

# **INDEPENDENT REVIEW OF RESTRAINT IN JUVENILE SECURE SETTINGS**

Peter Smallridge and Andrew Williamson

## RESTRAINT IN THE YOUNG PEOPLE'S SECURE ESTATE

<b>Secure Training Centres</b>	<b>Method used</b>
All (4 sites)	Physical Control in Care

<b>Young Offender Institutions</b>	<b>Method used</b>
All (17 sites)	Control & Restraint

	<b>SCHs</b>	<b>LA / Provider</b>	<b>Restraint used</b>
1	Aldine House Secure Children's Centre	Sheffield City Council	MAPA
2	Atkinson Unit	Devon County Council	GSA
3	Aycliffe Secure Services	Durham County Council	PRICE
4	Barton Moss	Salford City Council	DIVERT
5	Beechfield Secure Unit	West Sussex County Council	Team Teach
6	Clare Lodge Secure Unit	Peterborough City Council	CALM
7	Clayfields House Secure Unit	Nottinghamshire County Council	MAPA
8	East Moor SCH	Leeds City Council	MAPA
9	Hillside Secure Centre	Neath Port Talbot County Borough Council	GSA
10	Kyloe House SCH	Northumberland County Council	CALM
11	Lansdowne Secure Unit	East Sussex County Council	PRICE
12	Leverton	Essex County Council	SCAPE
13	Lincolnshire Secure Unit	Lincolnshire County Council	ECC&R
14	Orchard Lodge	Glen Care Group	GSA
15	Red Bank Community Home	St Helens Metropolitan Borough Council	PRICE
16	St Catherine's Secure Centre	Nugent Care	PRICE
17	Sutton Place Safe Centre	Kingston-upon-Hull City Council	PRICE
18	Swanwick Lodge	Hampshire County Council	Team Teach
19	Vinney Green Secure Unit	South Gloucestershire Council	GSA

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# 1. INTRODUCTION

It is now four years since the tragic deaths of Gareth Myatt and Adam Rickwood in Secure Training Centres. Gareth died whilst being restrained. Adam took his own life after being restrained. Their deaths, the Coroners' recommendations arising from the resulting inquests, and wide disquiet about the use of physical restraint on young people in custody led to our being invited by David Hanson, the Minister for Youth Justice, and Beverley Hughes, the Minister for Children, to review restraint across the young people's secure estate - STCs, Young Offender Institutions (YOIs) and Secure Children's Homes (SCH)

Our Terms of Reference were to:

- Encompass policy and practice on the use of restraint across a range of juvenile secure settings including STCs, SCHs and YOIs.

And make recommendations to Ministers on:

- The operational efficacy, safety, (including medical safety), and ethical validity of restraint methods, in juvenile secure settings, including Physical Control in Care (PCC)—the system of restraint used only in secure training centres—and the circumstances in which they may be used.
- The system of training provided to staff using restraint in juvenile secure settings, including how such training is monitored, reviewed and accredited.
- The arrangements for cross-departmental knowledge-sharing on use of restraint and behaviour management across a range of juvenile secure settings including STCs, SCHs and YOIs.
- The respective responsibilities of the Ministry of Justice, the Department for Children, Schools and Families, the Youth Justice Board, Her Majesty's Prison Service and individual providers of secure children's homes and other relevant institutions in relation to the safety and effectiveness of restraint including clarification of the approval methods for restraint techniques.
- The responsibilities of Local Safeguarding Children Boards in relation to the safety of restraint in their area.
- Whether the arrangements in place to record and monitor the use of restraint and the arrangements for sharing and analysis of information relating to deaths, injuries and warning signs exhibited following restraints, are adequate in all juvenile secure settings.

Our background is that we are both social workers, with many years' experience in practice and management. Both of us have been Directors of Social Services (in Warwickshire and Kent, and in Devon.) We now Chair NHS organisations (Andrew Williamson the Cornwall & Isle of Scilly Primary Care Trust and Peter Smalridge the Kent and Medway NHS and Social Care Partnership Trust) and we have worked together in various social care projects including in the Isle of Man and in Eastern Europe.

We have managed social services for children including residential services and we are both familiar with the concept of youth justice, and have managed the equivalent of Youth Offending Teams in the past.

We were pleased to be invited to conduct this review. Our approach has been one of openness. We have been interested to meet with and listen to the wide range of opinion on a subject of crucial interest to all those involved.

There are around 2,900 children and young people in custody at any one time in England and Wales. The sentences served by the young people range from those which are prescribed and relatively brief to "indeterminate" sentences for those deemed to have committed offences of such severity that a long sentence is considered necessary. Young people are also held on remand for varying period in the same establishments. These different custodial situations create significant managerial and operational difficulties for staff within the establishments.

The degree of violence and abuse to which many of these young people have been subjected in their short lives or that they may have perpetrated on others is often extreme and of huge concern to a civilised society. Whilst there are many questions to be asked about how this has come to be the case, we have concentrated on the nature and quality of the containment and care provided for them, and

how the culture of the establishments in which they are placed and the practices carried out in them affects the frequency and the nature of restraint.

Whilst on occasion restraint is essential to ensure the safety of young people or staff, it places all concerned at risk. We learned very early on in the review that there is no such thing as 'entirely safe' restraint. Restraint is intrinsically unsafe. Even where it does not end in physical injury the experience and the memory can be profoundly damaging psychologically.

We sought to understand whether restraint, when it is deemed necessary to be used, is ethical, appropriate, proportional and properly carried out.

We had demonstrated to us:

- Control & Restraint, prescribed for and used in YOIs;
- Physical Care & Control, prescribed for and used in the four STCs; and
- We have examined the differing methods applied in SCHs.

We personally visited 4 STCs, 5 SCHs, and 5 YOIs across the country and interviewed many young people, staff and managers, not only about their experiences of restraint but about the pressures and challenges of life in secure units.

We examined the background and legal context of the review, including the law on restraint and obligations towards national and international treaties like the UN Convention on the Rights of the Child.

We received evidence from a wide range of individuals and organisations with an interest in restraint, in particular the Children's Commissioners, the Children's Charities, the Howard League and Inquest, as well from statutory and other regulatory bodies such as the Youth Justice Board (YJB), the Inspectorates and other agencies.

We have been fortunate to meet with many of them, as we have Members and peers from Parliament who participated in the debates surrounding the Government's proposed amendment to the Secure Training Centre (Amendment) Rules 2007. We are especially grateful to have met the mother of Gareth Myatt, Pamela Wilton, and of Adam Rickwood, Carol Pounder, who gave powerful evidence to the review.

We would be remiss not to thank all of those who have helped us with this review, especially all of those young people who agreed to see us, the staff and their managers in establishments across the estate who gave their time and shared their experiences of restraint

We have been grateful to all those who have contributed their evidence and professional expertise to the review on the critical issue of restraint safety. We are especially grateful to John Parkes, Professor David Allen, Dr Brodie Paterson, Dr Anthony Bleetman, Professor Sue Bailey, Dr Heather Payne and Dr David Perry for submitting evidence to the review or for enabling us to draw on their published views. We also met with Dr Mary Piper, Dr Morris Zwi and Dr Ffion Davis and acknowledge the kind assistance of Caroline Twitchett and Colin Dale at the Department of Health.

We also wish to thank Di Hart from NCB, who provided invaluable research on restraint in SCHs, Gill Rigg at the Association of Directors of Social Services, Paul Cook and Trevor Wilson-Smith from the STCs, Andy Simpson and Jon Collier from Prison Service National Tactical Response Group and Louise Goodwin and her colleagues at the YJB. We particularly want to thank David Parkin from the Joint Youth Justice Unit in the Ministry of Justice and the Department of Children, Schools and Families, who worked tirelessly on our behalf, and for his calm and reasoned advice.

At the outset Ministers made it clear that we were to be given free rein to conduct our review and that there would be no interference in our work. We are pleased to confirm that this has indeed been the case, and that the conclusions and recommendations in this independent report are entirely ours.

**Peter Smallridge and Andrew Williamson**  
June 2008

*Explanatory notes*

1. Within our report we have preferred to use the term 'restraint' instead of the more technically precise but cumbersome 'Restrictive Physical Intervention' (RPI) under which the YJB has collected restraint data since April 2007 and which is defined as:

*"Any occasion when force is used with the intention of overpowering or to overpower a young person. Overpower is defined as 'restricting movement or mobility'"*

2. Our use of the term 'restraint' though conforms to 'RPI' by covering most types of physical and mechanical restraint but not the minor low-level interventions which are deemed 'non-restrictive', such as a hand on the shoulder to lead a young person away from an incident. This focuses our report on the most invasive and potentially dangerous interventions.

3. In our report:

Restraint 'methods' or 'systems' means the overall restraint package. e.g. Physical Control in Care, PRICE, Team Teach etc,

Restraint 'techniques', 'holds', 'locks' refers to individual elements within a restraint method or system, e.g. basket holds, prone, wrist flexion.

'Establishments' and 'secure units' mean, unless otherwise indicated, all individual YOIs, STCs and SCHs in the secure estate.

4. Although the term 'juvenile' is in our Terms of Reference we prefer to use 'young people' or 'children'. We use these terms interchangeably in our report. We have not followed the legal definitions for either but instead intend our comments and recommendations to apply to all those in the secure estate.

## **2. EXECUTIVE SUMMARY AND RECOMMENDATIONS**

### **Restraint in the secure estate**

During consultation we found widespread acceptance that it is sometimes necessary to use force to restrain children in the secure estate, where their behaviour poses a high degree of risk to themselves or others. But we found that policies and procedures for using restraint have tended to be developed in isolation with differing approaches between STCs, YOIs and SCHs and even within SCHs. We believe that the criteria by which restraint may be used should be consistent across the settings.

We propose six principles for using restraint in the secure estate, which focus on preventing the risk of harm. This would include risk of physical or psychological harm and risk of harm to a safe environment. The phrase 'good order and discipline' may be acceptable in legislation but in more general use, and particularly in guidance to staff, there is a risk of its being misunderstood as meaning simple compliance with staff wishes.

We examine the arguments in favour of recommending a single consistent method of restraint across the secure estate but the lack of medical evidence in favour of one specific restraint method, including our reservations about past data on injuries, and the differing population and challenges and risks across the secure estate, lead us to conclude that the current diversity of restraint methods is justified, even though we accept that under the present placement arrangements any young person can find themselves in any establishment.

But we would wish to see greater consistency across the estate. We recommend that the Government should set up a new mandatory Accreditation Scheme, which we see as essential for identifying and removing unsafe restraint techniques, training and trainers from the secure estate.

We recognise that accreditation may take some time to set up, so we lead with recommendations on pressing concerns about restraint in the secure estate, especially in YOIs and STCs, which, along with the recommendations for accreditation, reducing restraint, protecting young people after restraint and training, we consider to be the priorities.

### **Young Offender Institutions**

85% of young people in the secure estate are in YOIs but relative to STCs little scrutiny has been given to the use of restraint there.

We wish to see significant changes to restraint and behaviour management in YOIs. We propose the introduction of restraint techniques specific to young people, which will utilise non-pain compliant holds, together with a new behaviour management package to introduce better risk assessment of young people and provide staff with the skills to improve de-escalation and conflict resolution and so avoid the need to use force.

We accept that the pain-compliant techniques in the Control and Restraint (C&R) method used in YOIs will have to remain, as they are effective if force is needed to managing challenging behaviour by stronger, more violent young people, but consider them inappropriate as the main response when young people need to be restrained and wish to reduce reliance on them.

We also make recommendations about making an enhanced child-focused training programme mandatory for those working in the prison estate for young people.

### **Secure Training Centres**

We recommend the development of a new system of restraint for STCs to replace Physical Control in Care (PCC). We have found no evidence to favour a specific existing restraint method to replace PCC so we ask the Government to commission a new system of restraint to meet the range of challenges in STCs. We broadly define the elements of this system, which should remain primarily based on holds and draw on the view of the PCC Medical Panel and other evidence on safety.

Existing PCC holds, however, are increasingly inadequate to manage the physically stronger young people found in STCs, who can be violent, and do not provide enough means to bring to an end longer, more exhausting restraint incidents which can compromise the safety of young people. We have come to the conclusion that a degree of pain compliance may be necessary in exceptional circumstances, and consequently we make recommendations about the use of wrist locks in STCs. We understand how

irreconcilable the proposal is with the UN Convention on the Rights of the Child and how unpopular it is likely to be with the Children's Commissioners, the Parliamentary Joint Committee on Human Rights and others. Our natural inclination is to support their position on the use of pain. But in this report we bear a significant responsibility to young people and to staff to try to keep them safe and to protect them from physical harm as much as possible.

We make recommendations in our report that build in safeguards to minimise any use of wrist locks. These safeguards need to be allied to rigorous monitoring of the use of restraint involving pain in STCs.

## **Secure Children's Homes**

Our review provides, for the first time, a comprehensive survey of restraint methods and training in SCHs. These are diverse but generally felt to be appropriate to the ethos of SCHs and the needs of children there and are well integrated within behaviour management strategies.

However, our review found considerable inconsistency in the review processes to assure the safety of techniques, which vary according to the method. We believe that the Accreditation System which we recommend will bring much greater consistency and clarity and place SCHs, and other settings in the estate, in a better regulatory framework.

## **Recommendations for the secure estate**

As a key task for our review we sought to bring greater clarity and consistency across the secure estate. We make recommendations in the following areas:

To monitor use of force, provide oversight of accreditation and to give a strategic lead on helping to reduce use of force, we recommend that there should be a Restraint Management Board, chaired at Ministerial level, to cover restraint in all sectors in the secure estate.

To underpin the accreditation system, we recommend the creation of a central research base on the medical safety of restraint methods.

To help the research base, secure establishments and restraint providers need to be accountable for keeping and reporting accurate data on restraint use and injuries, and the Youth Justice Board should be more rigorous in scrutinising and quality assuring restraint data and taking action over inappropriate use of restraint or emerging concerns over safety.

