

Learning lessons bulletin

Complaints investigations | Issue 7

Use of force – further lessons

This Learning Lessons Bulletin examines the use of force on prisoners by prison staff. It is the Ombudsman's second bulletin on this topic.

In some ways it is reassuring that there are relatively few complaints to my office about alleged physical abuse of detainees by custodial staff. In 2014-15, of 2,303 eligible complaints received and accepted for investigation, only 50 involved such allegations.

They are, however, among the most serious and important complaints that I receive, as they go to the heart of the humanity and legitimacy of the prison system. Ensuring independent investigations into allegations of physical abuse is, therefore, essential to maintaining safety and giving assurance of the proper treatment of those in custody. My investigations also ensure that staff are held to account for misbehaviour and I have had to recommend disciplinary action on a number of occasions. Equally, in other cases, my investigations have provided assurance that use of force by staff was appropriate and their behaviour exemplary in difficult circumstances.

Prisons can be violent places and recorded levels of prisoner-on-prisoner and prisoner-on-staff assaults are at an all time high¹. Staff face enormous challenges in keeping order and control, so use of force must always be an option. However, it is only lawful if it is reasonable, necessary, involves no more force than is required and is proportionate to the seriousness of the circumstances. In my view, use of force should always be a measure of last resort, deployed only once all avenues of de-escalation have been exhausted.

In complaints about the issue, whether force was used is rarely in doubt, but there can be questions about whether it was justified and the tests of lawfulness met. The learning in this bulletin builds on that in a Learning Lessons Bulletin on use of force published in January 2014, and is intended to contribute further to ensuring safer custody.

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Background

Prison Service policy on the use of force is set out in Prison Service Order (PSO) 1600², Use of Force, which says that:

“the use of force is justified and therefore lawful, only if:

- it is reasonable in the circumstances
- it is necessary
- no more force than is necessary is used
- it is proportionate to the seriousness of the circumstances.”

PSO 1600 makes clear that it is important to consider the type of harm that the member of staff is trying to prevent, as 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 or limb
- risk to property
- 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. Risk to the good order of the establishment may be more difficult to judge, but someone refusing to obey a lawful order from an officer would not generally be sufficient on its own to justify the use of force.

The PSO also states that staff should always try to prevent a conflict wherever possible and

that control and restraint “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.” However, the PSO also recognises that sometimes staff may “have no other option than to use force” and says that “when force has become necessary, control and restraint (C&R) techniques are always the preferred option”.

In a previous bulletin on this subject³, we highlighted learning for prisons from our investigations into complaints about the use of force. The lessons from the original bulletin remain valid, but here we present some additional lessons which we have identified from more recent investigations.

A number of these cases involved ‘planned removals’, where a decision has been taken to move a prisoner from their cell to another location and a control and restraint (C&R) team of three staff (wearing protective kit, including helmets and shields) is assembled to carry out the removal because there is a possibility that the prisoner will refuse to move and/or react violently. Planned removals should be filmed with a hand-held video camera, which aids management review and staff training - and greatly assists our investigations.

De-escalation

Prison Service policy says it is very important that staff seek to defuse confrontational situations and resolve them peacefully, without the use of force wherever possible. It says that officers should explain their intention, and give clear, brief, assertive instructions, negotiate options and avoid threats.

When a planned removal takes place it is not unusual for there to have already been a level of non-compliance from the prisoner who is to be moved. This may have taken the form of, for example, smashing up their cell, making threats to staff or simply stating that they have no intention of leaving their cell. Attempts at de-escalation may already have been made, without success.

The arrival of the C&R team signals to the prisoner that the possibility of the use of force is now very

real. This may by itself encourage the prisoner to change their mind on compliance, particularly if staff also use de-escalation techniques, such as talking to the prisoner to reassure them and encouraging them to leave the cell peacefully.

However, in a number of cases, such as that of Mr A, we have found that there have been no attempts to de-escalate the situation once the C&R team has arrived at the cell. In these cases, it appears that staff have already decided that the prisoner will continue to be non-compliant and that the use of force is inevitable.

