this nature must be managed as a medical removal rather than a disciplinary move. It was unnecessary to have staff in PPE, and even more so to use a shield.

666. Incident 120, which was broadcast on local news during the hearing on w/c 29/11/21, did not require force to be used when it was initiated. The fact a DD made the decision is in my view alarming and sets the wrong example to staff. The detainee (D687) did have a ligature around his neck but was sat down and the only risk was a short drop, which could cause strangulation, but with staff who were within close

proximity (2m max) and had a rescue knife (referred to as a fish knife) available should he drop they could have easily reacted to avoid serious injury. The other factor is D687 was a man in crisis and all efforts should have been attempted to persuade him to remove the ligature and only use force as the very last resort. My conclusion is that this was not the case and the DD just wanted to end the situation, which he did but not with any consideration for the longer-term impact it would have. This is an example of crisis management and does not build effective relationships with the detainees when they are experiencing frustration toward the Immigration system.

667. During incident 135, D149 is seen to be in pain during the restraint. I am content this was not down to anything other than poor application of the handcuffs and a lack of understanding on the relocation technique. It is incidents of this nature that raise my concerns over the review process in place at the time. There is no mention of any training needs or development of individuals for this or the other incidents where staff struggle with basic techniques. Ultimately they centre has a responsibility for the health, safety and wellbeing of detainees in their care. They are liable for any injuries sustained, even when not deliberate, that result from incompetence from their staff. I conclude that incompetence and not anything else was the reason for the small number of occasions when detainees appeared in pain or complained of excessive force.

668. Throughout the reviews I did not observe the attendance on scene from senior managers (normally distinguishable by civilian clothes) and no reports mention their attendance (apart from 120). It is acceptable that the DCM group manage responses to incidents and planned removals but greater management oversight would assist in identifying correct practice and compliance with policy/legislation. The lack of visual leadership from senior managers above the DCM level can allow the development of unprofessional behaviour and for a small number of staff to act outside of policy. During the core day there is a dedicated duty manager and they should, where possible, attend any UOF incident, or respond to a general alarm for staff assistance as described in PSO 1600.There is a great deal of footage from the covert camera by the whistle-blower that would support my view. Discussions in offices are sometimes unacceptable and staff referencing violence on detainees in a joyful context can influence new staff and create a culture of believing staff can act in whatever way they feel, resulting in acts of inappropriate behaviour. It almost felt like some staff where being held in high regard by some colleagues due to how they

used force, and this is when unlawful actions are evidenced. Comments such as those observed concerning how to use a shield and where there are no CCTV cameras and describing some force as 'not C&R' bring about attitudes and behaviours not expected from staff and support accusations of systematic abuse.

669. The failure to properly introduce BWVC must be addressed and if the correct scrutiny and assurance process is introduced individuals who fail to activate a camera must be disciplined. There are numerous incidents where limited footage is available, despite the presence of staff with cameras. Failure to provide evidence when force is used can only increase suspicion of wrongdoing and inappropriate acts.

670. I am also concerned that it is only through the covert camera footage that action against staff has resulted. There are numerous examples of unprofessional behaviour which clearly did not get reported, and in some instances seem to be encouraged. Staff who fail to report wrongdoing, or inappropriate behaviour must also be challenged a sit is every person's duty to ensure detainees are treated with dignity and respect. The Home Office rightfully expects the highest standards of behaviour from staff and the clear failure at Brook House to challenge and make staff aware of their responsibilities must be a key objective in future improvement plans.

671. Other footage from the covert camera does include routine daily interaction and from what I observed staff appear to engage well with the detainees and although at times are extremely busy do try and address any concerns or answer any questions they are asked.

672. Finally I have provided a list below which represents incidents where force did not meet some or all of the general principles to justify force being used as described in paragraph 7.

Incident No:	Reason for finding that force did not meet some or all of the general principles to justify force being used.
105	Disproportionate and not reasonable. Rule 41 (2) the language used was provoking, disrespectful and unprofessional.