We recommend that all staff who have to use force must be trained in the key skills of monitoring and spotting warning signs during incidents. We also make proposals to make child-focused training geared towards NVQ level 3 across the estate.

We have looked at best practice within and outside the secure estate in how to avoid using force by placing restraint within the context of behaviour management, in which risk assessment has a key role. We make recommendations for future action, which include requiring all units to set out clear steps they are taking to minimise force through an auditable Restraint Reduction Strategy.

We also deal with improving restraint debriefings with young people and staff, the management of complaints and how to provide better independent scrutiny involving outside agencies, especially advocates and Local Safeguarding Children Boards.

We also examine how aspects of operational policy can contribute to restraint, including how poor or incomplete information on a young person can lead to them being considered an enhanced risk by default; and the effects of unnecessary and invasive strip-searching.

We conclude that whilst good policies, procedures, the training and preparation of staff, their supervision and management and the culture of the organisations in which they work are crucial factors in determining the frequency and propensity for restraining young people, in the end it is the judgement of the member of staff when an incident occurs which is the single most significant factor in how it is dealt with in practice.



## REVIEW RECOMMENDATIONS

### *Young Offender Institutions*

1. **The Prison Service must provide staff with safe restraint techniques which are designed specifically for young people and which do not rely on pain-compliance. As a matter of priority it should reintroduce properly resourced and managed pilots of Adapted C&R into YOIs. [Paragraph 8.33]**
2. **The Government should remove the nose control technique in C&R. Its continued use is inconsistent with the removal of the identical nose distraction technique in PCC. [8.7]**
3. **Batons should not be routinely deployed in the young person's estate. [8.39]**
4. **The Prison Service should ensure that it has adequate arrangements in place for regular central oversight and analysis of the use of force and reporting of injuries in YOIs. [8.21]**
5. **The Prison Service should adopt Therapeutic Crisis Intervention or a similar effective behaviour management approach in all YOIs. [13.14]**
6. **Staff responsible for training and co-ordinating use of force in YOIs should be brought within the management responsibilities of the Safeguard Manager. [8.38]**
7. **The Prison Service should make an enhanced Juvenile Awareness Staff Programme mandatory for all those working with young people. [17.11]**
8. **YOIs should be designated a specialist system within the Prison Service with their management a discrete specialism. Career opportunities should be created for managers and staff which reward their expertise in working with young people. [13.34]**

### *Secure Training Centres*

9. **The Government should permanently remove nose distraction and the double basket hold from the techniques currently used in PCC. [9.21]**
10. **The Government should commission the Prison Service NTRG to devise a new simpler, safer and more effective system of restraint to replace PCC in STCs. [9.42]**
11. **The new system must be built around a smaller core of safe techniques to cover the range of risks in STCs. Its development should be informed by latest medical evidence, including the PCC Medical Panel's conclusions on the safety and suitability of the head support, seated holds and the double embrace, and where appropriate by the evidence of the BILD expert panel. [9.42]**
12. **The new system should be based primarily on holds which avoid pain but should incorporate wrist flexion locks, as a Phase 4 technique, to be used in exceptional circumstances and subject to strict safeguards. Staff in STCs should be prohibited from using wrist locks unless: [9.42 & 9.45]**
  - a) Use has been approved in a prior individual risk assessment authorised personally by the STC Director/Duty Director and signed off by healthcare or
  - b) The safety of any young person or staff member during a restraint incident requires it to be brought to an end quickly. Authority to use wrist locks in these circumstances must be given following risk assessment by the Duty Manager or in emergency situations by the team leader present.
  - c) In all cases, de-escalation and other permitted, non-pain techniques should have been tried first before the use of wrist flexion is considered.
  - d) The risk assessment of young people should be reviewed weekly to determine whether prior authority for the use of wrist locks can be withdrawn.

- e) The STC should report all incidents of restraint requiring wrist flexion to the YJB monitor and Local Safeguarding Children Board for external scrutiny. Examination of the use of pain compliance in STCs should be on the agenda for each STC's LSCB meeting
  - f) Ofsted should review the use of pain compliance in STCs as part of their announced and unannounced inspection.
13. **The review of PCC should consider the provision of specific techniques suitable for vehicles to allow escort staff to move young people safely and effectively.** [9.46]

***Restraint in Secure Children's Homes***

14. **SCHs should remove the nose distraction technique and double basket hold where it is used as part of their restraint method.** [10.38]
15. **To provide an accurate picture of their use of force, SCHs should record and report to the Department for Children, Schools and Families restraint used on children placed on 'welfare' grounds.** [14.18]

***Future approach to restraint***

16. **To ensure a consistent approach to the use of force across the young people's estate, the Government should re-examine the legislation and guidance on restraint against these principles:** [12.23]
- Force should be used only as a last resort.
  - Force should be used only to prevent the risk of harm.
  - The criteria for using force should be consistent across settings.
  - The minimum force necessary should be used, and this is proportionate to the identified risk.
  - Only approved restraint techniques should be used.
  - Force should only be used in the context of an overall approach to behaviour management, including de-escalation and de-briefing, in which children and young people are actively involved.

***Future Accreditation and Regulation of restraint***

17. **To provide transparency and reassurance on the safety, effectiveness and ethical validity of restraint methods, the Government should establish a mandatory Accreditation Scheme for all restraint techniques, training and trainers in the secure estate.** [11.2]
18. **The Government should direct that only accredited restraint techniques, training and trainers will be permitted in the secure estate.** [11.18]
19. **Membership of the Accreditation Panel should include experts drawn from physiotherapy, paediatrics, child psychiatry, orthopaedics, PTSD and other disciplines, together with those with operational knowledge of restraint techniques.** [11.25]
20. **The YJB should give priority to completing the development of a new Risk Assessment Tool to be used to provide consistent, objective evaluation of the safety of restraint techniques as part of the proposed Accreditation Scheme.** [11.22]
21. **To underpin the Accreditation Scheme, the YJB should develop and maintain an evidence base of the relative risk and safety of all restraint techniques used in the secure estate, to include data on injuries or warning signs associated with use.** [11.22]
22. **The Government should establish a Restraint Management Board, chaired at Ministerial level, to provide better regulation, give oversight to the Accreditation Scheme and help drive down the use of restraint across the secure estate.** [11.27]

23. Ofsted and HMIP should consider establishing a joint unit which should specialise in the inspection of restraint regimes and practices. [14.21]

#### *Reducing Restraint*

24. All units should ensure that any use of restraint is placed within an overall behaviour management strategy. [13.2]
25. The YJB should proactively monitor compliance with the Behaviour Management Code of Practice to ensure establishments are using it for continuous improvement in managing restraint. [13.17]
26. Every STC, YOI and SCH should be required to produce, publish and report against a Restraint Reduction Strategy setting out how they propose to reduce the use of force on children and young people. [13.18]
27. The YJB should commission regular independent audits of the progress of establishments against their Restraint Reduction Strategies. [13.19]
28. Should there be developments in the building of STCs in the future, the architects and designers should be required to visit and examine some of the more recently built Secure Children's Homes. In particular Woodlands in Northern Ireland, which was the best designed we saw and in which restraint is being successfully minimised. [13.31]

#### *Reporting and Monitoring restraint*

29. All establishments should record all incidents involving restraint within 24 hours. All records should contain as a minimum: [14.22]
- The young person's details.
  - Staff involved in the restraint.
  - Description of build-up, incident and resolution.
  - The reason for the restraint.
  - Clear evidence of de-escalation techniques used to avoid use of force.
  - Description of holds used during the restraint.
  - Record of injury to the young person and any medical attention given.
  - Confirmation of debriefing for staff and the young person.
30. STCs, YOIs and SCHs should include in their reporting of restraint an opportunity for the young person to give their own views of the incident and to report any injuries. [14.23]
31. All establishments should produce analysis reports of restraint incidents at least monthly, focusing on continual improvement in reducing restraint. As a minimum they should examine: [14.24]
- The reasons for restraints.
  - What patterns of restraint emerge.
  - Restraint 'hotspots' - which locations predominate.
  - The time restraint incidents occur.
  - Which staff, or groups of staff, have been involved.
  - Risks in restraint techniques.
  - Training gaps identified.
32. SCHs and YOIs must come into line with STCs and submit exception reports to the YJB on warning signs occurring during restraint. [6.12]
33. The YJB should have in place a range of effective support and sanctions to back its Assurance Monitoring of restraint in the secure estate, including reporting concerns to Local Safeguarding Children Boards. [14.27]
34. All establishments should introduce recordable 'real time' CCTV in common areas to help monitor the use of restraint and assist decisions on safeguarding and child protection interventions. [15.5]

- 35. All incidents of planned restraint in the secure estate must be recorded on video. [16.5]
- 36. The focus of YJB monitoring should be on qualitative treatment of children not contract compliance. Monitoring must be timely, effective, noted and acted upon. [13.38]

*Protecting young people after restraint*

- 37. All establishments in secure estate should ensure that any restrained YP is seen by a health care professional for examination within 30 minutes of an incident. [15.2]
- 38. All injuries should be photographed, recorded on a body map and given the appropriate level of treatment. [15.2]
- 39. Establishments must have a formal debriefing with every young person subject to restraint within 48 hours of the incident, with a written record of conclusions and actions taken. The debrief should be done by a member of staff who was not involved in the incident. [15.10]
- 40. If the young person wishes it, an independent advocate should be present at the child's formal debrief. To help this, establishments must notify an independent advocate of every restraint within 24 hours of the incident, which should then determine whether the young person wishes an advocate to be present at the debrief. [15.10]
- 41. Independent advocates should keep confidential records of its debrief interviews with young people and should use them to report on an establishment's use of restraint annually to the YJB or more frequently if they have concerns. The advocacy service should also report to HMCIP or Ofsted as appropriate to inform inspections. [15.11]
- 42. All staff in the secure estate must have the opportunity after a restraint incident to debrief with their manager. [15.12]
- 43. Establishments should inform children and their parents or carers, of their restraint policy, methods used and safeguards in place. [13.25]
- 44. To help scrutiny of restraint incidents, including CCTV footage, staff from LSCBs and local child protection committees responsible for investigating child protection referrals should be trained in the relevant restraint methods used by their area's secure units. [15.17]
- 45. LSCBs must be properly linked in with any secure setting in its area and should be able to scrutinise restraint techniques, the policies and protocols which surround the use of restraint, and the incidents and injuries. [15.22]
- 46. LSCBs with a secure unit(s) in its area should report on its use of restraint annually to the YJB or more frequently if they have concerns. They should also report to HMCIP or Ofsted as appropriate to inform inspections. [15.21]
- 47. Establishments should inform the Local Authority, themselves members of the LSCB, in which the young person originates when they have been subject to restraint. [14.23]
- 48. Young people making a complaint about restraint should be given a target by which they should expect to hear of the outcome of their complaint and all complaint resolution forms should be signed off by the young person at the end. [15.14]
- 49. It should be mandatory for the establishment to put in writing to the young person affected, and their parent(s)/guardian, the outcome of every child protection referral on use of force grounds. [15.17]

*Training*

- 50. All staff in the secure estate should have consistent and comprehensive training in the awareness of risk factors in restraint, the monitoring of warning signs in young people and the need to take action quickly.

Training must include, in all settings:

- a) risk assessment
- b) recognition of distress or deterioration in physical condition whilst restraint is being carried out
- c) an understanding of the basic physiology of breathing
- d) training in basic resuscitation and airway management

an understanding of psychological and medical conditions which increase the risk of an adverse outcome. [6.53]

- 51. All staff in the secure estate should have received a core module of training, which must include training in use of restraint, before they are permitted to work with young people. [16.31]
- 52. There should be a requirement for more frequent refresher training in restraint. Ideally this should be on a 6 monthly basis, to enable staff to ensure that their skills are refreshed and assured for safety by qualified instructors. [16.31]
- 53. All organisations providing restraint training in the secure estate should ensure that they have quality assurance processes to audit locally provided 'cascaded' training. [16.31]
- 54. A National Vocational Qualification (Level 3) should be specifically developed for staff working in juvenile secure settings. The three current sets of National Occupational Standards relating to the training of staff in the use of restraint should be brought together under one body. Skills for Justice, Skills for Care, Skills for Security should be asked to address this matter, in conjunction with the Children's Workforce Development Council and the YJB. [16.35]

#### *Understanding restraint*

- 55. The Government should ask the Prison Service and YJB to examine the basis for the relatively low level of use of force per child reported in YOIs. This should include an assessment of the impact of the Prison Service adjudication system on managing young people without the need to use force. [5.21]
- 56. The YJB should research the reasons why the same young people can receive significantly different levels of restraint in different parts of the secure estate. [5.21]
- 57. The Government should explore the relationship between single separation and restraint by establishments in the secure estate influences their need to use restraint. [5.22]
- 58. The YJB should research the psychological impact that restraint has on both young people and staff. [6.57]

### 3. CHILDREN AND YOUNG PEOPLE'S VIEWS OF RESTRAINT

#### *Key messages*

- Young people accept that restraint may be justified on occasion but believe that it should be fair, proportionate and safe.
- Restraint is chaotic, traumatic and stressful and can have significant impact on both young people and staff.
- For some young people, restraint can trigger complex responses that make them actively seek it.

3.1 We are extremely grateful to all the children and young people around the secure estate we met during our review and who were prepared to share with us their often distressing and disturbing experiences of restraint. We were determined from the beginning that young people, as those who are most profoundly affected by restraint, physically and psychologically, should be given a proper voice in the review.

