

# Minimising and Managing Physical Restraint

Safeguarding Processes, Governance  
Arrangements, and Roles and  
Responsibilities

# Contents

<b>Introduction</b>	<b>2</b>
Background	2
Purpose	3
Target audience	3
Version update (2015)	3
<b>Chapter 1 – Safeguarding processes</b>	<b>4</b>
Summary of processes	4
1. Training delivery and quality assurance	6
Process description	6
2. Use of MMPR	8
Process description	8
The monitoring and scrutiny of use of force incidents	9
3. Keeping young people safe following the use of physical restraint	10
Process description	10
4. Local data collection	12
Process description	12
5. The use of data and other evidence to influence practice	12
Process description	12
6. Central data collection and analysis	14
Process description	14
7. Practice support	16
Process description	16
8. System oversight and amendments	17
Process description	17
<b>Chapter 2 – Governance arrangements</b>	<b>19</b>
Behaviour Management and Restraint Governance Board (BMRGB)	19
MMPR national team	20
Practice support	20
Medical safety	21
Serious injuries and warnings signs (SIWS) medical panel	21
<b>Chapter 3 – Roles and responsibilities</b>	<b>23</b>

# Introduction

## Background

In response to a recommendation made by the *Independent Review of Restraint in Juvenile Secure Settings* (IRR)<sup>1</sup> in 2008, the government commissioned the National Offender Management Service (NOMS) to develop a new restraint system for secure training centres (STCs) and under-18 young offender institutions (YOIs).

The new behaviour management and restraint system, Minimising and Managing Physical Restraint (MMPR), aims to provide secure estate staff with the ability to recognise young people's behaviour, and use de-escalation and diversion strategies to minimise the use of restraint through the application of behaviour management techniques. It sets out a number of physical restraint techniques. The use of force<sup>2</sup> on a young person must always be viewed as the last available option. The message within MMPR is clear – staff must assess all the available options to managing an incident (i.e. de-escalation techniques, verbal communication) prior to using restraint. Staff must be able to clearly demonstrate why restraint was necessary.

In line with existing legislation and guidance,<sup>3</sup> MMPR sits within a wider framework of effective behaviour management guidance. It is underpinned by a clear commitment to minimise the use of force in secure establishments and the YJB-contracted escort service for children and young people as stated in the providers restraint minimisation strategies. The fundamental principle of MMPR, as is clear from the title of the system itself, is to minimise the use of force as much as possible.

The MMPR system is designed to continually analyse the effectiveness and safety of individual techniques and the manner in which providers use them. There is a clear expectation that the process of learning, review and modification to the MMPR system is continuous.

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<sup>1</sup> Peter Smallridge and Andrew Williamson (sponsored by the Ministry of Justice and the Department for Children, Schools and Families) (2008) *Independent Review of Restraint in Juvenile Secure Settings*.

<sup>2</sup> The definition of use of force includes the use of MMPR techniques, and any use of force that is not an MMPR technique.

<sup>3</sup> YJB (2012) *Managing the Behaviour of Children and Young People in the Secure Estate: A Code of Practice; Use of restraint policy framework for the under-18 secure estate* (2012), YOI Rules (2000) and PSO 1600; STC Rules (1998); and Department for Education (2013) *Working Together to Safeguard Children: A Guide to Inter-Agency Working to Safeguard and Promote the Welfare of Children*.

## Purpose

This document outlines the processes that will ensure the safety and effectiveness of MMPR. These processes include safeguarding and governance arrangements, and the differing roles and responsibilities of all parties involved with the MMPR system. This document does not comment on the MMPR syllabus itself, such as the physical restraint techniques, or debate the ethical and legal issues associated with the restraint of children and young people.

This document sets out how organisations and individuals will work together to safeguard young people who may be subject to use of force in secure establishments and - where adopted - escort settings, and explains how the MMPR system will be reviewed and updated over time.

Importantly, the processes and structures described in this document are not aimed at replicating or replacing existing governance mechanisms already in place. Instead, the aim is to articulate, in one document, the interrelated processes that underpin the MMPR system, and formalise the agreed roles and responsibilities of all parties that play a part in the system.

## Target audience

This document is aimed at:

- policy officials with responsibilities for monitoring and taking action in relation to the safety and effectiveness of MMPR
- policy officials with a responsibility for ensuring that parties are fulfilling their roles and responsibilities under the MMPR system
- senior operational staff and managers (under-18 YOI governors/STC directors)
- external organisations that have a duty of care to young people (i.e. local safeguarding children boards)
- children's rights and interest groups with an interest in behaviour management and restraint-related matters.

## Version update (2015)

This document has been updated to reflect learning to date, changes to the safeguarding processes, governance structures, and roles and responsibilities of organisations that are a part of MMPR. The changes include, but are not limited to:

- the role of MMPR coordinators (pages 8-9),
- membership and role of the MMPR national team (page 8),
- the monitoring and scrutiny of use of force incidents (pages 10-11), and,
- the review of incidents reported via the serious injuries and warning signs (SIWS) process (pages 22-23).

# Chapter 1 – Safeguarding processes

This section outlines the safeguarding processes inherent to MMPR which contribute to its safety. The holistic approach of MMPR ensures that individual elements of the system are not considered in isolation.

For processes to have successful outcomes, they need to be well established, understood by all relevant parties, and informed by an effective use of data. The safety and effectiveness of MMPR is dependent on continuous monitoring and evaluation processes – both centrally and locally – in order to ensure that any safety issues are identified and that appropriate action is taken. The result of any action that is aimed to significantly change the MMPR system will be monitored by the appropriate governing bodies to ensure that it has produced the desired outcome. (The organisations responsible for ensuring that this takes place are outlined in Chapter 3.)

Additionally, internal and external investigations must take place should there be concerns raised or a complaint made following the use of MMPR. These processes have their own regulatory frameworks and they are therefore not covered in detail as part of this document.<sup>4</sup>

## Summary of processes

MMPR is based around a number of interrelated processes which enable the identification of concerns regarding local practice and the effective response to such concerns. These processes can be described as either ‘operational’ (i.e. local) or ‘structural’ (i.e. national), reflecting the need for both providers and central government to have in place robust processes to oversee the use of MMPR.

A basic overview is provided in Figure 1 on the following page.

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<sup>4</sup> For more information on external child protection investigation processes, see Department for Education (2013) Working Together to Safeguard Children: A Guide to Inter-Agency Working to Safeguard and Promote the Welfare of Children.