135	More force than necessary through incompetence in applying correct technique during the leg restraint and application of handcuffs.
134	Not necessary, was disproportionate to the risk and not reasonable to use staff in PPE
86	Not necessary, was disproportionate to the risk and not reasonable to use staff in PPE (Based on reports only, no footage observed).
81	More force than necessary due to poor application of technique. Not necessary for staff to wear unauthorised PPE
109	More force than necessary by using wrist flexion as opposed to applying handcuffs.
186	Being necessary is questionable due to the lack of information on the further risk after the initial incident had taken place.
120	Not the last resort and unnecessary use of leg restraint when none of the documents evidence a need for it to have been applied.
137	Not the last resort, not necessary or reasonable to enter and use force without attempting to persuade or engage in dialogue.
162	Use of head support longer than necessary, which was also disproportionate.
133	Unnecessary and disproportionate force due to intended compliance and poor scene management.

Statement of Truth

673. I confirm that I have made clear which facts and matters referred to in this report 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.

674. 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.

Signed: …J Collier…….. Dated: …14th January 2022……..

Jonathan Collier

Appendix 1

Jon Collier's CV

Qualifications:

- Chartered Institute of Personnel and Development associate member
- Certificate in Training Practice
- Use of Force trainer HMPS
- HM Prison Service certified adjudicator and adjudication liaison Officer
- HMPPS lead Investigator accredited
- A1 assessor/D32-33 NVQ assessor
- Manual handling instructor
- City & Guilds Conflict management trained
- TASER qualified operative
- Pyrotechnic Instructor
- Response Driving trained
- Working at Height, Method of Entry and Intervention skills trained operative
- National lead for intervention skills
- Cardiff University accredited Expert Witness
- British Amateur Weightlifting Association Instructor

HMPPS career history:

- Joined HMPS in 1992,
- Posted to HMYOI Reading following initial 12 weeks of training.
- Sports & games and weight training Instructor in Physical Education department.
- 1995 trained in Control & Restraint (C&R) advanced techniques.
- Qualified as a C&R instructor.
- 1995 - 2001 responsible for the delivery of C&R at HMYOI Reading then HMP Winchester and assist Instructor at the National C&R Centres.
- 1997 passed Senior Officer Examination and in 1999 took up Senior Officer Position at HMP Winchester.
- 2001 appointed a National Instructor. Area of responsibility include Intervention, PCC training and manual design and accreditation.
- 2008 promoted to Principal Officer.
- 2010 took over as litigation manager for NTRG.
- 2010-2013 Gold command advisor on Use of Force issues during serious incidents.
- 2013 accredited operational manager following secondment at HMP Cardiff.
- 2013-2016 team lead for operational staff at NTRG Kidlington
- 2017 – 2020 Head of Centre NTRG Hatfield Woodhouse

- 2021-present Operational practice delivery manager within the National incident Management Unit.

Expertise

Since taking over the role of subject matter lead for NTRG I have supported numerous internal investigations that are carried out under PSI 06-2010 Conduct and Discipline[160]. In addition, I have been the lead investigator on several disciplinary matters, ranging from UOF to unprofessional conduct and bringing the service into disrepute.

I provided evidence for two Coroner's Inquests following the deaths in custody of two children, who were being held in separate Secure Training Centres. I have represented HMPPS at a number of Coroner's Inquests involving adult male prisoners and acted independently for an Inquest following the death of a foreign national on a repatriation flight.

I provided an expert report for the Public Inquiry into a death in British military custody of a detained person.

My role includes providing evidence for the Crown Prosecution Service for criminal matters, involving both prisoners and prison staff. Some of these include joint reports where several expert witnesses have been appointed.

I completed the Bond Solon expert witness programme and gained accreditation from Cardiff University.

[160] National Offender Management Service PSI 06/2010 (Conduct and Discipline); Effective date: 19 April 2013 https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwjs-N3Dx-v0AhXKVsAKHWXTCl0QFnoECAMQAQ&url=https%3A%2F%2Fwww.justice.gov.uk%2Fdownloads%2Foffenders%2Fpsipso%2Fpsi-2010%2Fpsi_2010_06_conduct_and_discipline.doc&usg=AOvVaw366bGM3L6-ZbhgcreX_bzV

Appendix 2

Extract from the UOF training manual specifically for managing planned interventions

Section 3 Planned removal

The deployment of a 3 officer team is the approved method of dealing with a violent or non-compliant prisoner. It must only be used as a last resort after all other means of de-escalating (e.g. persuasion or negotiation) the incident, not involving the UoF, have been exhausted. The techniques to be taught in this Section of the syllabus, appertain to the formation of the team and the restraint of the prisoner. The main emphasise should be on control, particularly in the first instance, of the prisoner's arms and head.