#### **Overview**

- 3.2 The YJB's latest published data shows that at any one time in 2006-07 there were on average more than 2,900 children and young people held in the secure estate.
- 3.3 Half of the young people are aged 17 (with some 18 year olds completing their sentences), with around 28% 16 year olds, 15% 15 year olds, 5% 14 year olds, and 2% or fewer 13 and 12 year olds. Over 90% of young people in the secure estate are male. By ethnicity, around 71% in the secure estate over 2006/07 were classified as White, 13% were Black, 7% were Mixed, 4% Asian, 4% Not Known and 1% Other.
- 3.4 Whilst children in custody often display very challenging behaviour and at times threatening behaviour, they are the most vulnerable in society. Young people who are detained in custody present a wide-range of needs typically at a higher prevalence than the rest of the general population. These include having issues with substance misuse, lacking formal education or training or having physical or mental health problems, or often a combination.
- 3.5 There is a strong overlap between children in custody and children previously in care. A survey of juveniles held at Rainsbrook STC found that 60% had previously been looked after by local authorities, of which 27% had been in secure children homes, 35% had had three or more previous care placements and 10% had had five or more previous care placements.<sup>1</sup>
- 3.6 There is a high prevalence of mental health problems and/or learning disabilities in children and young people in custody. For example, evidence<sup>2</sup> suggests that at least 40 % of young offenders have a diagnosable mental disorder. A report published by the YJB found that a third of the 300 young offenders participating in the research had a mental health need. One in five young offenders were also identified as having a learning disability<sup>3</sup>. We found that 55% of young people at Medway STC had a diagnosed mental disorder, with 27% overall suffering from ADHD or were otherwise on the autistic spectrum.
- 3.7 Similarly, research commissioned by the YJB shows that young people in the youth justice system are more likely to have used both legal and illegal drugs. They are also more likely to suffer from substance misuse problems, even in comparison to other groups of vulnerable

<sup>1</sup> Reducing re-offending by ex-prisoners Report by the Social Exclusion Unit

<sup>2</sup> *National Service Framework for Children, Young People and Maternity Services: The Mental Health & Psychological Well-being of Children and Young People Standard* Department of Health and Department for Skills and Education, October 2004, paragraph 2.7

<sup>3</sup> *Mental Health Needs and Effectiveness of Provision for Young Offenders in Custody and in the Community*, YJB, 2005

young people. Use of Class A and Class B drugs is considerably higher among young people who offend than in other groups in the general population.

### Views of young people on restraint

- 3.8 Our methodology to gain young people's views on restraint was to insist, at every establishment we visited, that we should be able to meet them individually and privately – with no staff present. We usually asked to see those young people in a unit who had been restrained most often, but also made sure every time that we spoke to young people we had chosen randomly from the unit list on the day, to guard against any potential pre-selection. Every unit co-operated willingly in this.
- 3.9 To help add other dimensions to the voice of young people, we are grateful to: Di Hart, for allowing us to use the findings of her survey of SCHs; the NSPCC for providing us with the outcomes of consultation it conducted in January 2008 with 19 young people who were either in SCH or who had recently experienced life in the secure estate; VOICE, the independent advocates; the National Youth Advocacy Service; the Children's Rights Director for England; and the Children's Commissioners for England and Wales for their views and to all those others who helped us understand the children's perspective. These include, importantly, the staff in secure units, who day-to-day spend most time with young people in custody and who themselves can be profoundly affected by having to use force on children.
- 3.10 Many young people who end up offending seriously enough to be in custody have grown up with violence in their lives. They have witnessed and experienced adults using a physical response to control them and others. Consequently to them there appeared a certain inevitability about restraint and an acceptance that this is what is to be expected. VOICE revealed that restraint is an issue rarely raised with their visitors by young people. They attribute this to young people's feelings of helplessness. They feel there is nothing to be gained by raising concerns or they are worried it will make it worse for them.
- 3.11 The young people did talk openly and, we believe, candidly to us. Whilst we accept that there is a risk of exaggeration, we felt they generally gave an honest, consistent and, at times, raw account of their experiences.
- 3.12 We heard descriptions of restraint from all parts of the secure estate. While our impression is of incidents generally being more violent in YOIs and STCs, it would be quite wrong to say that SCHs are free of such incidents. One young person in a SCH, for example, described how he had been rugby tackled by "loads of people", and he alleged being lifted up and thrown in his room, damaging his ribs.
- 3.13 We speak in this review of 'restraint' but this is not a word young people use. They speak of being 'twisted up', 'ragged up', 'bent up', 'wrapped up' and 'jumped on', and, when restrained to their bedrooms, of being 'taken to their pad' or 'put behind their door'.

### How it feels to be restrained

- 3.14 As part of the review we have been on the receiving end of PCC and C&R holds. Restraint – at least those interventions which are more than a guiding arm on the shoulder – can be extremely painful. The testimony of young people to the review puts this bluntly:

*"you feel funny, dizzy, feel like your arm's breaking, blood goes to your head, your arm stings for about 10 or 20 minutes afterwards, numb and you feel sick with the nose one"*

*"I've had staff here lift me off my feet by my head. You fear for your life here, I'm scared they're gonna hurt me."*

*"Afterwards you have sore arms and wrists, throbbing and can't move the, like when your arms are dead"*

(Young people, variety of units)

- 3.15 Young people as a whole do not want restraint to hurt and do not want staff to inflict pain on them, either deliberately or accidentally. They described the intense pain of wrists being bent as though their bones were about to break, of shooting pains and numbness, of breathlessness from frontal holds on the floor and facial friction burns and of being held in

head locks by staff. Bruises can last for days if not weeks and experiences of pain in joints the day after being restrained was not uncommon. One said:

*"Loads of people here have been bandaged because of injuries to wrists from being twisted".*

(Jed, YOI)<sup>4</sup>

- 3.16 We found that experience of restraint and several years in secure units of various types had made some young people very knowledgeable about the risks to their safety and dismissive about the skill levels of some staff. Some had experienced both PCC and C&R, and could tell us the main differences – some in fact preferred the pain of C&R to the prolonged holds they had experienced with PCC because *"it gets it over with"*. Another said that the last time she had been restrained, in a STC:

*"They put my head below my heart. They shouldn't do that. I've got asthma. It happens a lot to kids with asthma. I've had an attack twice. I couldn't breathe and my eyes went all blurry"*

(Hayley, STC)

- 3.17 Unsurprisingly, although it is intended to gain control of situations, restraint does not always have a calming effect; many young people described how they get more agitated when restrained. The act of physical limitation placed on them had the opposite effect in making them angrier and determined to fight – quite natural responses in children no less than adults.

*"It makes you madder – you want to rip someone's head off. I felt like that for ages – pure adrenalin going round my body."*

(Theo, SCH)

- 3.18 Occasionally we were told that once embarked on restraint, staff are still too ready to pursue it to the end. That this remains the case is disturbing given the events which led to the death of Gareth Myatt. Even where the young person became 'compliant' and had stopped struggling, or alternatively were showing extreme distress, force was still applied. This may be due to staff caution and feeling that they had to continue to protect themselves but the young people thought it was more to do with staff losing their temper and wanting to 'teach them a lesson':

*"They don't respond to cries of pain here. They don't believe you and they don't stop."*

(Aaron, SCH)

- 3.19 We have heard testimony from young people of staff using ways of restraining that are clearly unauthorised and some of which are clearly assault. On each occasion we brought these incidents to the notice of the unit governor or manager after we have completed our interviews. In one YOI a young person accused one member of staff of smashing his head deliberately on the floor (*"they don't care they hate us"*) while in another YOI a young person described a restraint incident in which he was struggling with four officers and one reached down and squeezed his testicles hard to subdue him. Another said that when there lots of officers involved they can slyly punch you or knee you or stamp on your foot. In one STC, a young person said:

*"I kicked off a bit in Maths and got PCC'd. They smacked my head down and I started crying. They said 'if we have to do this again, it'll hurt twice as bad, it'll really be painful'"*.

(Rebecca, STC)

## The reasons for restraint

- 3.20 Children and young people in custody need to feel safe and to be safeguarded. Research and practical experience reveals that, in such circumstances, children recognise the need, on occasion, for staff to employ safe methods of restraint<sup>5</sup>. Our impression gained during the review matches that of the Children's Rights Director when examining restraint in residential

<sup>4</sup> All children's names have been changed

<sup>5</sup> B Goldson. (1995) *A Sense of Security*, London, National Children's Bureau, pages 10-11.



home and residential special schools<sup>6</sup>: that young people in custody do believe that people who are out of control should be restrained, but staff who do the restraining should do it fairly and safely.

- 3.21 Young people have a highly developed sense of what is *fair* and proportionate. Some young people we spoke to who had been restrained felt that it was right they had been restrained, although they often had little experience of other methods of managing their behaviour. Most often this was heard in connection with restraints for fighting with other young people. It was ok, we heard to be ‘wrapped up’ if you were in a fight, with either another young person or a member of staff, as it might get out of hand:

*“I was fighting. Yeah it was right, they had to stop me. If they hadn’t I’d have just carried on. People can get killed.”*

(Dane, YOI)

- 3.22 The concept of ‘fair’ restraint also came out if they had been smashing up their room or threatening to staff. They wanted the same behaviour to be dealt with consistently, and felt aggrieved when they had been restrained for actions which others had got away with.

- 3.23 What caused young people real anger – and the resentment was still apparent in many – was being restrained for breaking minor rules or refusing to comply with staff instructions.

*“I was told that I was being down graded to red level [of rewards]. I sat down while staff explained this to me. I said it wasn’t fair being moved to ....as I hadn’t done anything wrong and refused to move. Staff dragged me off the chair to stand me up then took me to the floor and twisted me up. I shouted at them to get off me, and swore at them but they were really hurting me. They got me up and took me to the other door twisted me up then I said I would walk so they cuffed me. The handcuffs cut into my wrist. I think too much force was used as I didn’t challenge them and was not a threat. I got a governors’ for this which was not fair”.*

(Paul YOI)

- 3.24 Some young people feel that force was used very quickly when they refused to carry out an instruction, and they had been unable to question that instruction, possibly due to their limited ability to express themselves. Young people gave examples of being restrained for refusing to go to education or to stop playing pool. They had no doubts that restraint is used too often, and too soon, in these cases. Warnings were cursory with not enough attempts made to talk the refusal through with the young person. The lack of decent alternative sanctions to restraint in some units – or failure to apply them where they existed - was mentioned:

*“In children’s homes they say ‘you’ll lose your TV’. But here they say ‘go to your pad’. When you say why, they say ‘are you refusing a direct order? Then they quickly twist you up”.*

(Michael, YOI)

- 3.25 There was also a perception that the purpose of restraint was to control and punish them. Some had the impression that staff enjoyed inflicting restraint.

*“If they like you they sometimes talk to you. But if they hate you they just grab you and ram you in your pad.”*

(Carl, STC)

- 3.26 Young people also perceive that restraint can be provoked by staff. Studies have shown how this can be a particular problem for black young people in custody<sup>7</sup>. We heard of children being riled until they felt ready to hit staff, when they would be restrained.

*“Staff came to my door in the morning and I was laid in my bed – they didn’t come in they just opened my door, looked at me and then closed the door. Then about 10 mins later I had to go for meds so I got out and went. On my way back I asked Miss in the office whether I could have a stereo lead and she told me to get out and go to my room, coz staff wanted me. I then saw two staff members taking my TV – I asked why they were taking it and they said because I wasn’t up in the morning. I said yes, I*

<sup>6</sup> Dr R Morgan (2004) *Children’s Views on Restraint* The Commission for Social Care Inspection

<sup>7</sup> *Just Justice A study into black people’s experiences of the youth justice system* The Children’s Society 2006

*was and they said 'no this is not what I have been told' then I was to sign the paper stating I had loss of TV and dine in for one day. I did not sign and was told that if I didn't it would be extended to two days. Mr .... came up and started getting involved and started shouting at me saying when we say stuff, just listen and do as you're told. I asked why he was getting involved and he said that he could do what he wanted. He started getting angry so I ignored him and went to sign the paper and he took it off me and made everything times two.*

*I asked why he'd done that and he didn't answer me. I signed it and as I was walking towards my cell, he accused me of bullying and being intimidatin'.*

(John, YOI)

- 3.27 The response of staff can often appear to young people to be over-zealous and unjustifiably aggressive. The weight of numbers involved in incidents can be frightening. Incidents which quickly went to first response brought "4 or 5 staff" into the vicinity immediately, ratcheting up the tension, in young people's eyes and then overwhelming them. Some staff were quick to employ a disproportionate response:

*"I was supposed to go to the medical room but I fell asleep. This screw came to the doorway and said 'I told you to \*\*\*\*ing get up'. I told him to shut up, so he came in and grabbed me round the throat. Then loads of them ran in".*

(Shane YOI)

- 3.28 Some children had been sexually and physically abused in the past and did not like an adult touching or holding them. Conversely, staff were able to describe worrying instances of children who actively sought restraint for sexual or other gratification and found these situations very difficult to deal with. We also heard that some young people, especially if they had been deprived of parental closeness, can value the human contact that restraint brings and the sense that someone cares enough to intervene physically to provide boundaries for them.

*"Young people want someone to take control of their chaos – they can understand it when it's physical but not emotional".*

(Member of staff, SCH)

- 3.29 Other views of young people towards restraint can be subtle and complex. In some extreme cases we heard that young people had used restraint almost as a protective device – in one case, a young person had lashed out at a bully when staff were near by, knowing that restraint would protect him from immediate retaliation.

- 3.30 The hurt felt may often be more enduring psychological as well as physical, with young people feeling humiliated at the experience. But some spoke of the 'need' to be restrained, to reinforce credibility with their peers as they are seen to be taking on' staff. One child endorsed the negative impact that an audience can have:

*"It's humiliating – you have to look like a strong person and fight more. They try to stop you looking"*

(Kai, SCH)

- 3.31 Respect was a big issue, with young people ready to acknowledge those staff who tried to build up relationships with them based on understanding, respect and care. Repeatedly we were told that being treated with respect by staff would go a long way to calming a young person and helping them to feel it was worth co-operating with the regime. We met many members of staff in YOIs, STCs and SCHs who understood this and took the time and effort to develop constructive relationships with young people where they could:

*"Kids expect you to be psychic about how they're feeling. We're not, we need time and skills to sit down and ask them the right questions, to get them to open up.*

(Prison Officer at YOI)

- 3.32 But sometimes staff were felt to enjoy too much the position they held over young people:

*"If they respect me, I respect them. But some want to be in power, so that they can tell you what to do"*

(Jay, STC)

These were the staff who, in the young peoples' eyes, were ready to resort prematurely and most often to physical intervention.

