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DYFED-POWYS  
POLICE AND CRIME  
COMMISSIONER

**Police and Crime  
Commissioner for Dyfed-Powys**

**Scrutiny Panel  
Dip Sampling Exercise**

**Review of 2017/18 Quarter 1 (April -June 2018)**

**Hate Crime Incidents**

**Use of Force**

**Panel Members' Findings & Feedback**

**August 2018**



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## **1.0 Overview**

At the seventh meeting of the Commissioner's Quality Assurance Panel held on 31<sup>st</sup> of August 2018, Members reviewed a random dip-sample of Hate Crime Incident cases. The Panel reviewed a total of 10 cases.

During the afternoon session the Panel received a training input on use of force, receiving information on what is considered as force, the recording requirements and what detail is expected to be seen on an use of force form.

Following their input the Panel reviewed five incidents where use of force was used, for each case they had body worn video footage and use of force forms to review and consider.

## **2.0 Background, Purpose and Methodology**

The background and purpose of the Panel along with how the dip sampling is carried out and what the Panel is asked to consider is detailed in the Quality Assurance Panel handbook, which is available on the [PCC's website](#).

## **3.0 Hate Crime Incidents**

The Panel reviewed 10 Hate Crime Incidents dating from April – June 2018. During the April meeting the Panel received a training input on Hate Crime, within this they received an overview of what a Hate Crime Incident is and the processes which are in place when recording such incidents. The Panel split into small groups to review a small selection of cases before discussing findings as a group. The Panel were asked to answer a series of questions which focused their scrutiny on safeguarding the vulnerable, supporting victims and supervision.

### **3.1 Safeguarding the Vulnerable**

Panel Members highlighted the following areas they considered to be best practice:

- The Panel felt that risks had been identified and had been dealt with appropriately in nine out of the ten cases reviewed. Comments noted by the Panel within their feedback forms included; that risk assessments were being completed, officers were identifying vulnerabilities and that Hate Crimes were being addressed and taken seriously.

- The Panel noted that vulnerability issues were being addressed in all of the 10 cases reviewed. Comments noted for the cases include; THRIVE<sup>1</sup> assessment used appropriately, a good awareness of issues and vulnerabilities shown by officers, providing reassurance where needed, individual signposted to services and support, past incidents identified and linked to case, with Police arriving promptly and that follow up procedures were being followed correctly.

Panel Members highlighted some areas of learning:

- It was felt that two of the cases were not appropriately dealt with as the Panel felt that the cases should not have been recorded as a Hate Crime. Members noted that the vulnerability issues in the cases had been addressed, however, felt that the cases should have been recorded solely as an attempted fraud/theft case and not a Hate Incident.
- It was noted in one particular case that although risks were identified, no risk assessment matrix appeared to have been completed.
- In two of the cases it was noted that although a risk assessment had been completed this was not signed or dated by the victim.
- The Panel questioned whether it would be beneficial if the police template found on the back of the risk assessment, allowed the option for N/A to be inserted to show that options had not been forgotten but had been considered and were not applicable.

### **3.2 Supporting Victims**

Within this section the Panel looked at whether a victim contract had been created i.e. consideration given to how the victim would like to be communicated with and supported throughout the investigation. From the sample it was found that the victim contract had been clearly recorded and created within just over half (6) of the cases. It was felt by the Panel that two of the cases within the sample were incorrectly recorded as a Hate Crime and therefore whether a victim contract had been created and whether a Hate Crime Support Officer had been appointed and made contact was not applicable. The Panel questioned whether Hate Crimes should qualify as a Hate Crime? Although the Panel noted that they did not feel that two of the cases should have been recorded as a Hate

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<sup>1</sup> THRIVE is a risk management tool which considers 6 elements to assist in identifying the appropriate response grade based on the needs of the caller and the circumstances of the incident; Threat, Harm, Risk, Investigation, Vulnerability and Engagement.

Crime, it was still recognised that both of these cases had positive police involvement with a large amount of effort and time being put into supporting the individuals involved in the case.

Members found that the victim had been updated in line with agreed contract within six out of the ten cases reviewed. Members noted that in two of the cases that officers were to be commended for their work in keeping the victim updated.

*"Prompt, proportionate, sympathetic but workmanlike approach displayed by all officers, regular contact with the complainant."*

Within the remainder of the cases reviewed the Members felt that the victim contract was not applicable either due to the situation or relating to the above belief that the cases were incorrectly recorded as a Hate Crime. A question arose from one particular case as to whether a responsible adult should have been nominated to receive updates on the victim's behalf due to the individuals' mental health.

The Panel noted that within eight out of the 10 cases reviewed a Hate Crime support Officer (HCSO) had been appointed and had contacted the victim within 48 hours of the incident being reported. Again, the two cases where a HCSO had not been in contact, the Panel felt that the question was not applicable due to the cases being a fraud incident and not a Hate Crime incident.

### **3.3 Strong Leadership**

The Panel found that within 9 out of 10 cases reviewed that a Supervisor had regularly endorsed the log. A gap of nearly two months was identified in one particular case; however the Panel noted that this may have been due to difficulty in locating the victim involved.

