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.

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

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

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

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

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