### **Another view**

- 3.33 These comments faithfully record what young people said to us. But we did not wish to overlook the positive things that young people said to us, quite freely, during our visits. These words reflect the constructive relationships that many young people had developed with staff across the secure estate and record their appreciation for what staff in secure units across the estate had done for them:

*"It's alright in here. It's a lot more chilled. They talk to you and treat you with respect. Education is brilliant"*

*It's calmer here and it's made me calmer. They look after you. I get respect here and I respect them back. It works both ways.*

*"Some staff do try to stitch you up but only some. Most are fair".*

*"I've only ever seen restraint to stop fighting. They talk to us a lot, tell us where we're going wrong, though I don't always want to listen".*

*"Do I feel safe here? Yes I feel safe, too safe I reckon".*

## 4. THE YOUNG PEOPLE'S SECURE ESTATE

### *Key messages*

- Serious violent and sexual offenders can be placed in YOIs, STCs or SCHs.
- The differing size, staffing levels and regimes in the secure estate have a bearing on their ability to manage behaviour without the need for force.
- STCs now manage an older mix of young people than for whom their restraint method was designed which is having implications for the effectiveness and safety of PCC.

### Overview

- 4.1 Ministers asked us to consider restraint in STCs, SCHs and YOIs. Together these three sectors comprise what our terms of reference call the 'juvenile secure estate', although, as we were to discover, varying approaches in those sectors belied the notion of a coherent and consistent estate, on the issue of restraint at least.
- 4.2 Between October 2007 and March 2008 we visited, in all three sectors, a total of 15 establishments (see Annex B). All our visits were announced and we were at pains to make clear that our visits were not inspections and we could not, nor would we wish to, supplant the proper roles of Ofsted and HM Chief Inspector of Prisons (HMCIP).

### Young Offender Institutions

- 4.3 In the light of the deaths of Gareth Myatt and Adam Rickwood, we understand that concerns about the use of force in the secure estate have been focused on STCs. But the substantial majority of young people in the secure estate – 85% - and consequently the greatest number of overall restraint incidents, are in YOIs, which are a particular focus of our review.
- 4.4 The average population in YOIs over 2006-07 was around 2750 (including a small number of 18 year olds serving out the remainder of a sentence). These are spread around establishments varying markedly in size. The largest (Ashfield) has a capacity of 400. The full breakdown of the young people's estate is:

**Table 1: YOIs**

<b>Young People only sites:</b>	<b>Places commissioned by the YJB</b>
Ashfield (private)	400
Huntercombe	360
Warren Hill	192
Werrington	160
Wetherby	360
<b>Split sites:</b>	
Brinsford	112
Castington	128
Cookham Wood	17
Downview	16
Eastwood Park	16
Feltham	240
Foston Hall	16
Hindley	192
Lancaster Farms	240
New Hall	26
Parc (private)	64
Stoke Heath	202
(Thorn Cross	Closed 01/04/08, during the review)

- 4.5 YOIs are mostly Prison-Service run (although Ashfield YOI and Parc YOI are privately operated, by Serco and Group 4 Securicor respectively).
- 4.6 The units in which young people are held may function as part of:
- Split sites, in which young people, aged 15-17, are co-located with 18-21 year olds on the same land but in separate housing units;
  - Young people only sites;
  - Mixed sites, in which both 15-17 year olds, 18-21 year old and adults are co-located. In such sites, the young people have no contact with adults. There are currently no under 18s housed on mixed sites.
- 4.7 YOIs are similar to adult prisons in design. In the majority of cases, they have had a long history of use for a variety of purposes, and were not purpose-built to deliver services to young people. Typically they have been developed or refurbished from buildings relinquished by the prison service from already existing sites, e.g. Cookham Wood.
- 4.8 The significant exception to the typical YOI is the recent development of dedicated units (Downview, Eastwood Park and Foston Hall) to better meet the needs of young girls. These units are designed to hold between 16 - 26 girls, smaller groups than seen in traditional YOI wings.

## Secure Training Centres

- 4.9 STCs were established by the Crime and Disorder Act 1994. They are purpose-built centres for young people, run by private operators under managed contracts with the YJB which set out detailed operational requirements. STCs are used for the placement of young people remanded or sentenced to custody between the ages of 12-17 years. There were on average around 250 young people in the STCs estate during 2006-07. The four STCs, and their individual capacities, are:

**Table 2: STCs**

Young People only sites:	Capacity
Hassockfield, Co Durham	58
Medway, Kent	87
Oakhill, Buckinghamshire	40 <sup>8</sup>
Rainsbrook, Northamptonshire	87

- 4.10 Hassockfield is operated by Serco, Medway and Rainsbrook by Rebound Children's Services and Oakhill by Group 4 Securicor.

## Secure Children's Homes

- 4.11 SCHs are a category of Children's Homes managed by local authorities and are subject to the policy and legislation relating to all children's homes.
- 4.12 A Children's Home can only be used for secure accommodation if it has been approved by the Secretary of State for Children, Schools and Families. This approval must be renewed at least every three years. All SCHs operating in England hold this approval for use as secure accommodation. In addition, SCHs are regulated by the Care Standards Act and the Children's Homes Regulations 2001.
- 4.13 SCHs provide care and accommodation for a diverse range of children between 10 and 17 years old who have been placed under either secure welfare orders by the local authority or under criminal justice legislation by the YJB. The YJB holds contracts with the relevant provider local authorities for bed places with some – but by no means all – SCHs. With the

<sup>8</sup> Oakhill's full operating capacity is 80, but is currently capped at 40 as the level at which the YJB considers the centre can safely operate.

exception of one SCH which is privately-run, all the SCHs with whom the YJB contracts are local-authority run.

- 4.14 There are currently 19 approved and operating SCH – 17 are run by local authorities, 1 by a voluntary organisation and 1 by an independent provider. There were approximately 330 young people accommodated in SCHs at the time of our report, at a ratio of roughly 2 YJB placement: 1 welfare placement.

**Table 3: SCHs**

<b>Name of Unit</b>	<b>Provider</b>	<b>No of beds<sup>9</sup></b>
Aldine House, Sheffield	Sheffield City Council	8 (5 YJB – 3 mixed/spot purchase)
Atkinson, Exeter	Devon County Council	16 (10 YJB, 6 welfare)
Aycliffe, Newton Aycliffe	Durham County Council	38 (30 YJB, 8 welfare)
Barton Moss, Eccles, Manchester	Salford City Council	20 YJB
Beechfield, Copthorne	West Sussex County Council	6 welfare
Clare Lodge, Peterborough	Peterborough City Council	16 welfare
Clayfields, Nottingham	Nottinghamshire County Council	18 (12 YJB, 6 welfare)
East Moor, Leeds	Leeds City Council	36 (34 YJB, 2 welfare)
Hillside, West Glamorgan	Neath Port Talbot Council	18 (15 YJB, 3 welfare)
Kyloe, Morpeth	Northumberland County Council	12 (3 YJB, 9 welfare)
Lansdowne, Hailsham	East Sussex County Council	5 welfare
Leverton, Brentwood	Essex County Council	16 welfare
Lincolnshire, Sleaford	Lincolnshire County Council	9 (7 YJB, 2 welfare)
Orchard Lodge, London	Glen Care (Independent Provider)	24 (18 YJB, 6 welfare)
Redbank, Newton-le-Willows	St Helens Council	29 (28 YJB, 1 spot purchase)
St Catherine's, St Helen's	Nugent Care (Voluntary Organisation)	17 welfare (girls only)
Sutton Place, Hull	Kingston-upon-Hull City Council	10 (8 YJB, 2 welfare)
Swanwick Lodge, Swanwick	Hampshire County Council	16 (10 YJB, 6 welfare)
Vinney Green, Emersons Green	South Gloucestershire Council	23 (20 YJB, 3 welfare)
<b>TOTAL</b>		<b>219 YJB, 114 Welfare, 4 spot purchase</b>

- 4.15 SCHs are generally accepted to be the most suited and best placed to safeguard and promote the rights and welfare of children and young people, so we note with concern that 11 SCHs have closed since 2000, including Gladstone House in Liverpool during the course of our review.

### **Distinctions within the Young People's Secure Estate**

- 4.16 STCs, YOIs and SCHs are differentiated by a range of characteristics including their size, staffing levels and training, and the types of young people who are placed within them, all of which has some bearing upon their ability to manage the behaviour of the young people there and the use of restraint.

#### *Age of young people*

- 4.17 STCs were developed primarily to accommodate young people between 12-15 years. However, after 2000, with the introduction of the Detention and Training Order, STCs began taking young people up to the age of 17. The Criminal Justice and Police Act 2001 also enabled young people to be remanded to an STC.
- 4.18 The average age of those looked after by STCs as a consequence has increased. At the time of our report the average age of a young person in the STC sector was now 15 years and one month. This places them between the age range of YOIs (16 years and 5 months) and SCHs (14 years and 6 months).
- 4.19 We are cautious about drawing firm conclusions from these figures. The differences between a young person aged, say, 14 and one aged 16 may at first appear self-evident, but there are a range of factors which can influence, or impair, the physical and psychological development of young people. The greater challenge for a unit may come from caring for highly disturbed and vulnerable younger children rather than in managing older young people. In any event, all three sectors have experience of managing physically powerful young people; no part of

<sup>9</sup> Information provided by YJB and correct as at 28 May 2008

the secure estate is distinct in that. But from evidence and our observations we have concluded:

- **YOIs manage the older young people who are likely to pose the greater physical challenge for staff when using force;**
- **STCs are likely to be managing a greater mix of physical and psychological maturity and this has implications for the breadth of different restraint techniques they may need; and**
- **STC senior management and staff have been consistent in their message to the review that the increasing age range of the young people they look after is one of the key factors undermining the effectiveness of the STCs' method of restraint, Physical Control in Care, which was devised for 12-14 years olds.**

*Offending, sentences, average length of stay and turnover*

4.20 No sector has a monopoly on serious offenders. Regardless of age, serious violent and sexual offenders can be placed in significant proportions in all settings (with pressure on beds and the availabilities of vacancies influencing the YJB's placement strategy):

**Table 4: % of population in each sector in custody for each offence type (at 28 March 08)**

Offence Type	SCH %	STC %	YOI %
Non-violent <sup>10</sup>	32	28	35
Sexual <sup>11</sup>	9	4	4
Violent	40	52	46
Breach	19	16	15
<b>Total</b>	100	100	100

- 4.21 By far the largest portion of the population held within all three sectors is for offences considered violent. On our visit to Rainsbrook STC, 50% of the young people on remand there were charged with murder or attempted murder. At the time of our visit to Vinney Green SCH, 50% of the young people there had been convicted of murder, manslaughter, rape or arson
- 4.22 There is a higher instance of young people held for sexual offences in SCHs. The YJB and others have explained that this is a difficult combination and adds to the complexity of managing these young people in a closed environment, and who are placed with a high number of potentially violent young people.
- 4.23 Data on the average length of stay confirms a picture of high turnover within the estate, with the overall average length of stay being approximately 76 days. This figure is influenced primarily by the large number of short-term Detention and Training Orders which make up the majority of the population, and remands which are the second most numerous element of the population. "Both of these factors", the YJB describes, "indicate a population which exhibits significant churn. Rainsbrook STC, for example, averaged 28 admissions per month in 2007.
- 4.24 We have not seen any official figures which provide average length of stay for a young person in each of the three sectors. But responses from SCHs during our visits suggest that young people typically stay around 3½ – 4 months in those units, slightly longer than the average length of stay reported in STCs and YOIs. **This more stable picture in SCHs may help young people there to become more settled into trusting, positive relationships with staff and to make an investment in the regime, and to provide time for staff to understand the behaviour of the young person and manage them constructively without the need for restraint.**
- 4.25 On final consideration is that SCHs can refuse placements, (albeit that there are some restrictions as to the freedom with which refusal criteria may be used), while STCs ability to manage the mix of young people they look after is constrained by their 'no refusal policy' because of the contractual penalties which follow should they accept a young person referred. YOIs are also unable to refuse young people placed directly from court.

<sup>10</sup> Non-Violent Offence Types consists of the following: Arson, criminal damage, death or injury by dangerous driving, domestic burglary, drugs, fraud and forgery, motoring offences, non-domestic burglary, public order, racially aggravated, theft and handling of stolen goods, vehicle theft and other and unknown offences.

<sup>11</sup> Violent offence types include Violence against the person, and Robbery.

## Staffing

- 4.26 A low ratio of staff to young people inevitably affects the capacity of staff to engage in building relationships, take time to de-escalate potentially violent episodes and reflect upon their responses. We believe all of these practices are essential requirements in reducing restraint across the estate.
- 4.27 Staffing levels are more intensive in SCHs than other sectors. The staff ratios for supervising young people range between 6 staff to 8 young people, to 1 staff member for every 2 young people, which is significantly different to the ratio within the prison service. Furthermore, most staff are qualified to NVQ level 3 or above in child care.
- 4.28 The staffing ratio in STCs is approximately 3 staff members to 8 young people, or a minimum 2 staff to every 7 young people, placing them between YOIs and STCs. Staffing levels are stipulated within the contract with the provider and assessed as a performance target.
- 4.29 With the exception of the dedicated girls units which have higher staffing levels similar to STCs, **YOIs have the lowest staff-to-young offender ratio of all sectors of the estate, of approximately 3-6 officers for 30-60 young people. We believe that the relatively low staffing levels in YOIs call into question the level of meaningful engagement between staff and young people and mean that activities take place within much larger groups, providing a greater challenge to engage the young people.**
- 4.30 The turnover of staff is also crucial to the stability of an establishment; high turnover can compel instability. Staff turnover levels within STCs vary between the individual establishments but typically STCs have a higher turnover rate of staff than YOIs. Less than half of all staff at Rainbrook STC had been there for 3 years or more (and we did not see figures for front line custody staff alone). Staff turnover at Medway STC is about 5% per month but losses are highest in front-end custody staff. Both YOIs and SCHs have lower staff turnover levels.