3.1 The role of the UoF supervisor

Staff who may be required to supervise planned UoF incidents (i.e. Orderly Officers and Duty Governors) must be confident and capable of doing so. It is recommended that they attend regular refresher training in UoF basic techniques.

Planned UoF incidents are supervised by an officer who is accountable for the management of the incident until the prisoner is re-located ("the supervising officer"). Normally, this officer will be the Orderly Officer or Duty Governor (at least senior officer rank, although competence and experience are as important as rank).

Prior to intervention in a planned incident the supervisor must:

- Make every reasonable effort to persuade the prisoners to terminate the incident peacefully
- Assemble the UoF team (and any necessary reserves)
- Ensure that all staff present are UoF trained and currently qualified (i.e. at least refreshed in the previous 12 months). Non up to date staff must not take part in a planned UoF intervention
- Request that healthcare provide any pertinent medical details (e.g. that the prisoner is pregnant) and that they attend the scene in order to observe the intervention and relocation (and give them reasonable time to attend the scene)

- Consider the use of a video camera to record the intervention and relocation
- Brief the team about the current situation, the prisoner involved and the route to where the prisoner will be relocated

It is recommended that all staff are provided with, and wear, protective equipment in a planned UoF incident. Protective equipment that should be worn is detailed below:

- Short shield/ mini shield (may be carried by the number 1)
- Helmet
- Shin/ knee guards
- Forearm guards
- Gloves
- Flame retardant overalls (if required)
- Safety boots with steel toe caps

The supervising officer will decide, in conjunction with the Number 2 and 3 whether to remove some items of protective equipment (e.g. helmet, shield) before escorting a prisoner through an establishment. Normal practise would be to remove shields and helmets.

During UoF intervention, movement and relocation the supervisor must:

- Unlock any doors to facilitate the entry of the team
- Monitor the condition of the prisoner during the incident – with particular regard to any medical warning signs
- Be prepared to release the prisoner from all UoF holds immediately if it becomes necessary to do so on medical grounds
- Monitor the condition of staff involved in the incident and be prepared to replace staff that are showing signs of fatigue, who have been injured or who are not using correct UoF techniques
- Make a decision as to whether (and when) to apply ratchet handcuffs
- Liaise closely with the number 1 in making efforts to de-escalate the situation throughout intervention, movement and relocation. Restraints must not be used for longer than necessary
- Make a judgment as to whether the prisoner can be released from restraint and escorted to the relocation venue
- Request advice from the Duty Governor or Duty Director as to whether a full search under restraint is required upon relocation (or make a decision if the Duty Governor or Duty Director is not available)

After relocation of the prisoner the supervisor must:

- Ensure that after the cell has been secured, the prisoner is observed until a medically qualified person from healthcare (registered nurse or doctor) is able to attend and complete an F213
- Consider the use of a video camera to take pictures of the prisoners to show any injuries that might have occurred (only with the prisoner's consent)
- Ensure that any member of staff injured during the incident is offered medical attention
- Debrief all staff and collect the UoF Forms – Annex A 'Officer's Statement' off all staff involved at any point in the UoF (these reports must be completed by staff independently of other staff involved in the incident)
- Complete the UoF Form (main section) and Annex A in the role of supervisor of the incident
- Pass all completed paperwork (supervisor and officer statements) to the Orderly Officer in order that it can be stored correctly
- Where the prisoner is known to be at-risk, ensure that the ACCT case manager is aware of the incident

Appendix 3

List of footage referred to in report

Appendix 3

Table of Use of Force Footage referred to in the First Report of Jon Collier

UoF log no:	Footage name	Format	Start and endpoint of relevant scenes	Detainee cipher	Date
105/17	KENCOV1007/ BBC000596 - KENCOV3012	V2017042500020	08:47-26:36	**D1527**	25/04/2017
	KENCOV1007/ BBC000596 - KENCOV3012	V2017042500021	00:00-27:49		

	KENCOV1007/ BBC000596 - KENCOV3012	V2017042500022	00:54-01:22		
	KENCOV100/ BBC000596 - KENCOV3012	V2017042500023	00:00-01:00		
135/17	KENCOV1027 / BBC000617 - KENCOV3042	V2017053100010	1:43-4:42	**D149**	31/05/2017
	KENCOV1027/ BBC000617 - KENCOV3042	V2017053100016	0:00-4:04		