The Ombudsman considers that the arrival of the team, in effect, creates a new situation. At this point, genuine efforts should be made to resolve the matter peacefully, whatever the previous level of non-compliance. Although this may not always be successful, it should always be attempted.

Lessons to be learned

Lesson 1

The arrival of the C&R team in a planned removal should be treated as a new situation.

Case study A

Mr A complained that force had been used on him unnecessarily.

Mr A was in his 40s and had no history of violence towards staff. One evening, staff put a note under his door telling him he was going to be moved to another wing the next day. During our investigation, he told us that

he had been very worried about this because he thought there was a prisoner on that wing who had previously assaulted him in another prison. The following morning he expressed his concerns to officers in the wing office and also to the chaplain. He was told by an officer that the wing manager would come to talk to him about his concerns, but this did not happen. Instead, a planned removal was arranged as staff thought he would refuse to move.

When his door flap was opened later that day, Mr A was surprised to see a group of officers “dressed in riot gear” (the C&R team). The Supervising Officer told him to come to the door to listen to instructions because he was being moved to another wing.

Mr A said in reply that he would rather go “down the block” (i.e. to the segregation unit). At this point, the Supervising Officer opened the door without further discussion and the C&R team entered the cell at speed, pushing Mr A to the back of the cell with the shield. He was then restrained with his arms behind his back and handcuffed.

In their Use of Force statements⁴ completed after the event, the officers wrote that they thought Mr A had picked up a pen from the desk and that he might have used this as a weapon. However, the video footage showed no sign of aggression or resistance from Mr A once the cell door was opened. Mr A could be heard saying, “Was that even necessary, though?” after he was restrained. He could then be seen walking compliantly to the new wing, without any verbal or physical resistance, supported on either side by an officer. Once they got to the new cell, the Supervising Officer decided full relocation procedures were not necessary as Mr A was compliant.

We concluded that the Supervising Officer was far too quick to initiate force, and that this was done without any attempt at persuasion or de-escalation, contrary to PSO 1600. Although Mr A indicated resistance to the move when he said, “No, I want to go down the block, then”, he was not posing any physical threat and the good order of the

establishment was not at risk at that point. The Supervising Officer did not appear to understand that force should be a last resort, and that he had a duty to try to resolve the situation without using force.

We also concluded that the prison should have addressed Mr A’s concerns about the move before the planned removal. As it turned out, the prisoner he had been worried about had already moved to another wing. If Mr A had been told this, there is every reason to believe he would not have objected to moving wings. We were satisfied that this situation could and should have been resolved without the use of force and we upheld Mr A’s complaint.

Team briefings

Before a planned removal, the C&R team are given a briefing about what has happened already, what has been said to the prisoner and what risks might be present (such as whether the prisoner has a history of violence towards staff or is likely to have a weapon). Ideally, briefings should be videoed.

We have found a number of cases where the team were told at the briefing that they should give the prisoner “one more chance” to comply and then use force. In Mr B’s prison, we found that briefings like this were routine. The Ombudsman takes the view that this is not appropriate because it pre-disposes the team to use force. The briefing should instead explain the situation and likely risks, rather than being prescriptive about what the team should do when they arrive at the cell. The Supervising Officer and the C&R team leader (the ‘Number One Officer’) need to make a dynamic risk assessment based on the prisoner’s responses when they arrive at the cell door. These crucial decisions and actions should not be pre-planned. As in all circumstances, de-escalation should be attempted first, with force used as the last resort.

The Ombudsman recommends that the briefing officer finish by saying, "Remember: use of force is a last resort."

Lessons to be learned

Lesson 2:

Briefings prior to a planned removal should cover the likely risks rather than being prescriptive about when force should be used.

Case study B

Mr B complained that force had been used on him unnecessarily in the segregation unit.

Our investigation found that Mr B was unhappy about some of his treatment while in the segregation unit and, in his words, “fully rebelled” by smashing up his cell and going on a dirty protest. He broke the observation hatch and threw excrement onto the landing.