## Size and cost

- 4.31 SCHs are relatively small. Most have between 16 and 24 places with, typically 8 young people per unit with individual bedrooms and en-suite facilities. SCH are the most costly units, at around £210k per place per annum, which reflects the significantly different regime to YOIs, which are the least expensive of the three sectors to operate at £56k per place per annum.
- 4.32 The size of SCHs, coupled with their staffing levels, mean that they should be better equipped to provide child-centred services and deal with more complex problems which a young person may present, especially where safe, close supervision is required. Young people feel safer in smaller units, with staff with whom they feel comfortable and who are consistently there. The Chief Inspector of Prisons has commented of YOIs:
- “One of the most important factors in creating a safe environment is size. The other places where children are held - Secure Units and Secure Training Centres - are small, with a high staff-child ratio. The Prison Service, however, may hold children in what we regard as unacceptably high numbers. Units of 60 disturbed and damaged adolescent boys are unlikely to be safe ... There are therefore already significant barriers to the Prison Service being able to provide a safe and positive environment for children”<sup>12</sup>*
- 4.33 Not only are YOIs bigger, but the existence of split sites (see paragraph 4.6) may mean that any attempt to create a child-centred service on such sites is difficult, because the adult culture inevitably dominates. In Chapter 13, our report proposes changes to begin to address how this culture influences restraint on young people.

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<sup>12</sup> HM Chief Inspector of Prisons Annual Report 2005-06



## 5. LEVELS OF RESTRAINT IN THE YOUNG PEOPLE'S SECURE ESTATE

### *Key messages*

- Restraint is used in every unit in all sectors of the secure estate but, per child, most often in STCs and SCHs.
- Figures on use of force are questionable and direct comparisons between sectors are difficult. More needs to be known about the use of restraint, particularly in YOIs.
- Recent trends show that levels of restraint are falling across the secure estate.

### Overview

- 5.1 Our objective in this chapter is to present a comprehensive picture of the use of restraint across the various secure settings. We seek to set out, wherever appropriate, possible explanations for differences in the use of restraint between settings and in places highlight the need for caution in interpreting the data. Even taking account of these factors, the degree to which the figures are directly comparable is limited by fundamental differences in the statutory requirements governing restraint in different settings.
- 5.2 The circumstances in which a child may legally be restrained are not consistent. For example, an amendment last year to the STC rules allows restraint to be used “for the purpose of ensuring good order and discipline” in STCs, whereas in SCHs restraint may **not** be used “simply to secure compliance with staff instructions.” The criteria for the use of restraint in different settings are considered in depth in chapter 12 but the information presented below must be considered in this context.

### Levels of restraint in the secure estate

- 5.4 The YJB requires every YOI, SCH, STC and commissioned STC escort provider to send monthly returns on:
- young people in the secure unit, split by age, gender & ethnicity
  - Restrictive Physical Interventions (RPIs), split by age, gender and ethnicity
  - number of young people involved in the RPIs split by age, gender & ethnicity
  - RPIs involving injury to young people split by defined types of injury:
    - minor injury requiring no treatment
    - minor injury requiring medical treatment
    - serious injury requiring hospital treatment
  - RPIs involving injury to young people split by gender and ethnicity
  - RPIs involving injury to staff split by defined types of injury (as above)
  - Duration of RPI (since 1 April 2008)
  - Reasons for RPI split by defined reasons based on STC Rules (since 1 April 2008)
  - Distraction techniques used (from STCs and STC escort providers only)
  - Instances of handcuffs being used (from STCs and STC escort providers only)
- 5.5 All establishments report this data on standard forms provided by the YJB. This data is then reported quarterly to Ministers at the Department for Children, Schools and Families and the Ministry of Justice. The YJB also reports to Ministers, via a traffic light system, on exceptional concerns, for example on the levels of restraint in any one establishment or any significant movement or trends in restraint.

- 5.6 The most recent comprehensive survey of restraint in the secure estate was given in January 2008 by David Hanson in answer to a Parliamentary Question from Lynne Featherstone MP. In it he confirmed that restraint is used in every establishment within the secure estate:

**Table 5: Volumes of restraints on young people in the secure estate April – November 2007**

Establishment	Type	Apr 07	May 07	Jun 07	Jul 07	Aug 07	Sep 07	Oct 07	Nov 07
Haddockfield	STC	49	56	38	49	96	49	42	44
Rainsbrook	"	20	26	21	42	50	29	52	45
Oakhill	"	33	108	151	149	86	71	67	55
Medway	"	68	80	66	146	81	53	81	67
Ashfield	YOI	40	30	29	27	27	53	37	59
Parc	"	8	6	5	8	6	3	5	5
Brinsford	"	10	4	11	4	4	27	7	12
Castington	"	18	8	13	22	20	12	18	18
Feltham	"	24	24	24	45	24	17	37	18
Hindley	"	21	22	26	54	30	30	27	31
Huntercombe	"	29	26	33	30	43	21	43	47
Lancaster Farms	"	23	42	31	49	52	15	20	22
Stoke Heath	"	9	10	13	14	20	13	11	12
Thorn Cross	"	0	0	0	0	0	0	0	0
Warren Hill	"	11	29	28	22	17	14	10	15
Werrington	"	29	18	27	20	30	14	17	22
Wetherby	"	31	23	21	44	22	44	33	34
Cookham Wood	"	3	11	0	2	0	0	1	0
Downview	"	9	0	0	0	4	2	2	2
Eastwood Park	"	0	0	0	0	0	7	7	0
Foston Hall	"	5	13	10	0	4	6	12	0
New Hall	"	3	3	5	4	3	3	9	23
Aldine House	SCH	4	4	0	0	5	1	2	2
Atkinson Unit	"	2	6	8	15	18	12	5	10
Aycliffe	"	24	14	24	23	20	27	18	7
Barton Moss	"	7	12	6	11	15	9	9	8
Clayfields	"	11	8	0	0	0	23	18	5
East Moor	"	50	70	57	32	28	14	26	59
Gladstone House	"	3	12	15	4	5	14	23	7
Hillside	"	3	2	6	5	4	5	0	2
Kyloe House	"	4	3	1	6	0	1	0	0
Lincolnshire	"	20	51	22	8	13	7	7	12
Orchard Lodge	"	4	6	10	27	30	31	25	10
Red Bank	"	30	14	25	24	26	39	25	6
Sutton Place	"	8	0	0	5	17	11	7	4
Swanwick Lodge	"	7	5	7	7	9	1	1	0
Vinney Green	"	8	6	7	6	13	4	8	6

- 5.7 Over the eight month period, there were on average 24 restraints happening every day across the secure estate. Incidents peaked in July 2007, with a total of 891 restraints that month (on average 29 per day), the highest since February 2006.
- 5.8 By overall volume, restraint is used most in YOIs, which has significantly the highest population, and in STCs, which does not. These sectors accounted for about 37% of the

overall total each, with the remaining 26% occurring in SCHs. The Prison Service accepts that:

*“We are very conscious that C&R is being used widely in the Prison Service’s Young People’s Estate in the face of significant levels of challenging behaviour and concerted indiscipline.”*

5.9 For just four establishments the level of restraint in STCs between April and December 2007 was extraordinarily high. In the period, restraint was used 2070 times in STCs.

**Trends in the use of restraint**

5.10 Latest unpublished figures provided to us by the YJB show that overall restraint is falling across the secure estate. **Between October and December 2007, the last quarter for which figures are available, restraint incidents fell from 711 to 551**, with restraint in December 2007 at least 10% lower than in any other month in 2007.

5.11 Both STCs and SCHs have reported a significant drop in the use of force in this period. Restraints in STCs fell from 242 in October to 201 in December, while in the same month SCHs recorded just 96 restraints, their lowest figures since the YJB began collecting data. The picture in YOIs is more volatile, but their restraint total of 254 in December was their lowest in the quarter. We welcome this improvement, and wish to see it sustained, although we question the accuracy of some of the underlying data.

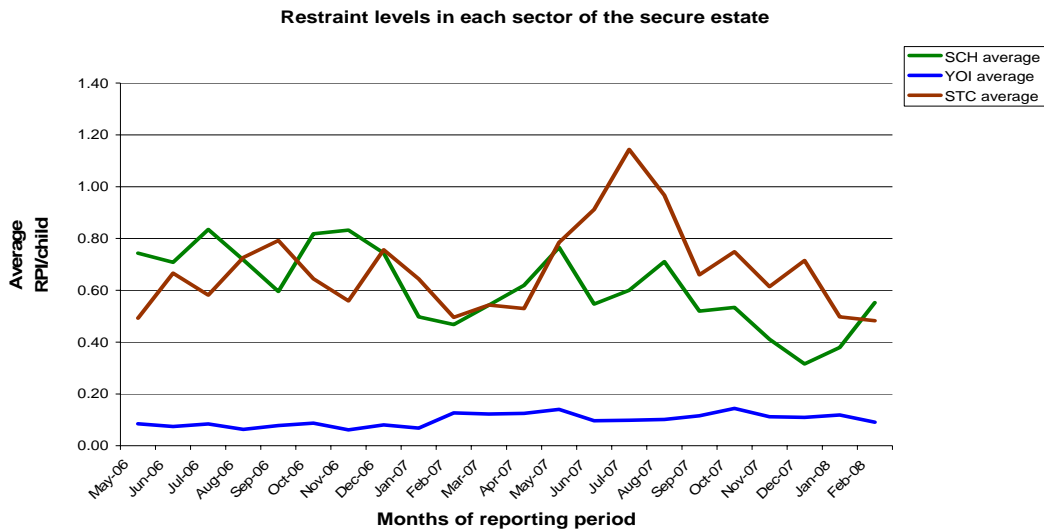
**Use of restraint by sector**

5.12 **Taken on their own, overall numbers of restraint tell us only so much. They do not, for example, take account of the number of young people within each sector or within each establishment; nor do they reveal anything of the particular factors or issues which can influence the use of restraint in any unit.**

5.13 To provide a more meaningful comparison of the relative levels of restraint in STCs, YOIs and SCHs, the YJB measures the level of ‘RPI per child’ in the three sectors and uses the results to report exception reports and analyse trends.

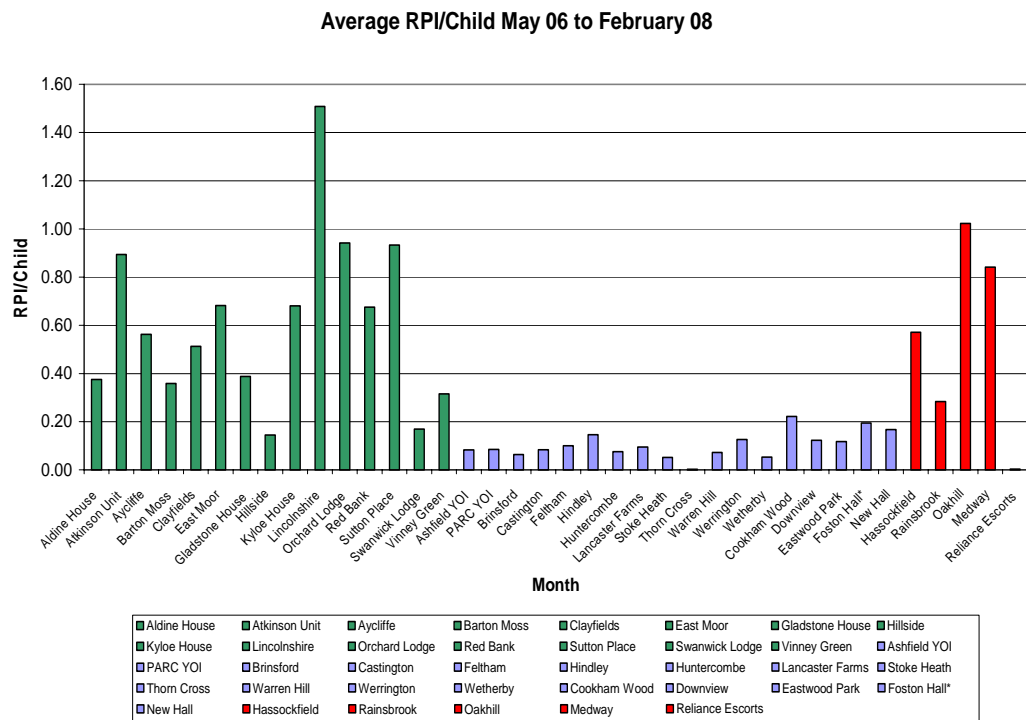
5.14 **The resulting figures provided by the YJB show that from May 2006 to February 2008, the highest incidents of restraint, per child, were in STCs and SCHs.**

**Table 6: Comparison of restraint levels in SCHs, YOIs, and STCs April – November 2007**



5.15 Breaking the information down into individual establishments shows the disparities more vividly:

**Table 7: Restraint levels per child in the secure estate May 2006 – February 2008**



5.16 At face value, these figures challenge some preconceptions about restraint. **They show that, per child, SCHs use restraint as often as STCs** and in some units use it much more. They do not substantiate the assumption that SCHs will have lower levels of restraint because of their perceived skill at de-escalation and behaviour management.