**Figure 1: Safeguarding MMR – overview**

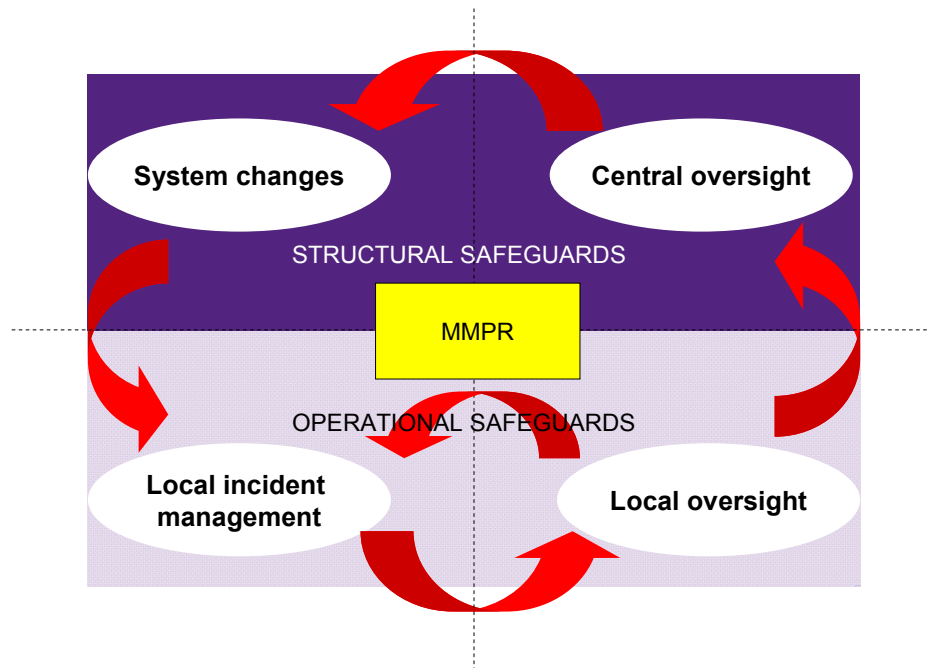


Figure 1 illustrates the various stages where processes take place on a local level (i.e. operational safeguards) and national level (i.e. structural safeguards) to form part of a whole system of analysis and action. Each part of this process is linked to and informs the others: they are not separate or exclusive measures.

Individual providers are responsible for:

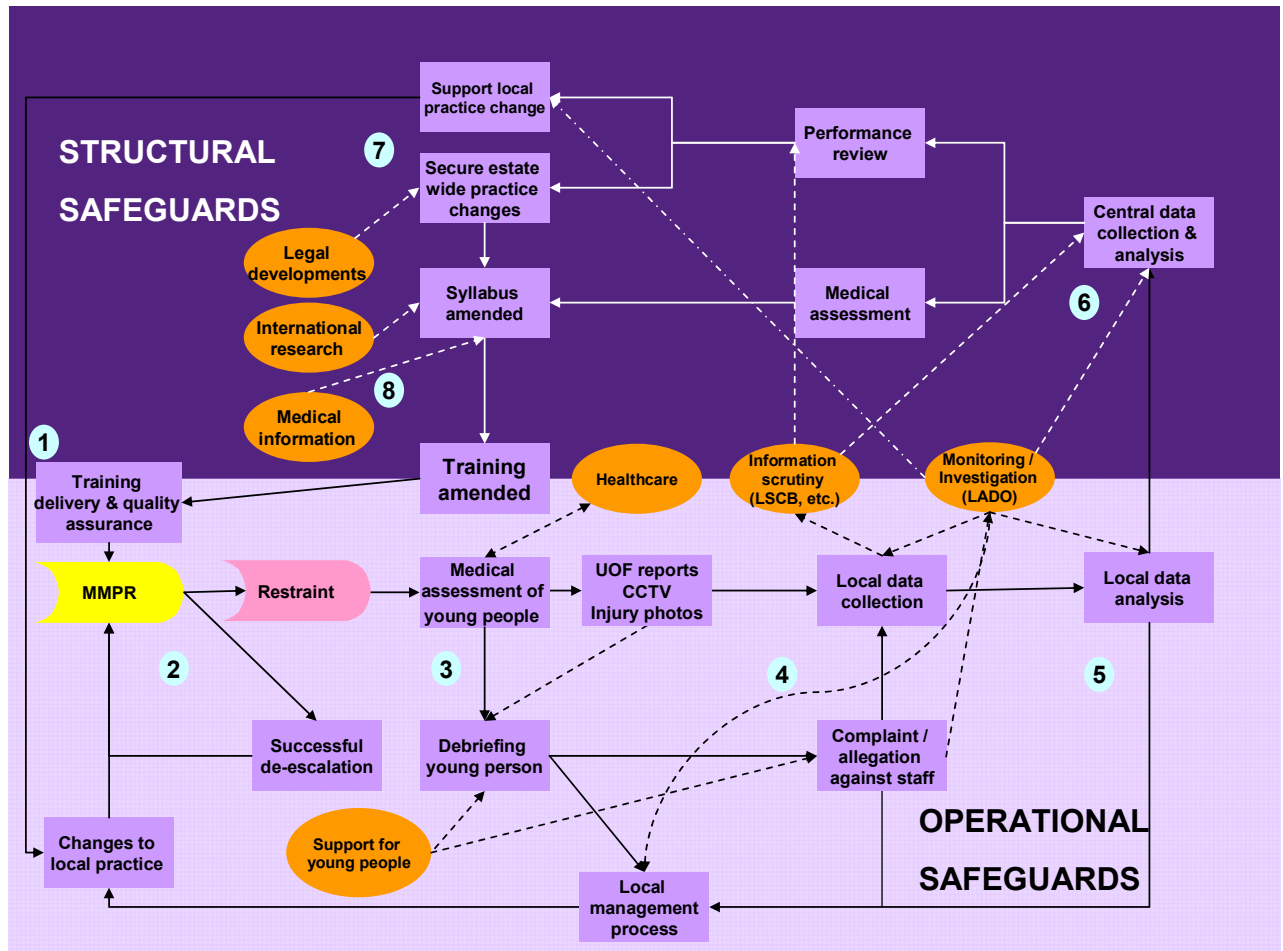
- managing incidents
- monitoring local practice (local oversight of incident management)
- identifying required changes to practice and applying lessons learned (local oversight)
- implementing change and reviewing results (local incident management)
- feeding into central oversight.
- acting appropriately on issues identified from learning and reviews.

National organisations:

- provide external scrutiny of local practice and share effective practice across the secure estate (central oversight)
- address operator performance issues (central oversight)
- analyse and make changes to the effectiveness and safety of techniques, training and guidance (system changes).

Using the high-level division of processes outlined above in Figure 1 as a basis, it is possible to describe in more detail the necessary processes to ensure the safety of MMR. These are outlined in Figure 2 on the following page.