### **3.4 Hate Crime Incident Lead Comments**

There were two crimes of Theft / Fraud which had been incorrectly recorded as having a hate element and would appear as though the hate M/O was selected in error by the recording officer/s. Following the Quality Assurance Panel review, this has now been corrected.

Whilst it was acknowledged that one crime record did not have a risk matrix, this has been reviewed and we are satisfied that appropriate support measures were put in place. We also note that the Hate Crime Checklist had not been used which would have prevented this over-sight. We are able to confirm that there is

no necessity to have the risk matrix signed by the victim unless there is an expectation of sharing information with partner agencies.

The panel questioned whether it would be beneficial for the police template (located on the back of the risk matrix) to allow the option of N/A to be inserted to demonstrate that options had not been omitted but had been considered and were not applicable. We can confirm that these free text boxes are obsolete and the information is now recorded within the crime log. However, Inspector Brian Jones has committed to raising this with the Crime and Harm Reduction Team for consideration as it was felt that as a valuable suggestion it should be explored further.

We are concerned that half of the crimes did not have a victim contract as this is a mandatory expectation. We are launching the revised Operational Guidance and Checklist in the month of October and will once again work towards ensuring that staff are clear of this expectation before sampling compliance.

It was pleasing to note the regularity of Hate Crime Support Officer (HCSO) deployment and their value is evident. Overall, performance appears to have improved across the Force area and further improvements should be noted following the launch of the revised Operational Guidance.

Along with my team, I am grateful to the Quality Assurance Panel and their work supporting us to secure future improvements, particularly the identification of risk and enhanced victim service. I hope they will be available to continue this work with us in the near future.

#### **4.0 Use of Force**

The Panel were given an overview of what is deemed as use of force and how these incidents are recorded. It was explained that use of force includes; handcuffing, shield use, unarmed skills, irritant spray, ground restraint, body restraint, Taser, firearms, spit and bite guard, dog deployment, baton and tactical communication. The Panel were given an example of a use of force form and an overview of the requirements for recording incidents were given to the group.

The Panel reviewed 5 incidents where use of force was used, for each case there was body worn video footage and at least one use of force form available, this allowed the Panel to view the footage, to check whether the use of force used was necessary and proportionate and then to check the recording of the incident via the relevant use of force form submitted. As this was the first time for the Panel to look at use of force the Members reviewed each case as a group, the Panel viewed the body worn video footage available and then a detailed

discussion followed each incident, ensuring that all feedback was collected giving the general overview of each case reviewed.

### **Case 1:**

Within this case the Panel viewed one body worn video footage and two use of force forms. Force used within this case included; handcuffing, ground restraint, body restraint, irritant spray and tactical communication.

Panel Members highlighted the following:

- The Panel felt that this incident had been dealt with well and that reassurance was given throughout to the individual, who had identified himself as having mental health issues. It was noted that the officers handled the mental health concerns appropriately and sensitively.
- The Panel noted the use of force was necessary and reasonable under the circumstances with the method of force being proportionate and the minimum necessary.
- It was felt by the Panel that the irritant spray was perhaps used too close to the individual and before giving sufficient warning, it was noted that possibly the escalation of the officers having to use the spray could have been communicated clearer. However, the Panel agreed that the spray was necessary in the situation.
- A delay of over a month was noted in the completion of one of the use of force forms submitted.

### **Case 2:**

Within this case the Panel viewed one body worn video footage and one use of force form. Force used within this case included; handcuffing, ground restraint and tactical communication.

Panel Members highlighted the following:

- Members highlighted that the officers showed a good awareness of possible mental health issues or significant alcohol consumption. It was noted that the incident was dealt with fairly and appropriately.
- The Panel noted that the use of handcuffs was missing on the use of force form submitted, however it was recognised that this form of force may have been noted on an additional form by the 2<sup>nd</sup> officer, which the Panel did not have sight of.

### Case 3:

Within this case the Panel viewed one body worn video footage and one use of force form. Force used within this case included; handcuffing, ground restraint, irritant spray and tactical communication.

Panel Members highlighted the following:

- The Panel noted that there is no record of handcuffing or restraint methods noted on the use of force form submitted although it was evidenced on the body worn video footage.
- The Members felt that although the use of the irritant spray was necessary and a reasonable level of force for the circumstances, it was felt that there was insufficient warning given to the individual that the spray would be used prior to it being activated.
- The Panel also questioned what the correct wording is for warning individuals that the spray will be used, it was noticed that the word "PAVA" was used and this would be unclear to some individuals, possibly "pepper spray" would be a more recognisable phrase.
- A question was also raised regarding whether an additional box is needed on the use of force form for officers to note the time and date of the incident. Currently this information is not recorded on the form, which understandably would make linking the forms and footage together extremely difficult.

### Case 4:

Within this case the Panel viewed one body worn video footage and one use of force form. Force used within this case included; handcuffing, ground restraint, spit and bite guard, body restraint and tactical communication.

