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.

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