5.17 **But we view these figures with caution.** There may be a range of factors which explain the disparities:

- there may be differences in the nature of incidents that get reported because of different interpretations of the meaning of an 'RPI';
- the low numbers of children in SCHs can mean that one particularly disturbed child can cause a dramatic increase in incidence data;
- there may be other factors such as the higher ratio of staff to children, so that incidents in a SCH are more likely to elicit an intervention from staff or as one child put it: *'they're in your face'*.
- the relative level of disturbance of the children, with SCHs taking particularly vulnerable children and may include a high incidence of restraint to prevent self-harm.

5.18 **The comparatively low use of restraint in YOIs surprised us, but again there are reasons to be circumspect about the figures.** We found disparities between RPI figures reported to Parliament in answer to Lynn Featherstone MP and the local figures on RPI kept by establishments. In Feltham and Lancaster Farm YOIs, monthly local data we saw on recorded use of RPI did not always match that given in response to Lynn Featherstone, suggesting that the Prison Service may be under-reporting use of force in some months (and, it must be said, over-reporting it in others). We also found some remaining confusion in YOIs about *what* they should be recording as a use of force, despite the common definition of RPI introduced by the YJB and Prison Service attempts to provide guidance to establishments. Use of Force paperwork we saw concentrated mainly on those incidents in which the full 3 officer C&R was employed, which might suggest that 'lower tariff' incidents requiring only one or two members of staff were not being as fully recorded.

- 5.19 Since our visits the Prison Service have confirmed to the YJB that YOIs were reporting against the RPI definition correctly although they did find some inaccuracies which they retrospectively adjusted.
- 5.20 Other than the figures, there may be issues particular to the Prison Service which explains their relative success in keeping down use of force:
- The Prison Service may be much more successful than STCs and SCHs at looking after young people safely without the need to resort to force. YOI staff may be relatively adept at intervening with de-escalation and conflict resolution techniques without needing recourse to restraint (although this would not fit with our impressions from visit to several YOIs).
  - The use of adjudications in YOIs – a quasi-judicial process through which alleged offences against the discipline of establishments are heard and punished where appropriate, including with the loss of association, earnings and other privileges – may play a role in reducing restraint. Young people in YOIs had a clear understanding of adjudications and punishments handed down in this process may help to provide clarity of boundaries without the use of force. Adjudications are available only to the Prison Service. The availability of segregation facilities in YOIs provides a way of managing volatile situations which is not open to SCHs or STCs.
  - Young people in YOIs are generally older, more mature and arguably may be less volatile than those in SCHs and STCs, and as a result may present generally fewer challenges for managing behaviour than are found in the other sectors.
  - The restraint figures in YOIs may simply be a product of their relatively lower staffing levels. Staff might ‘miss’ some incidents which could have led to restraint, for example assaults or bullying by young people against other young people. We heard claims that prisons tacitly accept a high level of ‘peer management’ by young people within YOIs (one prison officer called it “appeasement”).
  - The figures may reflect the regimes in YOIs, where young people spend more time in their rooms than their counterparts in STCs and SCHs, hereby reducing time and opportunity for flashpoints which may come with greater association and other common activities.
  - The potential use of pain-related C&R may also have a deterrent effect.
- 5.21 All this illustrates the difficulties of taking restraint figures at face value. We have not been able to conduct a forensic analysis of the reasons for the relatively low use of force figures in YOIs but we believe that the Prison Service and the YJB should.

**Recommendation**

The Government should ask the Prison Service and YJB to examine the basis for the relatively low level of use of force per child reported in YOIs. This should include an assessment of the impact of the Prison Service adjudication system on managing young people without the need to use force.

**Use of single separation**

- 5.20 Single separation is the removal of a child from association with his or her peers. STCs and SCHs operate in similar ways, where it is used as a form of control to prevent a young person causing damage to property or harm to people, or in the case of STCs, where necessary to maintain order and discipline. STCs and SCHs may not use single separation as a form of sanction and there is a time limit of 3 hours in STCs (but not SCHs) beyond which they may not detain a young person in single separation.
- 5.21 Single separation in YOIs is more complex. Rules governing its use allow separation to be used as a form of punishment and for removal from association to be used for a variety of reasons, from maintaining good order or discipline (but not to exceed 72 hours without Secretary of State authority) to where the young person has been found guilty, on adjudication, of an offence against discipline (maximum duration is 21 days)

- 5.22 The use of single separation by units in the secure estate can impact on their use of restraint. Single separation is generally used more in SCH (1.62 per child between October and December 2007) than in STCs (0.54 per child). SCHs also singly separate a child longer than STCs. There is evidence that some SCHs are increasing their use and duration of single separation to manage behaviour and this is helping to reduce their use of restraint. The link between single separation and restraint is not fully understood and the Prison Service does not currently collect data on it but plans to do so in the future.

**Recommendation**

The Government should explore the relationship between single separation and restraint to see how use of single separation by establishments influences their need to use restraint.

**Variances in use of restraint within sectors**

- 5.23 The overall figures in Table 5 reveal significant variances in the use of restraint within each sector. For example, 35% of all restraints in STCs in this period were in Oakhill alone, where the Chief Inspector of Prisons<sup>13</sup> has condemned the:

*“staggering levels of use of force by staff, often in response to the all too frequent assaults by children on staff and on other children”.*

- 5.24 Since this assessment Oakhill has had some success in reducing its restraint levels.
- 5.25 In YOIs, Wetherby, Werrington, Huntercombe, Lancaster Farms and Feltham show relatively high levels of restraint. While use of restraint is significantly higher in East Moor, Aycliffe, Lincolnshire and Red Bank than in other SCHs.
- 5.26 Reported reasons for the variances in the volume of restraints in a unit are typically the presence in a unit of a particular difficult to manage young person or people who are responsible for a disproportionate number of restraints, the particular mix of young people placed together in an establishment and the churn of the population. 10 young people were responsible for 55% of restraints in Medway STC during July 2007. The jump in restraints at Orchard Lodge over the summer of 2007 stemmed, we were told, from the presence of one young person, who received 48% of all restraints at Orchard Lodge in July and 33% in August. East Moor SCH's high levels of restraint in the summer of 2007 were caused, we heard, by the number of young people there with attention deficit hyperactivity disorder and other behavioural difficulties. Another SCH told us that *“our restraints are as high as the sort of children we take”*.
- 5.27 We encountered several examples of young people who had received high levels of restraint in one establishment but whose behaviour had not attracted the same need for force after moving to another unit. In some cases, it appeared to be because the move was closer to home and brought more family visits. Others were more suited to the culture and ethos of their new unit.
- 5.28 We believe that significant lessons may be learned if these young people with high levels of restraints were tracked on moving through the secure estate and the reasons for any changes in restraint used on them examined.

**Recommendation**

The YJB should research the reasons why the same young people can receive significantly different levels of restraint in different parts of the secure estate.

**Ethnicity**

- 5.29 YJB figures from April to December 2007 show that not only is there a continuing over-representation of BME young people within the youth justice system, notably young Black

<sup>13</sup> HMCIP (October 2007) *Report of an unannounced inspection of the management, care and control of young people at Oakhill secure training centre*

people and people of mixed race, but Black and Minority Ethnic young people were more likely to be restrained than White young people, especially in YOIs.

<b>Table x: Ethnic Analysis of restraint data – April 2007 to December 2007</b>		
	<b>BME</b>	<b>White</b>
<b>STCs</b>		
% of children in unit during the month	24	76
% of children restrained <sup>14</sup>	23	70
<b>YOIs</b>		
% of children in unit during the month	28	72
% of restraints used	35	64
<b>SCHs</b>		
% of children in unit during the month	18	82
% of restraints used	19	81

## Gender

5.30 YJB figures also show that young women, regardless of ethnic background, are marginally more likely to be restrained than young men, regardless of sector.

<b>Table #: Gender Analysis of restraint data – April 2007 to December 2007</b>		
	<b>Male</b>	<b>Female</b>
<b>STCs</b>		
% of children in unit during the month	59	41
% of restraints used	60	40
<b>YOIs</b>		
% of children in unit during the month	97	3
% of restraints used	93	7
<b>SCHs</b>		
% of children in unit during the month	77	23
% of restraints used	79	21

<sup>14</sup> The YJB reported that Oakhill's ethnicity figures for December 2007 were incorrect, leading to problems reconciling the restraint percentages.

## 6. THE SAFETY AND ETHICS OF RESTRAINT

### *Key messages*

- There is little consensus on the causes of injury and death from restraint use and claims about the relative risks of restraint techniques are controversial and cannot easily be substantiated by the evidence available.
- It is difficult to offer clear guidance on the more contentious types of restraint, like holding young people prone face-down on the floor. More research needs to be done.
- Irrespective of technique, monitoring and interpreting warning signs during restraint is critical and must be improved if restraint – related deaths are to be avoided.
- There is a case for pain compliance, properly managed, as an alternative to prolonged use of non-compliant restraints that can cause danger to young people.

### Overview

- 6.1 Our intention, when we embarked on this review, was to provide definitive guidance on the medical safety of the restraint techniques used in the secure estate, so that we could isolate those posed most risk to children and endorse only the safest for use in secure settings.
- 6.2 This has proved difficult. **No restraint is 100% safe. As many of those who have contributed to the review have acknowledged, it is an area of controversy and competing claims and there is little consensus among medical experts about the causes of injury and death associated with restraint use or the relative risks associated with alternative methods of restraint.** We respect the genuine differences of opinion which exist. There is instead general agreement that the causes of mortality are complex and involve many factors. There is a wide range of both physical, psychological and medication issues which appear to increase the risk of adverse outcomes occurring.

### Restraint safety in the secure estate

#### YJB evidence on restraint injuries

- 6.3 We examined what the most recent injury data from secure units, provided by the YJB, told us about the safety of restraint techniques.
- 6.4 **We conclude that it is difficult to place faith in the accuracy of some of the reported restraint injury rates, especially those reported by YOIs on injury arising from C&R. This, together with the limited period in which the YJB has collected data, prevent us offering firm conclusions on the relative safety of restraint techniques used in the secure estate.**
- 6.5 Since April 2007, the YJB has collected data on three categories of restraint injury:

#### ***Minor Injury (no medical treatment required)***

*This includes red marks on the skin, welts, superficial cuts and scratches, and bruises, which do not require medical treatment of any kind, including first aid. If a child is seen by a nurse or GP as a precaution (for example, to assess if any further injuries were sustained) this should not be counted as medical treatment.*

#### ***Minor injury requiring medical treatment***

*This includes cuts, scratches, grazes, bloody noses, concussion, serious bruising and sprains where medical treatment is given by a member of staff or a nurse. Treatment could include cleaning and dressing wounds, providing pain relief, and monitoring symptoms by a health professional (e.g. in relation to concussion). This includes first aid administered by a staff member.*



**Serious injury requiring hospital treatment**

*This includes serious cuts, fractures, loss of consciousness, damage to internal organs and poisoning. Where 24-hour healthcare is available the child may remain onsite. At other establishments, the child will be taken to a local hospital. Treatment will reflect the more serious nature of the injuries sustained and may include stitches, re-setting bones, operations and providing overnight observation.*

- 6.6 We have seen the resulting injury data for 2007-08. From this evidence:
- Wide variations are found in injury rates in YOIs, again raising questions about the credibility of reporting. While Hindley YOI declared 122 injuries from 337 incidents of C&R (36%), Feltham reported just 18 in 379 (5%) and none at all in 307 incidents from July 2007 to March 2008. This seems unlikely. YOIs reported 6 serious injuries requiring hospital treatment in 2007-08.
  - Around 10% of restraints involving PCC in STCs resulted in injury to a child. Of these 80% were minor injuries requiring no treatment. Hospital treatment was required on two occasions during the year. But the credibility of figures appears undermined by data from Oakhill, which reported that children were injured in just 2.5% of PCC incidents, well out of step with the other STCs. In one 6 month period, Oakhill reported just four injuries – all minor – from over 400 PCC incidents.
  - Divergences were also apparent in SCHs, with most injuries recorded in 31% of incidents in Hillside (which uses the General Services Association restraint method), Orchard Lodge (also GSA) and Lincolnshire (Ethical Care Control & Restraint UK). There were no serious injuries reported in SCHs in 2007-08.
- 6.7 It is not only the possible discrepancies in reporting which make us cautious about associating injury rates definitively with each restraint method:
- the numbers are too small;
  - the threshold for defining and reporting injuries may vary between establishments;
  - other factors such as a cramped environment or type of floor covering may account for some injuries;
  - it is impossible to know if staff are using the methods correctly; and
  - the threshold for using restraint may vary (if it is used rarely and only in extremely violent situations the rate of injury may be higher).

**Exception reporting**

- 6.8 Alongside reporting of injuries, the YJB has instigated a system of exception reporting to enable it to assess medical risks arising when restraint is used in the secure estate.
- 6.9 Under this system, establishments should report warning signs to the YJB. The following signs should be reported to the YJB under the system of exception reporting.
- Stuggling to breathe
  - Young person complains they are unable to breathe
  - Nausea
  - Vomiting
  - Swelling to face or neck
  - Abnormal redness to face
  - Blood spots on face or neck (Petechiae)
  - Young person goes limp or unresponsive
  - Change in degree of agitation
  - Respiratory arrest
  - Cardiac arrest
- 6.10 These warning signs, complied by the YJB with medical advice are *“all phenomena that might indicate that a young person has been placed at risk during the course of restraint”*. With this data, the YJB collects details of the holds used during the restraint so that they determine whether particular techniques are implicated in adverse outcomes of restraint. The exception reports are then examined by a medical advisor on risk assessment, provided to the PCC

Medical Panel (see Chapter 9) and fed to the Prison Service NTRG which developed PCC. From February 2006 to December 2007, 84 exception reports on PCC were received from STCs. Of these 87% had involved the use of head control, 87% had involved the figure of four and 65% the double embrace hold (though this is related to their use – at Rainsbrook between November 2006 and October 2007, use of the Figure of Four (318 times) and Double Embrace (255 times) together accounted for 61% of all holds used.).