Figure 2: Safeguarding MMRP – a detailed process map



Key	
Rectangle – a safeguarding process	Solid line – an action that takes place on a regular basis
Oval – an external process/input	Dashed line – an action that takes place on an ad-hoc basis

Each stage of the processes outlined in Figure 2 is described in more detail below.

## 1. Training delivery and quality assurance

### Process description

#### *Secure estate staff (those who receive MMRP training)*

Staff and management at individual establishments, escort providers and external parties, undertake rigorous and comprehensive MMRP training, delivered by expert and specialised trainers – a combination of the MMRP national team and local trainers (known as MMRP coordinators). The training provides learners with the ability to recognise a young person’s behaviour, assess threat and use de-escalation and diversion strategies to minimise use of force by the application of behaviour management techniques. Through training,

staff will understand the risks associated with the physical restraint techniques, and the legal and ethical framework in which they are to be used.

Staff understanding is assessed through a written test and a number of scenario-based exercises informed by operational incidents, and they must be able to demonstrate the required level of understanding before being authorised to use MMPR in an operational environment. Staff will not be approved to work directly with young people until they have demonstrated the required aptitude.

Staff receive a minimum of one day's refresher training every six months, and are assessed on both the practical and theoretical aspects of MMPR through practice based scenarios, tailored to reflect common situations that staff encounter in each establishment and escort setting (e.g. certain types of incidents, young people and behaviours). MMPR coordinators are responsible for the delivery of the refresher training, supported and overseen by the MMPR national team.

### *Trainers*

Local training is quality assured by the MMPR national team within the NOMS, who are responsible for the MMPR syllabus, and senior managers at each establishment and the escort service. The MMPR national team provides additional support and training to staff and managers at individual establishments and escort service where it is identified as being necessary, perhaps due to practice issues, and when required to do so due to revisions to the MMPR syllabus, e.g. any modification to a particular restraint technique.

The membership of the MMPR national team is mainly comprised of trainers with previous experience of working in the prison service. To ensure representation of the STC sector, staff with experience of working in STCs were appointed to the MMPR national team to help deliver the training. The representation of STCs in the national team has proved valuable in terms of facilitating cross-sector learning, particularly for members of the team who are less familiar with the STC environment.

The MMPR national team is supported by an independent medical advisor and a behaviour management expert, who play a vital role in risk assessing and analysing the operational evidence around MMPR physical restraint techniques, and who develop the behaviour recognition and effective decision-making elements of the syllabus.

Quality management frameworks have been developed for the MMPR national to provide assurance that the roles and responsibilities of the team are being appropriately managed. These include; the delivery of initial and refresher training, quality assurance of training, SIWS process, and use of independent advisors.

### *MMPR coordinators*

Each provider using MMPR has a team of MMPR coordinators. The role and responsibilities of the MMPR coordinator, in both STCs and under-18 YOIs, include;

- the delivery of training on the MMPR syllabus, supported and overseen by the MMPR national team



- providing ongoing support and feedback to operational staff using MMPR within their establishments or escort service
- undertaking quality assurance of use of force incidents (i.e. reviewing use of force reports and incidents recorded on camera); and,
- attending relevant meetings that monitor use of force and behaviour management issues.

### *Outcomes*

1. A workforce that is highly skilled in managing young people's behaviour by using de-escalation methods.
2. A workforce that can correctly and safely apply the physical restraint techniques and that understands the potential risks associated with each one.
3. A robust monitoring arrangement of specialist trainers who quality assure a provider's use of MMPR and address staff training needs.

## **2. Use of MMPR**

### **Process description**

The use of MMPR is prescribed in the training manual<sup>5</sup>. Each member of staff must ensure that their use of MMPR conforms to the manual and the training that they have received. This includes elements of managing behaviour both through de-escalation and through physical restraint techniques. All uses of force are locally investigated and any action, if required, is taken. This might, for example, be in the form of addressing staff training needs, offering guidance or taking disciplinary measures.

Use of force must always be viewed as the last available option. Staff must always consider and assess the likelihood of de-escalation strategies achieving the desired outcome before considering restraint. Dr. Daniel K Sokol, an honorary senior lecturer in medical ethics and law, was consulted and helped develop an ethical basis for using force on young people. There are two questions posed as part of Dr Sokol's principles of ethics, which staff should always ask themselves before applying any force on a young person.

- Have I exhausted all reasonable options?
- Am I acting in the best interests of either the young person or others?

At all times, the minimum amount of force necessary should be applied during the application of a physical restraint. Any use of force must be reasonable and necessary, and used in a way that is proportionate to the risk posed.

The use of MMPR in every secure establishment and the escort service must be informed by lessons learned from internal incidents and incidents from across the secure estate that have been successfully de-escalated without the need to resort to use of force. This will assist providers to continuously minimise their use of force. The Youth Justice Board for England and Wales (YJB) and

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<sup>5</sup> See MMPR manual published on the Justice website.

providers have a role to play in identifying and disseminating effective practice in this area.

## The monitoring and scrutiny of use of force incidents

There are a number of review processes in place for the monitoring and scrutiny of use of force incidents under MMPR. These include:

- the review and quality assurance of every use of force incident by senior managers and MMPR coordinators (local trainers).
- a review by local authority designated officers where an incident is submitted to them as part of a child protection referral.
- quarterly quality assurance visits to providers by the MMPR national team. At these visits, a selection of use of force incidents are reviewed to identify learning on the effectiveness of training and to ensure local quality assurance processes are working as expected.
- YJB, NOMS and MMPR national team undertaking detailed reviews of practice, including the use of pain-inducing techniques, as and when required.
- a process to review any use of force incident where either a serious injury or medical warning sign or symptom is reported, including:
  - internal scrutiny by the provider.
  - external scrutiny of the incident by the MMPR national team and the independent medical adviser to the National Offender Management Service (NOMS).
  - on a quarterly basis, obtaining further medical advice about each incident from the serious injuries and warnings signs (SIWS) medical panel<sup>6</sup>, to identify any learning points pertaining to the medical safety and effectiveness of physical restraint techniques.

Additional local activities undertaken include:

- regular 'use of force' meetings involving multidisciplinary teams, which focus on reviewing camera footage and devising strategies and/or actions required in response to use of force incidents.
- regular meetings looking at restraint minimisation attended by senior managers, the MMPR co-ordinators and external partners, such as a representative from the local safeguarding children board and YJB monitors.
- review of use of force incidents by the on-site YJB monitors and performance managers
- once a use of force is recorded, providers must ensure that relevant people/agencies are informed about the use of force. These include as a minimum:
  - the young person's 'home' local authority (either through the YOT worker and/or a young person's social worker)

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<sup>6</sup> See page 23 for details on the MMPR medical panel.