	KENCOV1027 / BBC000617 - KENCOV3042	V2017053100019	TBC		
	KENCOV1028	V201706010017	04:15 - 05:00		
	Disk 52 UOF 135.17 BWC.mov (bodyworn)	N/A	Entirety		
	Disk 53 S2120002.mp4 [view first] (bodyworn)	N/A	Entirety		

	Disk 53 S2120003.mp4 (bodyworn)	N/A	Entirety		
134/17	KENCOV1025/ BBC000615 - KENCOV3040	V2017052700019	00:00-06:30 06:35-06:52 07:47-08:45 15:00-16:22 20:10-27:51 27:52-29:59	**D1914**	27/05/2017
	KENCOV1025/ BBC000615 - KENCOV3040	V2017052700020	00:00-03:04 05:27-23:42 27:59-29:50		
	Disk 50 UOF 134.17 CAM 3.MP4 (bodyworn)	N/A	Whole clip		

	Disk 50 UOF 134.17 CAM 2.MP4 (bodyworn)	N/A	Whole clip		
	Disk 51 27May2017 2129.mp4 (CCTV)	N/A	0:00-22:48; 26:20-end		
81/17	Disk 23 S1940004.mp4 (G4S footage - debrief) (bodyworn)	N/A	Entirety	**D1234**	**28/03/2017**
	Disk 23 S1940003.mp4 (bodyworn)	N/A	00:00-1:37		

	Disk 24 28March2017 (CCTV)	N/A	00:32-11:49		
109/17	Disk 3 UOF 109 17 27Apr2017+C47N/A+D46 (CCTV)	N/A	6:17 (18:16:50) - 9:05 (18:19:52)	**D191**	27/04/2017
186/17	Disk 14 03Aug2017.mp4 (G4S footage) (CCTV)	N/A	04:36 -06:38; 14:30-17:58	**D642**	03/08/2017

120/17	KENCOV1016/ BBC000605 - KENCOV3025	V2017051300011	02:05-30:00	**D687**	13/05/2017
	KENCOV1016 / BBC000605 - KENCOV3025	V2017051300012	00:00-02:25 04:14-06:41		
	KENCOV1018	V2017051600021	0:25-2:22		
	Disk 2 UOF 120 17 (G4S footage) (CCTV)	N/A	From 6:17 (18:16:50) to 9:05 (18:19:52)		

	Disk 42 13May2017 1356.mp4 (CCTV)	N/A	From 6:17 (18:16:50) to 9:05 (18:19:52)		
137/17	KENCOV1030	V201706050013	12:50- 16:25	**D390**	05/06/2017
No log	KENCOV1019 (CT undercover filming)	V2017051700009	01:51-05:22	**D275**	17/05/2017
		V2017051700010	00:00-01:31		
		V2017051700012	03:35-04:15; 14:04-15:37		
		V2017051700013	02:37-04:27; 18:44-25:22; 25:33-30:00; 06:52-08:47		
		V2017051700014	01:34-02:16; 02:17-08:07; 08:33-08:49; 09:12-09:41;		

			10:09-15:25; 19:04-20:25; 21:23-21:31; 29:36-30:00		
		V2017051700015	00:00-02:40; 03:05-04:40; 07:33-07:48; 10:02-21:07; 25:14-26:26; 7:10-30:00		
		V2017051700016	02:51-03:34; 07:55-17:09; 21:16-30:00		
		V2017051700017	00:35-02:55; 04:53-09:00; 12:47-15:05; 17:42-18:55; 18:56-23:00; 24:05-24:16; 24:50-25:41		
		V2017051700018	00:15-17:04; 20:33-30:00		
		V2017051700019	14:20-14:40; 17:30-17:50		
	BBC000609 (CT video diary) VD	KENCOV3032	14:20-14:40; 17:30-17:50		
	BBC000611 (G4S footage) VD	KENCOV3034	14:20-14:40; 17:30-17:50		

114/17	KENCOV1012 BBC000601 - KENCOV3019	V2017050400021 V2017050400025	17:45-29:59 00:00-00:10	**D1527**	04/05/2017
	KENCOV1012 / BBC000601 - KENCOV3019	V2017050400022	00:00-09:09 15:41-28:18		
	KENCOV1012/ BBC000601 - KENCOV3019	V2017050400028	00:30-00:55		
	KENCOV1014 / BBC000603 - KENCOV3021	V2017050800011	01:51-02:50		