He subsequently told an officer that he had finished his protest and wanted to move to a clean cell as there was excrement, glass and water all over the floor. A planned removal was arranged.

Having considered the available evidence, we concluded on the balance of probabilities that the use of force against Mr B was justified because staff had a reasonable fear that he was armed with a weapon and because he did not initially comply with their instructions.

However, we were concerned that, when the Supervising Officer briefed the C&R team before the removal, he told them that they should give Mr B “only one chance” to comply with instructions before they initiated force. The officers told our investigator that this instruction was common practice at the prison in planned removals.

PSO 1600 is clear that each set of circumstances is unique and should be judged on its own merits. However, this is unlikely to happen if staff are routinely briefed that prisoners should be given only one chance to comply with instructions before force is used. Briefing in this way actively discourages staff from attempting to de-escalate the situation and means that force becomes viewed as an immediate rather than a last resort.

We recommended that the Supervising Officer receive formal advice and guidance that he should not be prescriptive about how many orders should be issued before force is initiated, since this is for the officers involved to judge at the time according to the specific circumstances.

The role of the Supervising Officer

In planned removals there is usually a C&R team of three or more officers, plus a more senior Supervising Officer. The Supervising Officer's role throughout the removal is critical.

PSO 1600 says the Supervising Officer is responsible for ensuring that force is only used after all reasonable efforts at persuasion have failed (or are judged unlikely to succeed). The Supervising Officer must also monitor the condition of the prisoner during the incident and liaise closely with the Number One in the C&R team in making efforts to de-escalate the situation throughout the intervention, movement and relocation.

In Mr C's case and in others we have investigated, the Supervising Officer has not performed their role properly and has effectively ceded responsibility to the Number One. When asked why they did not take responsibility themselves, the typical response is, "I had full confidence in my Number One". A Supervising Officer may well have full confidence in the Number One, but the two roles are different. Because the Supervising Officer is not personally involved in the use of force, they have the ability to see the situation as a whole and make judgements in a way that the Number One, who will be fully involved in the high adrenaline of the restraint, cannot do. Supervising Officers must stay with the incident from start to finish and perform their important role to its full extent.

Lessons to be learned

Lesson 3:

The roles of the Supervising Officer and the Number One Officer in the C&R team are different.

Case study C

Mr C complained that staff had used unnecessary and excessive force while moving him to the segregation unit.

Our investigation found that Mr C was unaware that he was to be moved until the C&R team arrived at his cell door. He complied with the Supervising Officer's

instructions to go to the back of the cell, face the window and show his hands.

However, the Supervising Officer, who had very little previous experience of C&R incidents, failed to communicate this to the Number One before he opened the cell door. As a result, the Number One formed the wholly incorrect impression that Mr C had not been compliant and he immediately entered the cell and initiated the use of force, pushing Mr C against the back wall with the shield before the team restrained him using C&R. We concluded that, if the Supervising Officer had communicated effectively with the Number One, it is unlikely that there would have been any need to use force.

We also found that, once the team had entered the cell, the Supervising Officer did not put himself in a position where he could see into the cell and that he effectively passed all his responsibilities to the Number One. When we interviewed him, the Supervising Officer said that in his opinion it was best for the Number One, who was in the cell, to monitor the prisoner. However, the PSO is clear that it is the Supervising Officer's responsibility to monitor the prisoner. Staff engaged in a restraint commonly suffer from an understandable degree of tunnel vision and may also have difficulty hearing through their helmets. In this case, it appears a number of officers did not hear Mr C saying more than once during the restraint that he could not breathe. The Supervising Officer did hear him, but made no attempt to check Mr C either in the cell or when he was brought out, or to alert the Healthcare staff who were present.

In addition, although Mr C was compliant and not aggressive when he was brought out of the cell, the Supervising Officer did not reassess the situation and did not test his compliance. As a result, Mr C was walked some distance to the Segregation Unit with lock restraints (staff controlling each arm), rather than handcuffs, despite being fully compliant. The Supervising Officer also oversaw a strip search⁵ with four officers present, contrary to policy.