- the young person's parent/carer
  - the young person's key worker/personal officer.
- regular YJB commissioned interviews and focus groups with young people in each establishment, led by Barnardo's advocacy service, to obtain young people's views on MMPR and the support received during post-incident debriefs. Learning achieved through this work helps to inform the development of the MMPR syllabus, delivery of training, and also helps to improve behaviour management and restraint-related practice at individual establishments.

### Outcomes

4. The use of force on young people is minimised.
5. The use of force is viewed as the last available option to safely and effectively manage an incident.
6. Use of force is applied as safely as possible, through use of force supervisors and incident managers,<sup>7</sup> who monitor, assess and respond to risk throughout an incident.
7. Increase individual providers accountability to review and quality assure every use of force incident and ensure that appropriate action is taken.
8. Effective communication and information-sharing processes ensure that all relevant agencies working with young people are able to tailor their approaches accordingly in order to safely address any behavioural issues associated with individuals.
9. Medical oversight will ensure that evidence about the medical safety and effectiveness of MMPR physical restraint techniques is collected, analysed and acted upon.
10. Involvement and scrutiny from external stakeholders leads to greater openness, transparency and objectiveness.

## 3. Keeping young people safe following the use of physical restraint

### Process description

After a use of force incident, the following processes are necessary:

- ensuring staff and young people are medically assessed as soon after the incident as is practicable, and that their well-being is maintained.
- as per the *Independent Review of Restraint* recommendation, carrying out debriefing for the young people and staff directly involved in the incident
- providing young people with the option to speak to an independent advocate.

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<sup>7</sup> The use of force supervisor and incident manager are specific roles within MMPR that have responsibilities distinct from those of other staff members during a restraint incident. Training is delivered to staff on how to perform these roles. See MMPR manual, volume 4, published on the Justice website for more information.

- sharing information with relevant individuals and organisations external to the provider(e.g. local authority designated officer).

The need to ensure the medical safety of both staff and young people is a key priority. As per the *Independent Review of Restraint* recommendations, providers must ensure that they are able to call on immediate medical assistance for young people, including obtaining a paediatric report where hospital treatment is required. Any injuries should be given the appropriate level of treatment and be recorded on a body map. Providers may wish to take photographic evidence of the injuries, although this might not always be appropriate given the history of abuse that some young people in the secure estate have

Additionally, both young people and staff should undergo a separate, debriefing process. The outcome should be an agreed action plan to encourage positive behaviour by the young person, thereby minimising the likelihood of future behaviour deteriorating to the point at which there is a need to use force.

It is important that all young people are provided with support after a use of force incident, and especially throughout the debriefing process. Some young people will benefit from advocates being present during the debriefing process, others may wish to speak to their key worker/personal officer, social worker or Independent Monitoring Board. The decision to engage with support services should always be led by the young person.

The formal complaints process provides a further layer of accountability and support for young people. If a young person makes an allegation against staff following a use of force, or if there are concerns about a serious injury that was incurred during an incident, a child protection referral must be made to the local authority designated officer, and reported to the YJB.

### *Outcomes*

11. Debriefing helps staff to work in partnership with individual young people to develop and agree strategies to promote positive behaviour, better exercise their professional judgement and discretion, thereby leading to improvements in practice, and to aim to avoid the need for future use of force.
12. Debriefing informs a providers approach to the management of behaviour and minimisation of use of force.
13. Debriefing staff provides an opportunity for them to reflect on an incident and their decision-making process, and to help identify any individual practice issues.
14. Young people have access to external support (i.e. advocates, social workers, personal officers, youth offending team (YOT) workers, etc.).
15. Young people fully understand the debriefing and complaints processes, and how they are able to benefit from these processes.

## 4. Local data collection

### Process description

#### *Local arrangements*

Under MMPR, each provider records use of force data on a technique-by-technique basis, including additional details on the reason for use of force, the antecedents to the incident, the staff involved, the de-escalation methods that were deployed, and a comprehensive narrative of each incident. Injuries and/or medical warning signs will also be recorded and, as far as possible, these will be clearly linked to the physical restraint techniques that were used, if such injuries or warning signs are believed to be a direct result of an application or misapplication of a particular technique. Providers record this information onto forms and submit these to the YJB and the NOMS. Both organisations have a duty to respond to any concerns about the way in which a provider is using MMPR, or the safety and effectiveness of the techniques within the MMPR syllabus.

Providers must have clear arrangements to ensure that each individual use of force incident is recorded and reported. These arrangements apply uniformly to all departments and units in the establishment, and it is the responsibility of individual providers to ensure that they are understood by all relevant members of staff.

#### *CCTV and other visual/audio evidence*

Use of force data will be complemented by video and audio footage and, where relevant and appropriate, information from the debriefing of young people and staff. This material is to be stored safely for future review, together with other files on a providers data system to provide an accurate record for any future investigation.

#### *Outcomes*

16. Every incident of use of force is recorded accurately, comprehensively and to required national quality standards.
17. Local data collection and reporting enables effective analysis of each incident.
18. CCTV footage is viewed to help identify whether restraint techniques have been applied correctly, as well as to study the antecedents to a use of force.
19. CCTV footage provides valuable evidence for child protection referrals.

## 5. The use of data and other evidence to influence practice

### Process description

Providers are required to regularly analyse use of force data and to have in place effective governance arrangements to ensure that this analysis occurs. These processes should capture, and bring together in one place, evidence from a number of different sources.

The primary focus of data analysis pertains to:

- the management of individual young people
- changes to practice.

Data should be used by providers to identify known areas of risk or hotspots where use of force incidents tend to occur, such as communal areas. These areas of risk should be fed back to local practitioners to inform local approaches to behaviour management. This is best achieved by establishing regular, multi-agency meetings. Additionally, local management structures and processes need to be in place to ensure any necessary follow-up action is delivered and that changes to practice are made. Practice changes must always be introduced with the explicit aim of minimising the use of force. If an agreement on practice changes cannot be reached, external views (such as those of the local safeguarding children board) must be considered.

While it is important that providers continuously seek to improve existing local practices, it is not possible as part of this process to make changes to the MMPR syllabus or techniques. These changes have to be made centrally. Providers, through their relationship with the MMPR national team, have a role to play in informing the central monitoring of MMPR by providing operational evidence to form the basis upon which changes to MMPR can be made.

Local safeguarding children boards (LSCB) will attend quarterly meetings to review individual establishments' use of force, and relevant data as part of their statutory responsibility for monitoring restraint. Any key findings from the meetings and analysis of data will be reflected in the LSCB's annual reports, and shared with the secure establishment, its local MMPR coordinators and YJB monitors.