	KENCOV1014 / BBC000603 - KENCOV3021	V2017050800017	TBC		
	KENCOV1015 / BBC000604 - KENCOV3024	V2017050900016	10:00 - 13:30		
	Disk 41 05May2017 1727/mp4 (CCTV)	V2017050900016	00:45 - 05:57 and 23:35-36:35		
162/17	Disk 25 28June2017 2319.mp4; (CCTV)	N/A	1:30-6:56; 09:04-13:09	**D2054**	28/06/2017

	Disk 26 20170628222251_E2047N_0007.mov (bodyworn)	N/A	00:00 - 09:19		
	Disk 26 20170628221925_E2047N_0006.mov (bodyworn)	N/A	00:00 - 02:25		
	Disk 27 28June2017 221.mp4 (bodyworn)	N/A	00:00 - 09:15		
164/17	KENCOV1039 BBC/ BBC000630 - KENCOV3073	V2017070300005	01:58:00-06:15; 08:55:00-18:20; 20:40:00-	**D87**	30/06/2017

			21:30; 24:00-end		
	KENCOV1039 BBC/ BBC000630 - KENCOV3073	V2017070300008	01:00-01:50 02:45-03:15		
	KENCOV1039 BBC/ BBC000630 - KENCOV3073	V2017070300009	00:00-04:15		
	Disk 28 **D87** .mp4 (bodyworn)	N/A	00:00 - 01:16		

	Disk 28 D87 (3).mp4 (bodyworn)	N/A	00:00 - 10:21		
	Disk 28 D87 (2).mp4 (bodyworn)	N/A	00:00-02:59		
	Disk 29 D87 (2).mp4 (bodyworn)	N/A	00:00-00:28		
165/17	KENCOV1039 BBC/ BBC000630 - KENCOV3073	V2017070300005	TBC	**D87**	30/06/2017

	KENCOV1039 BBC/ BBC000630 - KENCOV3073	V2017070300006	00:00-00:50		
	KENCOV1039 BBC/BBC000630 - KENCOV3073	V2017070300008	07:40-08:46 12:10-12:50 13:50 -14:10		
	KENCOV1039 BBC/ BBC000630 - KENCOV3073	V2017070300010	00:00-01:15		
	Disk 29 D87 SH (1).mp4 (bodyworn)	N/A	Disk 29 D87 D87 SH (1).mp4		

	Disk 29 D87 (1).mp4 (bodyworn)	N/A	00:00-01:13		
	Disk 29 D87 SH.mp4 (bodyworn)	N/A	00:00 - 05:59		
	Disk 29 D87 SH (3).mp4 (bodyworn)	N/A	00:00-05:08		
	Disk 30 30June2017 1733.mp4 (bodyworn)	V2017070300010	02:10 - 14:47		

129/17	KENCOV1022 BBC	V2017052400004	07:57:00-18:15	**D52**	22/05/2017
133/17	KENCOV1022 BBC	V2017052300026 V2017052300028	Entirety	**D1978**	23/05/2017
	Disk 48 20170523210142_e1606N_0013.mov (bodyworn)	N/A	Entirety		
	Disk 48 20170523205517_E1606N_0012.mov (bodyworn)	N/A	Whole clip		

	Disk 48 20170523211507_E1606N_0015.mov (bodyworn)	N/A	Whole clip		
	Disk 49 26 May 2017 2158.mp4 (CCTV)	N/A	00:00-17:37		
142/17	KENCOV1031 BBC Disk 55 06June2017 1526.mp4 CCTV	V20170606000011 N/A	00:00-12:49 7:40-16:00	**D1538**	06/06/2017

130/17	Disk 44 22May2017 1728.mp4 CCTV Disk 47 22May2017 1729.mp4 CCTV	N/A	01:00 - 01:48 12:55 - 15:40	**D2034**	22/05/2017
136/17	Disk 4 UOF136 17 03June2017 (CCTV)	N/A	1:26 - 1:45	**D1538**	03/06/2017
158/17	Disk 08 20June2018 0813 [note that 2018 is a typo: the footage has 2017 on it] (CCTV)	N/A	2:58 - 3:38	**D1747**	20/06/2017