We concluded that the Supervising Officer had failed to perform his role properly and

had effectively become a bystander. We recommended that he receive formal advice and guidance and refresher training.

Avoiding one-on-one incidents

C&R techniques are the preferred option when force is necessary. The techniques taught and used have been developed over a long period with the aim of allowing officers to bring a refractory prisoner under control, while minimising the risk of injury to the prisoner and to staff. C&R requires at least three officers, one to control and protect the head and one for each arm.

If it is necessary to use force when fewer than three officers are present, staff may use what are called 'personal safety' techniques to protect themselves or others. PSO 1600 says:

"Personal safety techniques are taught for use in the very rare circumstances when all methods of trying to control or evade a violent situation (e.g. by verbal de-escalation, pressing an alarm bell and awaiting assistance, running away, etc) have failed and the individual concerned is acting in self-defence or for the protection of a third party (e.g. another member of staff or prisoner). These techniques should be used when C&R is impractical."

We have recently investigated cases where an officer has become involved in a personal safety situation unnecessarily. This resulted in a one-on-one struggle, with high risk of injury to both parties because of the uncontrolled nature of the physical engagement. This situation can arise when a member of staff is reluctant to let a prisoner do something they have given them express orders not to do. Instead, the officer uses force to prevent the prisoner deliberately flouting their authority. It should be stressed that the cases we are describing here do not involve the prisoner doing anything that would create a risk to the officer or a third party, but doing something that is not in itself harmful (such as finishing a phone call). In the case of Mr D (below), he was having a shower instead of collecting his meal.

It may be a natural reaction for officers to want

to ensure that their authority is not ignored and the prisoner complies with instructions. But the policy is clear that they should not use force in a one-on-one situation unless there is a risk to life or limb, and that all other options are preferable, including letting the prisoner carry on.

Staff have a range of sanctions that can be used after the event, including IEP warnings and charging the prisoner with a disciplinary offence. This is a safer and more considered means of maintaining authority, rather than getting into a one-on-one use of force.

Lessons to be learned

Lesson 4:

A one-on-one use of force is very risky and should be used only if there is immediate risk to life or limb

Case study D

Mr D complained that he had been assaulted by an officer when he was trying to have a shower. He told the investigator that instead of collecting his meal, as he had been instructed, he had gone for a shower because he had not had his hour out of his cell that day. Mr D accepted that the officer told him he could not take a shower. He said the officer then assaulted him for ignoring this instruction.

The officer said that he had initiated personal safety techniques in order to defend himself because Mr D was abusive towards him and then "pushed past" him to get to the shower. The result was a one-on-one struggle, lasting a number of minutes, with both prisoner and officer sustaining injuries.

The question for the Ombudsman to consider was whether the force used by the officer, with just him and the prisoner present, was absolutely necessary.

Mr D was deliberately disobeying a direct order and we were very critical of him for this. However, Prison Service policy is clear that personal protection techniques should

only be used as a last resort, when there is an immediate risk of harm to an individual. In this case, we concluded that the officer should have let Mr D have his shower, and should have dealt with the blatant disregard of a lawful order by charging him with a disciplinary offence. Alternatively, if the officer thought it was necessary to prevent the prisoner having a shower for reasons of good order and discipline, he should have brought in other officers (either by pressing the alarm or shouting for assistance) to carry out a proper C&R restraint on Mr D (after appropriate attempts to resolve the situation without resort to force).

Both the officer and Mr D sustained injuries during the tussle, illustrating the risks of one-on-one restraint and why it should be avoided if at all possible, unless there is an immediate risk to life or limb.

Examination by a healthcare practitioner

Prison Service Order 1600 stipulates that:

“An appropriately qualified healthcare professional (doctor or registered nurse) must be informed whenever force has been used to restrain a prisoner. He or she must examine the prisoner as soon as possible and must complete a F213 in all cases even if the prisoner appears not to have sustained any injuries. The prisoner must see an appropriately qualified healthcare professional within 24 hours of the incident occurring.”