### *Outcomes*

20. Data analysis processes ensure that providers monitor and identify local use of force-related trends to continuously inform and improve local practice.
21. Aggregated records of all incidents ensure proper accountability and monitoring of practice to inform the providers' restraint minimisation strategies and compliance with safeguarding standards.
22. Accurate and effective recording processes inform the development of safe and effective de-escalation and use of force practices.
23. Accurate recording and reporting of data informs the effective analysis and monitoring by national organisations such as the YJB and the NOMS of the safety and risks associated with individual restraint techniques.
24. Local data collection processes enable providers to better tailor training and supervision to individual staff members' needs, with the aim of continuously improving local practice.
25. Local data collection and analysis informs the plans to manage the behaviour of individual young people.
26. Video footage (from CCTV, handheld cameras, and body worn videos) in post-incident analysis contributes to the safety of MMPR and is used as part of the debriefing process with staff and, when deemed appropriate, with young people.

27. Effective communication and information-sharing processes ensure that all relevant agencies working with young people are able to tailor their approaches accordingly in order to safely address any behavioural issues associated with individuals.
28. External scrutiny of providers leads to greater openness, transparency and objectiveness.

## 6. Central data collection and analysis

### Process description

A central data collection process for MMPR has been developed and is adopted by each provider alongside the implementation of MMPR. It collects and analyses each providers use of force. The data consists primarily of the quantitative information supplied by providers as part of their monthly data returns to the YJB.

The MMPR data collection system has been developed to allow more detailed and meaningful analysis of use of force and to provide operational evidence about the medical safety and effectiveness of individual restraint techniques. The evidence that is gathered will help inform any subsequent action that needs to be taken in terms of amendments to the MMPR syllabus.

A number of areas of practice are reviewed by the MMPR national team (including their independent medical advisors), MMPR coordinators, and YJB monitors, among others. These include:

- warning signs and symptoms<sup>8</sup>
- the use of pain-inducing techniques
- injuries to young people or staff
- use of force-related child protection and safeguarding referrals.

There will be a higher level of scrutiny and wider information gathering for incidents that involve these issues, and a more in-depth analysis of this information by appropriately qualified professionals, i.e. those with necessary medical and operational experience.

Where specific concerns about the use of force emerge, additional information (such as CCTV footage, individual incident reports or behaviour management plans) may be requested from providers by central agencies such as the YJB or inspectorates.

Figure 3 on the following page provides an overview of the central data collection process and the governance arrangements that monitors this process.

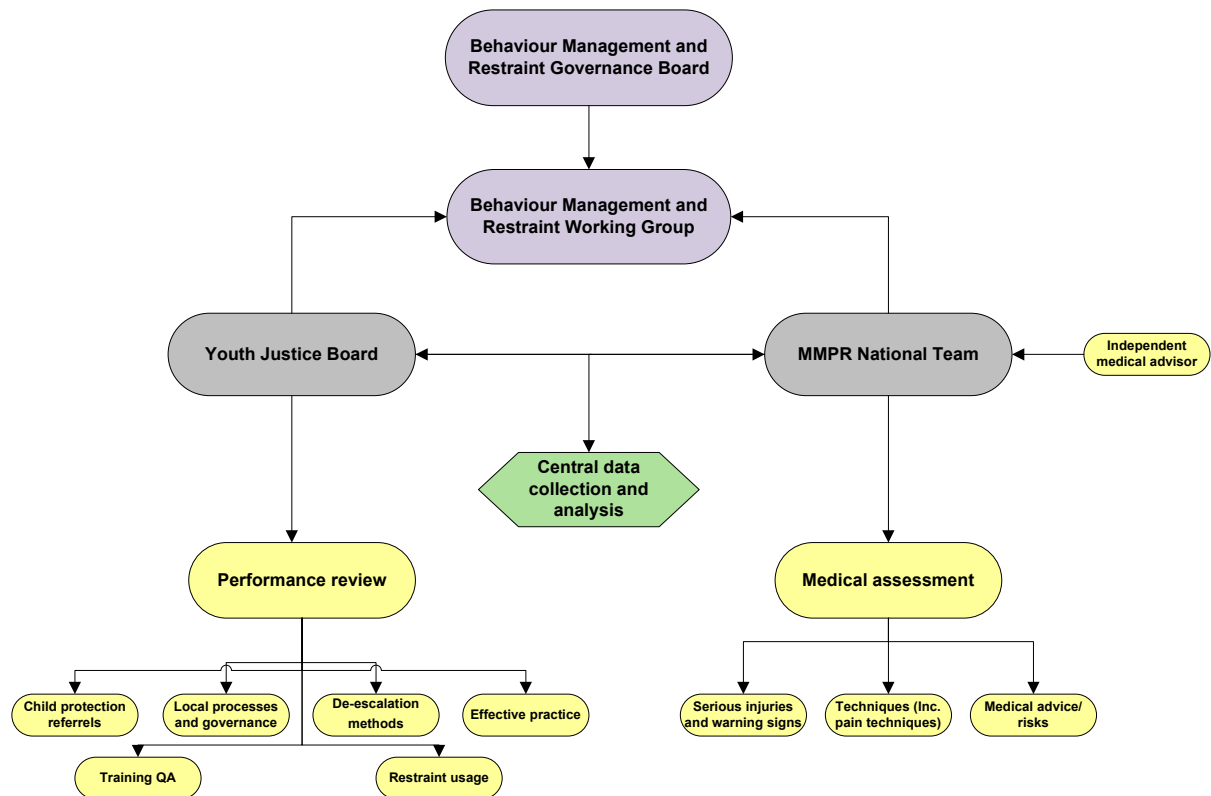
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<sup>8</sup> These are outlined in the medical advice volume (volume 3) of the MMPR syllabus, published on the Justice website. Staff are instructed to observe and monitor a young person during a restraint and look for any signs that suggest the individual's condition might be deteriorating. Some of the signs/symptoms include vomiting and breathing difficulties.

As part of the Government's commitment to increase transparency and more frequent communication with stakeholders on behaviour management and use of force-related issues, data on the use of MMPR is published.



**Figure 3:**  
Central data collection process



The MMPR national team, supported by their independent medical advisor, will review information related to the effectiveness and safety of the physical restraint techniques within the MMPR syllabus. The team recommends any changes to the MMPR syllabus, be it to the physical restraint techniques or significant alterations to training methods, to the Behaviour Management and Restraint Governance Board (BMRGB). The BMRGB makes recommendations to the Secretary of State for Justice for ministerial approval of the recommended changes. The MMPR national team will ensure that related actions are delivered and report their outcomes to the BMRGB.

### Outcomes

29. Central and local data collection and analysis processes improve local approaches to behaviour management.
30. Central and local data collection and analysis processes ensure the medical safety and effectiveness of individual restraint techniques.