- 6.11 This system of exception reporting is beneficial in helping to identify risks in restraint but in practice it has applied only to PCC in STCs. We see no reason why it should be limited in this way. We were concerned to hear that although the YJB has asked SCHs for exception reports they have failed to provide any this year, despite intervention by the Department for Children, Schools and Families. The Prison Service do not produce exception reports to the YJB either but we were told that instead they have their own process for identifying risk issues arising from C&R, which we deal with in more detail in paragraph 8.22 of this report.
- 6.12 We believe that consistency and better identification of restraint risks demand that SCHs and YOIs join STCs in reporting **exceptions risks to the YJB. Other parts of the secure estate need to be as consistent in the level of vigilance of medical safety and exception reporting to the YJB as STCs.**

#### Recommendation

YOIs and SCHs must come into line with STCs and submit monthly exception reports to the YJB on warning signs occurring during restraint

### The research evidence on restraint safety

- 6.13 Despite the recent efforts of the YJB to capture injury data, research associated with restraint use, especially on children and young people, is lacking. This is an enduring problem. A preliminary survey<sup>15</sup> in 2003 into deaths associated with restraint use in health and social care in the UK acknowledged:

*“There is actually little UK data on restraint use. The absence of data on restraint use (including data on routine use as well as the frequency of untoward events) makes it extremely difficult to comment on: the relative risks involved in restraint; the comparative risks involved across a wide range of individual procedures; and the relative risks involved in a wide range of individual procedures; and the relative risks involved in alternative interventions, including seclusion, mechanical restraint or medication”*

- 6.14 Dr Heather Payne, in her evidence for the Howard League Carlile Group in 2005<sup>16</sup>, also concluded:

*“The use of physical restraint for children and young people in secure custodial (as opposed to health based) settings has very little evidence base”.*

- 6.15 The position seems little changed in the three years since Dr Payne’s assessment. In his evidence to this review, for example, John Parkes summed up the difficulty<sup>17</sup>:

*“The scientific evidence on safety during restraint is weak. Guidance is often based on the opinions of individuals deemed to be ‘experts’ but little empirical evidence supports the recommendations made”.*

- 6.16 It has been suggested in relation to restraint in care settings that:

*“An ideal technique is one that is safe for both those with whom it is used and for those who apply it; it offers a high degree of control over challenging behaviour and poses few or no risks to the physical or emotional health of either party. Most*

<sup>15</sup>B Paterson, P Bradley, C Stark, D Saddler, D Leadbetter and D Allen (2003) *Deaths associated with restraint use in health and social care in the UK. The results of a preliminary survey* Journal of Psychiatric and Mental Health Nursing 2003

<sup>16</sup> Payne H (2005), *Use of Physical Restraint on Children and Young People – safety and effectiveness*. Evidence to Howard League Carlile Group

<sup>17</sup> Evidence to the review of John Parkes, Senior Lecturer, Coventry University

*techniques are not ideal however. A technique may be safe for the carers applying it, but unsafe for those receiving it; in other words, it may offer a high degree of control, but pose significant risk to the person being restrained. Conversely, it may be safe for service users, but unsafe for carers because it is ineffective and fails to achieve control over behaviour. Finally, it may be unsafe for both parties in that it is both ineffective and risky.”<sup>18</sup>*

- 6.17 **On the evidence available, we have not felt able to state that any one restraint technique would be completely safe to use on everyone in the juvenile secure estate.** But we believe it is valuable to look at what evidence there is about the injuries and fatalities associated with the main types of restraint techniques and to examine the current guidance in the secure estate and other settings on the safety of restraint.
- 6.18 In considering this approach, we have taken as our starting point, and built upon, the advice on the main areas of danger and concern in restraint highlighted in the Scottish Institute for Residential Social Care’s excellent guidance ‘Holding Safely’.

## Risk implications of restraint techniques

### Prone restraint

- 6.19 The term prone restraint means to hold a child ‘face down’, when on the ground, usually with their head to one side. This is used as part of restraint practice in some parts of the secure estate, such as Team Teach used in Swanwick Lodge and Beechfield SCHs. We saw young people who exhibited signs of it in facial abrasions or who were able to describe experiences of it.
- 6.20 Face-down floor restraint has been described as:
- “along with pain compliance, the most controversial type of physical intervention used in human care services”<sup>19</sup>.*
- 6.21 We heard that the prone restraint has been associated with a number of deaths in health, social care and criminal justice settings, giving rise to the term ‘positional asphyxia’, i.e. that someone is prevented from breathing by the position of their body.
- 6.22 Early research<sup>20</sup> suggested that restraint in a prone position caused significant effects on breathing and in extreme cases might be fatal. One survey of restraint-related deaths – covering amongst others the *Hartford Courant* (1999) investigation in the US into 142 reported deaths in mental health connected to the use of physical restraint, the Police Complaints Authority (2002) report into 9 deaths between 1998-9 and the Paterson et al (2003) report on 12 deaths in UK care services between 1979-2000 – together with an analysis of forensic case studies and experimental studies, concluded that:
- “there are strong suggestions....that there is some association between the use of prone restraint and heightened risk of restraint death”*
- 6.23 4 restraint-related deaths in the Prison Service between 1991 and 1995 led to a review of Control and Restraint techniques and guidance to staff that prisoners must not be left face down with hands held behind their backs. Prone restraint was implicated by the independent inquiry into the death of David Bennett in the Norvic Clinic medium secure unit in 1998, which called for a strict time limit to be imposed on any restraint in a prone position, citing concerns regarding positional asphyxia.
- 6.24 The association of prone restraint with a number of fatalities has led to questions about its safety. The Millfields Charter of 2005 called for the abolition of prone restraint holds from care environments, while in her evidence to the Carlile inquiry, Dr Payne asserted:
- “Prone restraint, excited delirium and positional asphyxia may be associated with fatal outcomes. The use of prone restraint should be discontinued until it can be shown to be safe. The inducement of excited delirium and positional asphyxia must be avoided by using recommendations from National Institute for Clinical Excellence guidance*

<sup>18</sup> David Allen (200#), *Risk and Prone Restraint – Reviewing the evidence*

<sup>19</sup> Allen

<sup>20</sup> Allen

*about avoidance of pressure on thorax, etc, and close monitoring of restraint situations.”*

6.25 Dr Payne’s opinion was passed to all SCHs by DCSF in November 2007, which has led some SCHs to decide not to use prone restraint until further advice is issued whilst others interpret the letter to mean they must have safeguards in place if they do use it.

6.26 ‘Holding Safely’ advises:

- *Restraining children in a prone position carries a higher risk of serious harm than other holds done correctly, and as such should always be treated as a final option.*
- *Restraining children in a prone position is more likely than other forms, such as standing or seated restraints, to be seen by them as a punishment or as abuse.*
- *Service providers should only approve the restraining of children in a prone position when an assessment of risk shows that this is the least restrictive action necessary to achieve a safe outcome for all involved.*

6.27 The Welsh Assembly Government has gone further and banned prone restraints in health, education and social care settings. Its Framework for RPI Policy and Practice<sup>21</sup> states unequivocally that:

*“Under no circumstances, should any individual ever be restrained in a face down position”.*

(We understand that despite what appears to be a starkly clear statement, prone restraint can still be used in settings in Wales if a risk assessment determines it is safer to manage an incident than the alternatives).

6.28 A different perspective on prone restraint was given to the review by a provider of restraint training<sup>22</sup> which uses prone positions, who indicated that data from the use of prone restraint by services that have used their training since January 2003 shows that prone can be applied safely, as in 3000 instances of prone restraint only three have resulted in hospital attention, although these figures have not been independently verified. Hampshire County Council, which uses this same restraint training in its SCH, Swanwick Lodge (as well as in special education and mainstream school settings), commented to the review that in recent violent incidents in which prone was used in Swanwick Lodge (15 of 62 overall violent incidents):

*“the presenting behaviours were of such a high risk that [prone restraint] was the safest way of containing that behaviour”<sup>23</sup>*

6.29 The provider has also pointed to the results of recent research of 45 child and adolescent deaths related to restraints in residential placements in the US<sup>24</sup>, which while showing that 28 of the deaths occurred in a prone position, concluded:

*“The number of fatalities involving floor restraints needs further study and analysis.....this positional restraint risk question needs to be answered empirically by establishing prone, supine and side restraint usage before the field can determine risk via body position.”*

6.30 Another contributor to the review<sup>25</sup> considered that if properly used for short periods of time, prone restraint may be the only practicable way of managing a violent situation without exposing staff or carers to undue risk of injury themselves, although it should however be looked at after other techniques have failed.

6.31 The British Institute of Learning Disabilities (BILD), which accredits training in restraint, has declined to ban prone restraint, preferring to concentrate on the assessment of risks in the use of restraint techniques and on an overall reduction in the use of all forms of restraint.

6.32 Independent later research has also questioned the extent of the effect of restraint position on bodily functioning and the direct causality of the prone position in the deaths. John Parkes

<sup>21</sup> Welsh Assembly Government (2005), *Framework for Restrictive Physical Intervention Policy and Practice*

<sup>22</sup> Evidence of George Matthews, Team Teach Ltd

<sup>23</sup> Evidence of Hampshire County Council Children’s Services Department

<sup>24</sup> Nunno et al (2006) *Learning from tragedy: a survey of child and adolescent restraint fatalities* Child Abuse and Neglect 30

<sup>25</sup> Evidence of Dr David Perry.

reported to the review on recent research at Coventry University which examined the effect of restraint positions used with adults on lung function:

*“Our conclusion is that some, but not all, prone restraint positions have a significant effect on breathing...It is clear that recommendations given previously, either to consider all prone restraint as dangerous or to consider prone restraint as presenting no additional risk, are not supported by empirical results.”<sup>26</sup>*

- 6.33 Nonetheless, the recent draft guidance from the Care Services Improvement Partnership and the National Institute for Mental Health in England developed in the context of mental health inpatient settings<sup>27</sup> advises that:

*“Restraining service users on the floor – either in the prone or supine positions – should be avoided. In exceptional situations, if the service user needs to be placed in these positions it should be for the shortest possible period of time to bring the situation under control.”*

The guidance goes on to caution that:

*“Prone positions may be potentially only defensible where:*

- *they are supported by systematic risk assessments*
- *there is systematic demonstration that alternatives are ineffective*
- *there is demonstration that a greater risk would occur if not used.”*

- 6.34 We are aware that the secure estate is looking to us for guidance on prone restraint. But there are no simple answers. We are wary of over-simplification over prone restraint and are cautious on the issue. Where a young person is held face down with pressure only on the limbs the evidence is that there is likely to be only a small effect on lung function, and in these cases prone may be quite safe for most young people, for most of the time. However, more ‘forced’ prone restraint, when body weight is applied to the back or hips may be unsafe for almost everyone.

- 6.35 **In the light of the competing evidence we feel that we cannot make any recommendation to ban prone restraint, but we consider it prudent that when prone restraint is used there should be a re-assessment of the risks after control has been obtained in the initial restraint. There should be procedures in place to ensure that a senior member of staff responds to the incident, assesses the situation, evaluates the competing risks and implements an alternative to prone if safety demands.** Against this background, it is critical that further research is undertaken into effect of lung function and restraint. **We support the YJB’s recent commissioning of John Parkes to research the effect of different restraint positions on lung function.**

## Supine restraint

- 6.37 Supine means ‘face up’ when on the ground, and there are again many varieties of this procedure. It is, ‘Holding Safely’, explains, sometimes suggested that supine restraint is safer than prone restraint but it may be associated with risks of a different type. Supine restraint can interfere with a person’s ability to protect their airway. It carries the risk of choking or inhaling vomit<sup>28</sup>. We are told that there is no data to suggest that the supine position is safer than prone restraint<sup>29</sup>.

## Seated holds

- 6.38 There are many seated holds with different names in different systems and approaches to restraint. ‘Holding Safely’ mentions research which suggests that these techniques are seen by service users as less intrusive than prone restraint<sup>30</sup>.

<sup>26</sup> Evidence of Dr John Parkes

<sup>27</sup> Care Services Improvement Partnership and National Institute for Mental Health in England *National Minimum Standards for the Safe and Therapeutic Management of Aggression and Violence in Mental Health Inpatient Settings* (draft)

<sup>28</sup> L Morrison, PB Duryea, C Moore and A Nathanson-Shinn, A (2001) *The Lethal Hazard of Prone Restraint: Positional Asphyxiation*. Protection & Advocacy, Inc. Investigations Unit Oakland California

<sup>29</sup> Mohr et al (2003)

<sup>30</sup> AA McDonnell, P Sturmeay and B Dearden (1993) *The acceptability of physical restraint procedures for people with a learning disability* Behavioural and Cognitive Therapy 21.

- 6.39 However, we have become more aware of the elevated risks of this position since the death of Gareth Myatt as a result of a seated hold in PCC. 'Hyperflexion', where the individual is bent forward at the waist while seated, can severely restrict breathing. Evidence put to the review stated:

*"While the recognition of the potential problems that may arise from prone restraint appears to be growing ...other positions are not without foreseeable dangers. Seated restraint positions, often advocated as a more desirable and more dignified alternative to restraint on the ground, may involve significant risk if hyperflexion occurs"<sup>31</sup>*

- 6.40 John Parkes has investigated the effects of three restraint positions: a prone i.e. face down C&R restraint position, a supine, i.e. face up position, and a seated position, which was used as a control. He found no significant difference in recovery time between the seated position and the prone position, although there was a difference between prone and supine, and believes that there is little evidence to demonstrate that seated restraint positions are consistently safer than restraint on the floor.
- 6.41 Shortly after Gareth Myatt's death in 2004, use of the Double Seated Embrace was suspended in STCs. It was permanently discontinued following a full safety review of PCC undertaken by the YJB and concluded in 2005.
- 6.42 The PCC Medical Panel has recently pointed to the medical risks inherent in other seated holds still used in STCs. We look at this in Chapter 9 on the use of restraint in STCs.