This obviously protects the prisoner. It also protects staff from false allegations that the prisoner was injured in the use of force.

Prisoners are often seen very quickly after a use of force. This is particularly the case with planned removals when a member of healthcare will already be present. However, healthcare staff may take the view (perhaps on advice from uniformed staff) that it would not be safe to enter the cell to examine the prisoner because the prisoner is too angry immediately after the incident. In these circumstances, the prisoner will simply be spoken

to through the observation flap in the door. The prisoner, as was the case with Mr E, may also be too worked up to engage with healthcare immediately after the incident and may refuse to be examined, or may say that they have no injuries because adrenaline is masking the pain.

We do not consider that a brief look through a cell hatch meets the requirement for a prisoner to be examined by a healthcare practitioner. Where it is not possible to conduct a proper examination immediately after an incident, the prisoner should be seen again by healthcare a few hours later. This gives time for the prisoner to calm down and also for any physiological effects, such as bruising or pain, to develop. We also take the view that, wherever possible, the prisoner should be able to speak to healthcare staff out of the hearing of officers.

Lessons to be learned

Lesson 5:

A brief view by a nurse through the hatch of a cell door will not normally meet the requirement for a prisoner to be examined by a healthcare practitioner following a use of force.

Case study E

Mr E complained that he was punched in the face by an officer in a cell in the segregation unit in an unprovoked attack. He also complained that, although he repeatedly asked to see a healthcare practitioner, this did not happen for several hours. He told us that the nurse did not enter the cell to examine him but instead stood at the door, accompanied by the officer he said had punched him, and only spoke to him briefly.

There was no disagreement that force had been used on Mr E. However, the officer concerned denied that he had punched Mr E before he was restrained by other staff. Our investigation found that there was conflicting evidence about the extent of Mr E's injuries.

The healthcare officer who saw Mr E immediately after the incident recorded that he had no injuries, and a nurse who saw him

six hours later only recorded in a few words that he had cuts around his mouth. However, photographs taken by the prison about seven hours after the incident showed that Mr E had noticeable injuries - significant bruising and swelling to his face, grazing around his mouth and nose, and a split to the inside of his lip - which could have been consistent with being punched in the face. Staff suggested that Mr E had inflicted the injuries seen in the photographs himself in the hours after the incident.

We found that the healthcare officer had not entered the cell or examined Mr E. He said this was because Mr E was “animated and verbally aggressive”. Mr E was unaware that he had been examined by a member of healthcare.

We considered that, as it was not possible to examine Mr E at this point, there should have been a follow up examination later when he had calmed down. As it had been recorded on the Use of Force form that Mr E had been injured, as staff said it had been a very violent incident, and as Mr E was alleging that he had been assaulted by an officer, we also considered that it was unacceptable that it was six hours before he was seen again by a member of healthcare.

Moreover, the nurse who saw Mr E six hours later did not enter the cell or examine him either. Instead, she spoke to him while standing at the cell door accompanied by the officer Mr E said had assaulted him. The nurse did not record why she did not enter the cell. It was in Mr E’s interests to be examined and he co-operated with the taking of the photographs an hour or so later. Therefore, it seems likely that he would have co-operated with the nurse if he had been given the opportunity.

We upheld a number of aspects of the complaint, including that there had been a lack of effective medical examination, and made a series of recommendations to ensure appropriate learning and accountability.

Use of Force statements

After every incident where any type of force has been used, each of the officers involved must complete a statement (commonly known as an 'Annex A statement'). The purpose of these statements is for each member of staff to justify and explain their actions and provide a full account of the circumstances which led to the use of force. It is very common for the various accounts to differ in some respects, and that is to be expected as individuals can have very different experiences of the same incident.

The blank statement forms are headed with an instruction that staff must complete their statement in their own words and independently of other officers involved in the incident. However, we have seen a number of cases where there are suspicious similarities of language in the statements provided by different officers. In the case of Mr E described above, the language used in some of the statements was so strikingly similar that we concluded that the statements had not been written independently. Another example is the case of Mr F below.