## 7. Practice support

### Process description

Practice support can be requested by providers. It can also be initiated at a national level by the YJB and the NOMS where it has been established that a

provider's performance is not meeting the required standard, or where effective practice is identified and there is value in sharing this with other providers.

Local training is quality assured by the MMPR national team, who also undertake quarterly quality assurance visits to providers to identify learning on the effectiveness of training and to ensure local quality assurance processes are working as expected.

- Once an establishment starts using MMPR, additional support is provided by the MMPR national to MMPR coordinators over an interim period. The decision to provide providers with any further support will be based on a number of factors, including: evidence that the use of physical restraint is not minimised
- a relatively high level of warning signs or symptoms, and/or injuries to staff and/or young people
- a relatively frequent use of pain-inducing techniques
- a relatively high number of use of force-related child protection and safeguarding referrals.

The nature of support for individual providers will be proportionate to the assessed risks and can include:

- a review of management processes and local practice
- increased frequency of monitoring
- additional staff training.

### *Outcomes*

31. Practice issues are recognised and responded to.

32. Use of force is kept to a minimum by supporting providers in practice matters.

## **8. System oversight and amendments**

### **Process description**

Based on the scrutiny of data submitted by providers, the medical safety and effectiveness of physical restraint techniques is assessed by the MMPR national team. Should evidence suggest that the risk of injury as a result of certain techniques being used or misapplied has increased, these techniques (and associated training) will be reviewed for possible modification or, ultimately, withdrawal from operational use. The medical assessment itself will look in detail at any evidence of injuries and/or warning signs and symptoms associated with particular techniques. There will be particular scrutiny around the use of pain-inducing techniques, where there is a collective responsibility between the YJB, the NOMS and the Ministry of Justice to ensure that this takes place.

Additionally, the MMPR system will be informed by external research on a variety of subjects, such as UK and international developments in behaviour management and de-escalation methods, and the latest thinking and medical evidence on physical restraint techniques.

Should amendments to the MMPR syllabus be necessary, these will be agreed and implemented based on the latest available medical and operational evidence. The authority to make amendments to the MMPR syllabus rests with the Secretary of State for Justice, who will take the decision based on the medical and operational advice received from the BMRGB through the independent medical advisor, the MMPR national team and other parties, such as the SIWS medical panel (comprised of former members of the Independent Restraint Advisory Panel and Restraint Advisory Board), the NOMS and the YJB.

### *Outcomes*

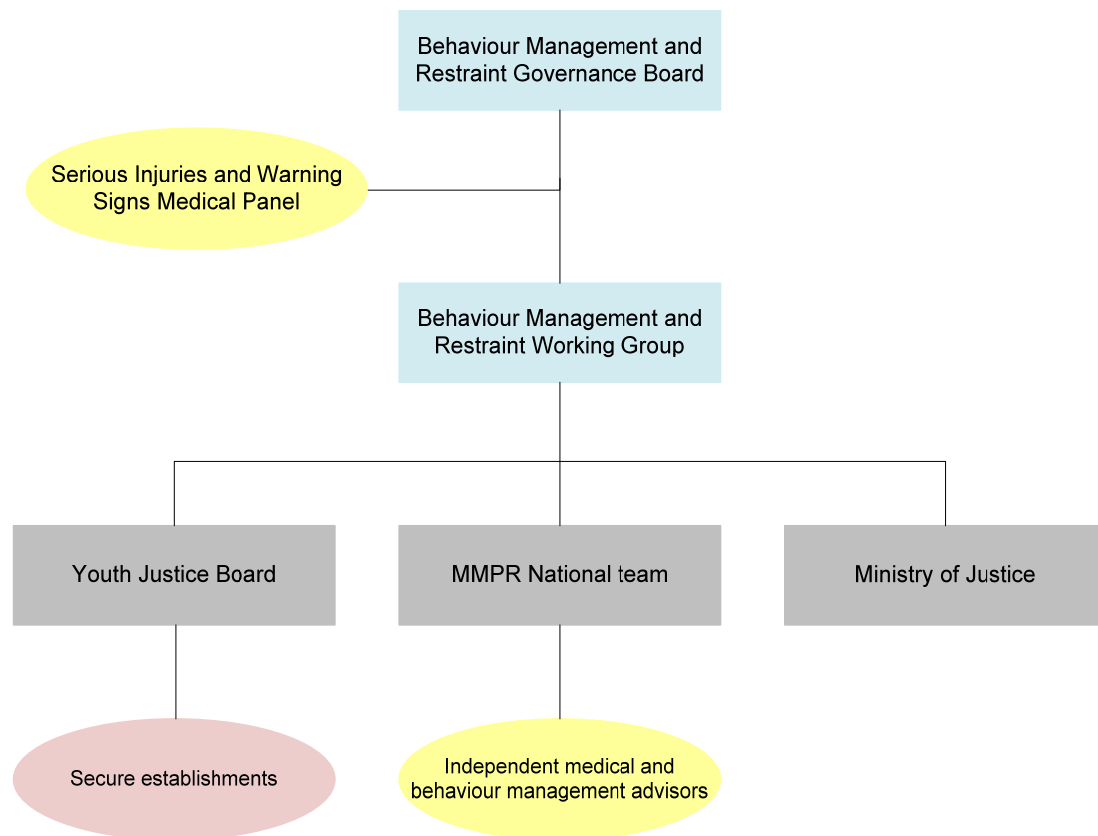
33. Continuous medical oversight will ensure that evidence about the medical safety and effectiveness of the restraint techniques is collected, analysed and acted upon.
34. Restraint techniques contained in the MMPR syllabus will always be based on sound medical evidence to ensure risks to health and safety are minimised.
35. Latest developments and effective practice in de-escalation methods and physical techniques will be identified and reviewed to inform the MMPR syllabus.

# Chapter 2 – Governance arrangements

The inquest into the death of Gareth Myatt<sup>9</sup> specifically highlighted the absence of agreed restraint-related central governance and accountability structures. This was problematic, as any concerns raised with regard to the safety and effectiveness of restraint techniques could not be adequately acted upon. In order to ensure the ongoing safety of MMPR, it is therefore necessary to have in place agreed robust and effective governance structures.

Figure 4:

## High-level governance structure for MMPR



## Behaviour Management and Restraint Governance Board (BMRGB)

<sup>9</sup> Gareth Myatt died in 2004 during a restraint while at Rainsbrook secure training centre.

The Behaviour Management and Restraint Governance Board (BMRGB), chaired by the YJB, has replaced the Restraint Management Board (RMB) (previously chaired by the Ministry of Justice), as the overall authority for overseeing and co-ordinating restraint-related practice across the under-18 secure estate. Membership of the BMRGB includes; NOMS, MoJ, NHS England, ex-Chair of the RAB and IRAP, and HMIP who have an advisory role on the board. The BMRGB has retained input from the MoJ in order to progress any outstanding or developing policy issues.