Panel Members highlighted the following:

- Members felt that the officers handled this case extremely well, showing patience and respect in an extremely challenging circumstance.
- It was noted that due to the use of a spit and bite guard the officers were in constant conversation with medical staff and reviewed the level of force required regularly.
- The Panel also noted that the individual was given sufficient warning prior to being issued with a spit and bite guard and a good explanation was

given to the individual of what was going to happen when this use of force method is used.

- Members noted that the officer wearing the body worn video camera left the individual with other officers on several occasions, within these periods of time no footage is available to be viewed. Due to the seriousness of the circumstances and the level of force that had to be used, Members questioned whether the camera should have been passed to other officers in the room, or whether the other officers should have also had their cameras turned on and recording. The Panel raised a concern that if ever there was any questions raised regarding the incident, evidence would be missing for certain periods of time, potentially leaving both parties vulnerable.

### Case 5:

Within this case there were three versions of the body worn video footage available and four use of force forms. Force used within this case included; handcuffing, ground restraint, body restraint and tactical communication.

Panel Members highlighted the following:

- The Panel realised that this individual was known to the police and that the minimum amount of force needed was used.
- It was noted that when the officers first arrived at the scene it was implied that they had a call with a concern regarding the individuals' welfare and that he had possibly taken an overdose. The Panel felt that when the officers initially arrived at the scene they did not question the individual much regarding this concern and the possibility that he may have consumed something. The officers were keen to remove him from the property due to his behaviour; no medical concerns were shown and the individual was not taken to hospital until much later. However, the Panel noted that the police may have received other information and knowledge prior to arriving at the scene.
- The Panel noted that some of the information on the four use of force forms did not match; however, the Panel recognised that different views on a situation and scene are to be expected at times.

#### **4.1 Overall findings**

- The Panel felt that all of the five incidents reviewed the use of force was necessary and reasonable in the circumstances.
- Within all incidents viewed the Panel felt that the force was proportionate and the minimum necessary.
- Within all five incidents the Panel felt that the individual was dealt with dignity and respect with no equality and diversity concerns were noted.
- The Panel felt that from the Body Worn Video Footage viewed, officers dealt with difficult and challenging situations respectfully and professionally.
- Due to an issue of linking forms with the relevant footage, this resulted in a small selection of incidents to review. The Panel highlighted that in the future it would be more positive to receive a wider list of incidents to be able to choose a random dip sample of cases to review.
- The Panel highlighted that there were use of force forms missing in some of the cases reviewed, however it was recognised that due to an issue with linking documents together, the documents may have been submitted, but were difficult to locate.
- The Panel suggested that it would be useful in the future when next reviewing use of force that they receive some background information of why the Police have been asked to assist. For example, in the incidents where officers were attending after a call, some information regarding what the police know before attending will help the Panel make an informed decision on whether the use of force used was justified.

#### **4.2 Use of Force Lead comments**

Using Force against another person is a significant power that is exercised by Police Officers and Staff. I am absolutely determined to ensure that this power is used appropriately, in a proportionate manner and only when necessary.

Once again I am grateful for the scrutiny being provided by the Panel, and am welcoming of the positive feedback that is received. Where appropriate this will be fed back to individual Officers, and if relevant highlighted to others as best practice. It is also good for Dyfed Powys Police to receive feedback from the Panel which highlights areas for concern or improvement, and likewise this will be fed back as appropriate.

### **Case 1**

During Officer Safety Training (OST) staff are briefed regarding the appropriate distance from a subject's face, that incapacitant spray (PAVA) should be used from, and what appropriate warnings should be given. This case is being reviewed by an OST trainer and individual feedback will be given if required.

Feedback is being given regarding the delay in submitting a use of force form. This will also feature as a Force wide communication.

### **Case 2**

No Comments to add

### **Case 3**

Comments as per case 1 regarding appropriate use of Incapacitant spray.

Staff are instructed to verbalise an intended use of PAVA immediately prior to its deployment, so that colleagues will be aware of its use. This is not intended to be recognisable to others around them.

An extensive investigation is currently ongoing to improve the use of force form and associated system, to improve the recording which will include time and date.

### **Case 4**

The introduction of Spit and Bite Guards has been a controversial issue for Policing within the UK. It is welcoming to read the positive feedback from the Panel regarding Officer behaviour during this incident.

BWV are for individual issue to Officers and the sharing of devices is not encouraged. However work is currently ongoing within the Digital Projects to ensure all of the appropriate staff are issued with a device.

## Case 5

Having reviewed the footage of this case it is evident that the staff concerned have acted appropriately and professionally throughout. There was other information relating to this incident that is not captured on the forms or BWV, however the scrutiny being provided is asking us the right questions – which in turn is causing intrusive activity on our part to ensure we are carrying out our duties legitimately.

I will continue to work closely with the QAP co-ordinator, and look for a resolution to some of the issues raised. This will include providing further information relating to an incident if possible.

There are a number of activities ongoing at the moment to improve data quality, and use of Body Worn Video. This should see an improvement in the packages being provided to QAP in the future.