Case study F

In the case of Mr F, the Annex A statements of two officers contained several paragraphs which were word-for-word identical. For example, the following paragraph appeared in both statements:

“Back to the evening in question I entered the establishment after the short journey from home. In the car I was starting to think about the situation I was called in for and was expecting some kind of confrontation in the cell.”

As one of the officers had completed his statement three months after the incident, it seemed very likely that he had copied the other officer's statement.

The Ombudsman understands that completing the Annex A statements can feel like a bureaucratic chore to officers, especially in the aftermath of a high adrenaline incident. However, it is totally unacceptable for one

officer to copy from another, as it defeats the purpose of the statements and is clearly against policy. It also gives the impression, rightly or wrongly, that staff have felt the need to co-ordinate their accounts, and this automatically raises questions about the credibility of what is said in the statements.

Lessons to be learned

Lesson 6:

Staff must write their Annex A Use of Force statements independently.

Endnotes

1. Ministry of Justice (2015) *Safety in custody quarterly bulletin: June 2015*. Available online: <https://www.gov.uk/government/statistics/safety-in-custody-quarterly-bulletin-june-2015>.
2. Policy on use of force is further stipulated in Prison Service Instruction 30/2015: Amendments to Use of Force Policy.
3. Prisons and Probation Ombudsman (2014) *Learning Lessons Bulletin: Use of Force*. Available online: <http://www.ppo.gov.uk/?p=3722>
4. Following a use of force, each of the officers involved must complete a Use of Force statement (also commonly known as an Annex A statement) to justify and explain their actions.
5. The Prison Service refers to such searches as 'full searches'.

Lessons to be learned

Lesson 1

The arrival of the C&R team in a planned removal should be treated as a new situation. Whatever the previous level of non-compliance, fresh efforts should be made at this point to de-escalate and resolve the situation without resort to the use of force, rather than assuming that the prisoner will continue to be non-compliant.

Lesson 2

Briefings prior to a planned removal should cover the likely risks rather than being prescriptive about when force should be used. It is not appropriate to decide in advance that the prisoner should be given 'one chance to comply'. Briefings should include a reminder that force should only be used as a last resort.

Lesson 3

The roles of the Supervising Officer and the Number One Officer in the C&R team are different. Supervising Officers must supervise through out the incident, communicating effectively with the Number One, monitoring the prisoner, assessing the situation and intervening where necessary. They must not pass their responsibilities to the Number One.

Lesson 4

A one-on-one use of force is very risky and should be used only if there is immediate risk to life or limb. Officers sometimes need to be prepared to let a prisoner ignore an order, and then deal with that prisoner's misbehaviour after the event (for example, by placing the prisoner on report).

Lesson 5

A brief view by a nurse through the hatch of a cell door will not normally meet the requirement for a prisoner to be examined by a healthcare practitioner following a use of force. This is particularly the case where the restraint has been violent or prolonged, where the prisoner alleges he has been assaulted by staff, or where there is any suggestion that the prisoner may have been injured. Where it is not possible for a healthcare practitioner to examine the prisoner safely immediately after a use of force incident, the prison should arrange for healthcare staff to visit again later when the prisoner has had a chance to calm down.

Lesson 6

Staff must write their Annex A Use of Force statements independently. Staff should use their own words and give their own account of what happened. If it appears that statements have not been written independently, this will inevitably cast doubts on the credibility of the statements.

The Prisons and Probation Ombudsman investigates complaints from prisoners, young people in secure training centres, those on probation and those held in immigration removal centres. The Ombudsman also investigates deaths that occur in prison, secure training centres, immigration detention or among the residents of probation approved premises. These bulletins aim to encourage a greater focus on learning lessons from collective analysis of our investigations, in order to contribute to improvements in the services we investigate, potentially helping to prevent avoidable deaths and encouraging the resolution of issues that might otherwise lead to future complaints.

PPO's vision:

To carry out independent investigations to make custody and community supervision safer and fairer.

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