The responsibilities of the BMRGB include:

- overseeing the MMPR implementation programme across STCs, under-18 YOIs, and the YJB-contracted secure escort provider.
- receiving reports on behaviour management and restraint in those using MMPR and identifying the best way to drive through any identified cultural and practice changes
- examining MMPR data and taking appropriate action
- ensuring all parties are discharging their duties as per the MMPR roles and responsibilities document
- ensuring the MMPR serious injuries and warning signs process is working effectively and that recommendations are being completed by relevant parties
- identifying any potential required amendments to the MMPR syllabus for consideration by NOMS and approval by ministers
- overseeing progress against accepted recommendations from the Independent Review of Restraint, Restraint Advisory Board, Independent Restraint Advisory Panel, relevant inquests, relevant reports by Ofsted and Her Majesty's Inspectorate of Prisons.

The BMRGB is informed by a working group who are directly involved in delivering the government's behaviour management and restraint work programme. The working group escalates any significant matters relating to restraint-related practice to the BMRGB.

## **MMPR national team**

The MMPR national team is supported by MMPR coordinators and senior managers with responsibility for use of force at each secure establishment and the escort service. The main responsibilities of the national team are to develop and maintain the safety and effectiveness of the MMPR syllabus, and work alongside MMPR coordinators in delivering training, and driving practice improvement at individual establishments.

The national team, with support from the YJB, provides local and national oversight of the MMPR system in terms of practice support and medical safety.

## **Practice support**

Practice support is given to providers where evidence suggests that the use of force has become a cause for concern. This can be for the following reasons:

- evidence that use of force is not minimised
- relatively high levels of warning signs or symptoms, and/or injuries to staff and/or young people
- relatively high number of restraint-related child protection referrals or complaints
- issues related to disproportionality, e.g. a relatively high level of use of force on young people from certain ethnic groups.

By working closely with each provider, effective ways in which use of force can be minimised are identified. These effective practice approaches are disseminated to other providers for information and, potentially, to inform changes to the MMPR syllabus.

## Medical safety

The MMPR national team, supported by independent medical advisors, provides regular advice on the medical safety, risks and effectiveness of MMPR techniques to the BMRGB. Based on its assessment of the evidence available, it advises on any necessary changes to the MMPR syllabus. This advice is primarily driven by a review of:

- injuries obtained during or as a result of a use of force
- warning signs and/or symptoms
- the use of pain-inducing techniques.

In addition to scrutinising evidence received from providers, the national team is responsible for ensuring that international research and practice is considered at all times – especially if evidence about previously unknown risks emerges or information about alternative de-escalation methods and restraint techniques is discovered.

The MMPR national team will take advice from all sectors of the under-18 secure estate, and elsewhere in terms of best practice. Medical expertise is provided by independent medical advisors, who work alongside the NOMS, and externally from the Independent SIWS medical panel, who analyse the operational evidence collected, recorded and reported by providers using MMPR.

## Serious injuries and warnings signs (SIWS) medical panel

The medical panel is tasked with providing medical expertise (in addition to the NOMS independent medical advisor) when reviewing serious injuries and warning signs (SIWS) incidents, as part of the process for determining the medical safety and effectiveness of MMPR.

The scope of the SIWS medical panel's work includes:

- attending quarterly meetings to review SIWS incidents in STCs and under-18 YOIs. This includes reviewing CCTV footage and paperwork concerning SIWS incidents to identify learning points

pertaining to the medical safety and effectiveness of physical restraint techniques

- providing a written report to the YJB and NOMS with their main findings and comments following each meeting
- providing ad-hoc medical advice, as requested by the YJB and/or NOMS, in relation to particular incidents, general subjects related to use of force, and individual behaviour management plans
- monitoring progress against SIWS-related recommendations and areas suggested for further consideration by IRAP.

The serious injury and warning signs reporting process<sup>10</sup> will play a significant part in helping inform the MMPR national team, providers, independent medical advisors and the SIWS medical panel about the effectiveness and safety of MMPR (for more about the system oversight safeguarding process, see Chapter 1). There is a collective responsibility for monitoring and playing an active role in this process between the YJB, the NOMS and the Ministry of Justice.

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<sup>10</sup> The MMPR serious injuries and warning signs reporting process is a system for providers to record and report in detail the circumstances of a restraint incident where either a serious injury or warning sign has occurred. Each incident must be investigated in detail with resulting conclusions and action taken clearly documented and explained.

## Chapter 3 – Roles and responsibilities

In addition to the governance structures, it is necessary to outline roles and responsibilities in relation to the ongoing monitoring and continuous improvement of the MMPR system. This not only includes outlining the duties of individual organisations, but also the purpose of working groups and management boards.

Table 1 over the next few pages outlines the organisations involved and their roles and responsibilities.

**Table 1: MMPR – Roles and responsibilities**

Organisation	Responsibilities
Ministers	Approve the MMPR system for use within the secure estate for children and young people. Approve the policy framework within which MMPR operates. Approve the publication of material related to MMPR.
Behaviour Management and Restraint Governance Board (BMRGB)	Overseeing the MMPR implementation programme across STCs, under-18 YOIs and where applicable secure escort provider. Ensuring all parties are discharging their duties as per the MMPR roles and responsibilities document Identifying any potential required amendments to the MMPR syllabus for consideration by NOMS and approval by ministers Overseeing progress against accepted recommendations from the Independent Review of Restraint, Restraint Advisory Board, Independent Restraint Advisory Panel, relevant inquests, relevant reports by Ofsted and Her Majesty’s Inspectorate of Prisons.
National Offender Management Service	MMPR development



Organisation	Responsibilities
(NOMS)	<p>Develop restraint techniques that are medically risk assessed.</p> <p>Develop an effective approach to behaviour management for use in under-18 YOIs.</p> <p>Develop an effective approach to debriefing young people and staff in under-18 YOIs.</p> <p>Make sure that restraint systems are always based on the most up-to-date medical and operational evidence to ensure the safety and effectiveness of individual restraint techniques.</p> <p>Ongoing employment of independent medical advisor(s).</p> <p>Establish and strategically manage the MMPR national team.</p> <p>Support to providers</p> <p>Provide advice to under-18 YOIs about practice in relation to the use of MMPR and approaches to behaviour management.</p> <p>Disseminate effective practice to under-18 YOIs.</p> <p>Scrutiny of MMPR</p> <p>Collectively responsible for developing a serious injury and warning signs system, analysing the data recorded and reported by such a system, taking any necessary action based on the analysis, and determining the result of such action.</p> <p>Take appropriate action relating to any learning or issues identified under the MMPR system</p>
MMPR national team	<p>MMPR development</p> <p>Develop and maintain the MMPR training syllabus.</p> <p>Manage and deliver the quality assurance process of MMPR training, including making any necessary changes to the MMPR training manual and associated materials (i.e. posters/handouts, medical</p>

Organisation	Responsibilities
	<p>advice, etc.)</p> <p>Deliver MMPR training to required implementation standards.</p> <p>Scrutiny of MMPR</p> <p>Develop and maintain a robust evidence base by analysing data from providers and international medical evidence.</p> <p>Analyse incident report forms and view CCTV footage where MMPR restraint incidents have resulted in warning signs/symptoms or injury, or where pain-inducing techniques have been used.</p> <p>Provide regular advice on the medical safety (supported by the SIWS medical panel and independent medical advisor), risks and effectiveness of MMPR techniques to the BMRGB. Based on an assessment of the evidence available, recommend necessary changes to the training and techniques within MMPR to the BMRGB.</p> <p>Practice support</p> <p>Support local staff in monitoring their use of force, investigating the causes of trends and addressing performance-related issues (i.e. an increase in a provider's use of force) through changes in local practice.</p> <p>Provide advice and support, in conjunction with local staff, to individual providers about practice in relation to the use of MMPR and approaches to behaviour management.</p>
MMPR coordinators	<p>STCs, under-18 YOIs and secure escort provider:</p> <p>To deliver training on the MMPR syllabus, supported as appropriate, by the MMPR national team.</p> <p>To provide ongoing support and feedback to operational staff using MMPR.</p> <p>To undertake quality assurance of restraint incidents (i.e. reviewing use of force reports and restraint incidents on CCTV footage).</p>

Organisation	Responsibilities
	Attend relevant meetings that monitor use of force and behaviour management issues.
Youth Justice Board (YJB)	<p>Central data collection</p> <p>Collect and collate data from providers relating to restraint and behaviour management.</p> <p>Share data with providers to help inform practice. This data will also be shared with the NOMS, the MMPR national team and the Ministry of Justice, and as part of the MMPR governance structure, the Behaviour Management and Restraint Governance Board, and the SIWS medical panel.</p> <p>Analyse the use of all restraint systems across STCs, under-18 YOIs and secure escort service, identify trends and issues, investigate the cause(s), and take or recommend appropriate action. Provide relevant information and evidence, particularly using contractual arrangements with STCs, to support the work of the MMPR national team and local staff in secure establishments and the YJB-contracted escort service, as well as the independent medical advisor.</p> <p>Collectively responsible for developing a serious injury and warning signs system, analysing the data recorded and reported by such a system, taking any necessary action based on the analysis, and determining the result of such action.</p> <p>Scrutiny of MMPR</p> <p>Review CCTV footage and investigations conducted by providers in relation to restraint incidents.</p> <p>Monitor training in MMPR and the way in which that training is quality assured by the MMPR national team.</p> <p>Performance improvement</p> <p>Use contractual levers to improve practice in relation to the use (and minimisation) of restraint across the secure estate.</p> <p>Disseminate effective practice across the secure estate for children and young people.</p>

Organisation	Responsibilities
	<p>Gathering evidence</p> <p>Respond, where possible, to the SIWS medical panel's requests for behaviour management and restraint-related evidence, and for research to be undertaken.</p> <p>Work collaboratively with the NOMS on identifying restraint-related performance issues that might have possible implications on MMPR training, techniques and medical advice on a local and national level. Ensure ministers are briefed and updated about issues pertaining to restraint in the secure estate.</p>
SIWS medical panel	<p>Review incidents involving serious injuries and warning signs from a medical point of view.</p> <p>Analyse MMPR data from a medical point of view, as and when required.</p> <p>Take account of national/international medical evidence regarding restraint techniques.</p> <p>Reassess physical restraint techniques and medical advice, if required.</p>
Ministry of Justice – Youth Justice Policy Unit	<p>Provide policy input to the BMRGB to progress any outstanding or developing policy issues.</p>
Secure establishments and YJB-contracted secure escort provider	<p>Ensure that the health and well-being of children is assessed and addressed following an incident.</p> <p>Ensure staff and senior managers attend initial and refresher MMPR training.</p> <p>Collect and analyse data regarding restraint to inform changes in local practice and/or escalate issues about the MMPR syllabus/training to the NOMS and the YJB (i.e. issues around efficacy of techniques, difficulties in successfully applying techniques, etc.).</p> <p>Fulfil requirements to record and report restraint data to national organisations.</p>

Organisation	Responsibilities
	<p>Ensure quality debriefs are undertaken with staff and young people after every restraint-related incident.</p> <p>Ensure staff with responsibilities related to restraint and local coordinators are performing their roles to the required standard.</p> <p>Ensure use of MMPR is informed by lessons learned from incidents that have been successfully de-escalated without the need to resort to the use of restraint.</p> <p>Ensure MMPR is fully integrated with the establishments' restraint minimisation strategy.</p> <p>Ensure that information is provided to young people, parents and carers regarding MMPR, including, but not limited to, the de-escalation methods and restraint techniques, and processes such as debriefing. This information must account for individuals with particular learning difficulties and be updated on an ongoing basis.</p>
Inspectorates (Ofsted and HMI Prisons)	<p>Deliver a joint inspection framework for inspecting STCs, encompassing the use of restraint.</p> <p>Robust scrutiny of the use of MMPR in under-18 YOIs and STCs.</p>
Local authority designated officer	<p>Effectively investigate any child protection referrals resulting from restraint incidents.</p>
Local safeguarding children boards	<p>Scrutinise their establishments' use of restraint.</p> <p>Scrutinise their establishments' policies and protocols which surround the use of restraint.</p> <p>Scrutinise restraint-related incidents and injuries, and restraint-related child protection and safeguarding referrals.</p>

Organisation	Responsibilities
	Produce an annual report on their local establishments' use of restraint to the YJB, or more frequently if they have concerns. They should also report to HMI Prisons or Ofsted, as appropriate, to inform inspections.
Advocacy service providers	<p>Attend restraint debriefs for young people, when requested by the individual, to provide support and advice.</p> <p>Report any restraint-related concerns to the YJB and head of the secure establishment.</p> <p>Share information and communicate with HMI Prisons and Ofsted to inform inspections.</p> <p>Conduct one to one interviews and focus groups with young people at each establishment to obtain young people's views on MMPR.</p>
Social workers	Act as advisors/consultants to governors with regard to any safeguarding matters raised within the establishment, including, importantly, restraint-related matters.
Independent medical advisor to the NOMS	<p>Provide medical opinion on the safety of MMPR techniques based on operational data and evidence, and recommend changes to the risk assessment of each technique.</p> <p>Provide advice regarding revisions to the medical advice within the MMPR syllabus.</p>