### **Basket holds**

- 6.43 Basket holds involve a young person's arms being held across their chest in an 'x' shape by staff. There are several versions involving combinations of one or two people with the staff and children involved variously standing or sitting.
- 6.44 'Holding Safely' describes two variations of basket holds as giving cause for concern:

*"Firstly, if you are doing a basket hold in a seated position the child must not be bent forward, as this will interfere with breathing. Secondly, staff can fall accidentally across a child's back (into a prone position) but continue to hold on. A basket hold should never be continued under these circumstances.*

*Sometimes staff pull a child's hands across their chest from behind, and it is less risky practice to hold the child's hands down to their hips – this should be done without pulling the arms back, as compressing a child's abdominal area will compress the diaphragm and interfere with their ability to breathe."*

- 6.45 Case reports have linked 'basket holds' to increases of restraint-related deaths in the US (Hartford Courant 1999).
- 6.46 On the advice of the PCC Medical Panel, the Government suspended the use of the double basket holds in STCs in December 2007. The Medical Panel have now made their final recommendation that it should not be used. We make our recommendation on this at 9.21

### **Duration of restraint**

- 6.47 We have been asked to give firm guidelines in our report on how long a young person should be restrained. This is understandable – there is strong evidence<sup>32</sup> that as the duration of restraint increases, particularly when face-down restraint is used, then the risk of adverse consequences, including death, increases.
- 6.48 **However, we do not feel it is right to specify time limits.** There are dangers about being prescriptive in this way. There is no agreement about what the limits should be – the 3 minute limit on prone restraint proposed by the Bennett Inquiry, for example, was not supported by the National Institute for Health and Clinical Excellence on analysis of the scientific literature.

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<sup>31</sup> Paterson et al (2003)

<sup>32</sup> Paterson et al 2003.

- 6.49 More importantly, **fixing time-limits runs the risk of confusing the primary responsibility of staff to monitor risk closely in all restraint incidents, to respond to warning signs whenever they arise and to end all restraints as soon as possible.** The PCC Medical Panel has recently agreed, advising that continual observation of holds is required to determine when the young person must be released, rather than stating that particular holds should be applied for no longer than a specified period of time.
- 6.50 We welcome the fact that since April 2008 the YJB has begun to collect monthly data on the duration of restraint incidents which will help to improve understanding of how the length of time of a physical intervention increases risk.

### Risk factors

- 6.51 The actual type of restraint is one element only. Whilst certain restraint positions can produce adverse physiological effects, such as a reduction in lung function, research suggests that there are a range of factors which can increase the risk of fatality in restraint including:
- Restraint position and positional asphyxia
  - Asthma
  - Obesity
  - Prolonged struggle
  - Physical ill health
  - Heart disease
  - Excitement/delerium
  - Acute mental disturbance
  - Prescribed medication
  - Illicit drug usage
  - Rhabdomyelosis (muscle damage)
- 6.52 We know relatively little about people's metabolism when in a state of heightened arousal necessitating restraint. But staff need a clear understanding of the inherent dangers of using restraint techniques. Children need to be protected from staff who do not understand the potentially serious medical implications of their actions. There needs to be a clear understanding by anyone using restraint techniques of the warning signs such as unusual body temperatures, bizarre behaviour, or if the young person suddenly becomes quiet.
- 6.53 Recognising these signs is dealt with in guidance such as Prison Service Order 1600, **but the inadequate monitoring or misinterpretation of warning signs has been implicated in a number of fatalities, not least the death of Gareth Myatt. Training must be improved if these tragic deaths are not to be repeated.**

<b>Recommendation</b>	
All staff in the secure estate should have consistent and comprehensive training in the awareness of risk factors in restraint, the monitoring of warning signs in young people and the need to take action quickly.	
Training must include, in all settings:	
e)	risk assessment
f)	recognition of distress or deterioration in physical condition whilst restraint is being carried out
g)	an understanding of the basic physiology of breathing
h)	training in basic resuscitation and airway management
i)	an understanding of psychological/medical conditions which increase the risk of an adverse outcome.

- 6.54 The NHS SMS Promoting Safe Therapeutic Services training programme should be considered as a model to be used across the juvenile secure estate.

## Psychological harm

- 6.55 Experience of restraint can be emotionally traumatic for both young people and staff. Children and young people can suffer from nightmares and intrusive thoughts arising from their restraint, which may persist for many years. In some cases, just experiencing restraint can cause real harm
- 6.56 The Department of Health and others have pointed to the risk of Post Traumatic Stress Disorder developing due to increased stress levels brought on by the threat or actual use of physical restraint. Research we have seen<sup>33</sup> shows women who have histories of childhood sexual abuse recalled the experience of being physically restrained as representing a re-enactment of their original trauma.
- 6.57 If we understood more about these feelings action to reduce restraint may be better directed.

### Recommendation

The YJB should research the psychological impact that restraint has on both young people and staff.

## The use of pain in restraint

- 6.58 The issue of whether pain has any role in restraining children and young people is hugely emotive and contentious. Almost all submissions to the review passionately argued against the use of any pain in restraint except in life-threatening situations. They supported the abolition of any restraint method which deliberately inflicted pain, including distraction techniques.
- 6.59 We understand those who feel that the issue is beyond objectivity, that using pain is so bad that the potential harm can never outweigh any potential benefits. We are instinctively against any use of pain. However, we believe it right to use our report to try to weigh up the evidence objectively on the use of pain in restraint.

## The meaning of 'pain in restraint'

- 6.60 There is some confusion about what pain in restraint means. For the purposes of our report, we have identified three main ways in which pain might be applied. The first two have attracted intense criticism.

a) **Deliberately as an inherent part of a restraint method.**

These techniques can also be called 'pain-compliant'. They are the main focus of this section. Their purpose is intentionally to impose pain as an intrinsic part of a control system, usually through applying and relaxing pressure on joints, such as wrist, thumb and arm locks, until control of a situation is established. The lock can then be relaxed to end the pain.

Only C&R in YOIs employs pain as a deliberate part of its technique.

b) **Deliberately as a part of a 'distraction technique'.**

These techniques are used as a 'distraction' only in specified and high risk situations where other methods would be ineffective; for example, when a young person has a grip on another or is threatening someone with a weapon. The most commonly described are nose, thumb and rib distractions which cause a short episode of pain and are meant to be followed by standard holds when the immediate danger has been averted. Some manuals limit the number of times a distraction technique can be used in an incident.

Distraction techniques are found in PCC, C&R and some methods in SCHs such as PRICE.

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<sup>33</sup> Mohr et al (2003).



c) **As an unintended consequence of the use of a restraint technique.**

Some restraint techniques, which usually involve holds, are intended to be effective without need for pain but pain may result inadvertently if the person struggles against the hold.

This may potentially occur with any restraint technique in the secure estate.

## The arguments against pain

6.61 **There are two main, powerful, arguments against the deliberate use of pain in restraint: that it is ethically unacceptable and that it is unsafe to use on young people, especially those methods which apply stress to joints.**

6.62 The position of the Carlile inquiry – that pain compliance and the infliction of pain is not acceptable and may be unlawful – has wide support. 11 Million and many others have argued that the use of techniques to inflict pain is in violation of a child's right under Article 37 of the UN Convention on the Rights of the Child to be free from torture or other cruel, inhuman or degrading treatment or punishment, and their rights under the European Convention on Human Rights. The Children's Rights Director for England said that children are clear that restraint should not use pain, either deliberately or accidentally inflicted. This was supported by recent consultation by the NSPCC with young people in custody, which reported that all but a couple of the young people said that if ever restraint was used there was never a need for pain. The Standing Committee for Youth Justice argued that pain techniques humiliate, subjugate and de-humanise the child and should be abolished. The British Association of Social Workers contended that the infliction of pain could not be justified in any situation. The Children's Commissioner for Wales spoke for many when she urged:

*"the immediate and permanent cessation of any method of restraint that deliberately imposes pain."*

6.63 This view was endorsed recently by the Joint Committee on Human Rights, in its report on the Use of Restraint in Secure Training Centres published in 26 February 2008:

*"There can be no justification for practices which involve the deliberate infliction of pain, such as the so-called distraction techniques, and we therefore recommend their abolition without delay".*

6.64 In its Code of Practice<sup>34</sup>, the YJB recommends:

*"Methods of restrictive physical intervention that cause deliberate pain must only be used in exceptional circumstances".*

6.65 As the Prison Service conceded in its evidence to the review, this means that about 85% of young people in the secure estate are in establishments which currently cannot meet a core principle of the YJB's framework for managing challenging behaviour.

6.66 The Secure Accommodation Network's Good Practice Guidance for the Use of RPIs in SCHs echoes the Code of Practice with a "strong recommendation" that the use of pain compliant techniques should be avoided wherever and whenever possible and:

*"with any use of pain compliance techniques it must be demonstrated that no reasonable alternative existed and that only force that was reasonable in the circumstances was applied".*

6.67 Holding Safely, commenting on the use of pain in child care, argues that:

*"pain increases the professionals have over vulnerable people and so increases the possibility of abuse".*

At the same time there is evidence that the use of pain reduces the chance of building up a therapeutic relationship within an establishment.<sup>35</sup> Using pain compliance in child care settings, in schools and in health settings is not considered an acceptable practice. The Royal

<sup>34</sup> Youth Justice Board *Code of Practice for Managing the Behaviour of Young People in the Secure Estate*

<sup>35</sup> Paterson et al (2003)

College of Nursing (1997) and the Mental Health Act Commission (1999) have advised that physical interventions should not rely on the infliction of pain.

- 6.68 The use of pain can be seen as reinforcing the cycle of violence that too many young people have known all their lives and undermines work to help them develop positive behaviours. In custodial settings there are serious doubts that de-escalation work can ever be successful in institutions which have recourse to pain as part of its restraint response. It can be seen as reinforcing a culture based on intimidation and fear. The very fear of pain can cause psychological distress, without it even being applied. Equally, trying to limit the use of pain compliance to certain circumstances may be dubious when staff know that 'legitimised' pain is always available to them.
- 6.69 There is also evidence that pain thresholds may be increased when young people are aroused, stressed and angry, leading to the overuse of pain pressure to achieve an effect, with potential damage to the bone and joint. It was often said to us that the risks of broken wrist bones increase with the use of the wrist locks. In any event, for some, considerations of the efficacy of pain compliance miss the point. As one restraint training provider told the review.

*"I guess pain compliance might be quick and get results. But you then again could hit them with a baseball bat. That would work too".*

### A role for pain compliance

- 6.70 **The key arguments for a role for pain compliance lie primarily in its role in preventing greater harm to children and its success on large and powerful individuals.** Whilst there is acknowledgement that pain should never be used where a non-painful alternative can safely achieve the same objective, it may be ethically defensible to use a restraint technique that causes pain if it is the only viable and practical way of dealing with a violent incident which is "dangerous" from the perspective of other young people or of staff and of preventing an even greater harm occurring. The Prisons and Probation Ombudsman remarked in his evidence that talking of the deliberate infliction of pain on children raises very sensitive moral questions but:

*"if it handled properly, closely monitored and staff are properly trained to use it – pain compliant methods could be an alternative to protracted use of non-compliant restraints that cause greater distress".*

- 6.71 There may be much less risk of positional asphyxia with pain compliant than with non-pain compliant methods of restraint. We heard that restraint deaths rarely occur immediately; they are more commonly associated with prolonged restraint.
- 6.72 Dr Brodie Paterson<sup>36</sup>, in the context of the use of pain in mental health settings, refers to cases such as David Bennett, when the service user is highly resistant, aggressive and of superior height and body strength, as posing a serious challenge to the staff's ability to implement such actions. Dr Paterson, points to the paradox that:

*"There are thus genuine concerns that the eschewal of pain compliance by reducing the ability of staff to achieve rapid control and move to safer management, while carried out with the best of intentions, might in some cases inadvertently decrease the safety of both service users and staff, by prolonging the duration of restraint-related struggles and decreasing staff's ability to exert effective control".*

- 6.73 We heard often that the use of pain compliance, while possibly preventing prolonged restraint, is associated with high injury rates in children, especially wrist injuries as a result of the deployment of the wrist lock. This is commonly put down to the use of force on immature bones. We have not found evidence, however, to help us substantiate this. Comments made to us by a Consultant in Trauma who regularly works in A&E maintained that "young bones are 'green' and therefore more supple and less likely to break in these circumstances than older, more brittle bones", and a review in 2005 for the YJB on PCC and behaviour management in STCs<sup>37</sup>, which Dr Anthony Bleetman made available to our review, states:

<sup>36</sup> B Paterson (2005) *Thinking the Unthinkable: a role for pain compliance and mechanical restraint in the management of violence?* Mental Health Practice April 2005 vol 8 no 7

<sup>37</sup> T Bleetman, P Boatman, J Salt and E Jenkinson *Review of Physical Control in Care and Behaviour Management in Secure Training Centres*

*“We were unable to find any medical investigation or a single case study reporting injury rates in children associated with pain compliance techniques. There was no evidence to suggest that the immaturity of bones predisposes children to increased injury rates. This does not mean that a risk is not present; simply that it has not yet been identified and quantified.”*

6.74 Finally, during our review we became aware that the distinctions that are often drawn between ‘pain-compliant’ restraint techniques and ‘non-pain compliant’ techniques are not always so straightforward, nor necessarily helpful in understanding their impact on young people. The ethical distinctions between pain and non-pain techniques may not be so stark. This is very well illustrated in Dr Paterson’s description of the various practices of pain compliance which continue to exist in some health settings, which we feel has telling parallels for the juvenile secure estate:

- *“The deliberate application of pain, usually ‘across a joint’, to attempt to gain control and by doing so to effect either escape or to achieve some degree of control.*
- *Placing the service user in a form of restraint such that if he or she struggles the movement will result in the infliction of pain. In such instances, the pain is sometimes described as ‘self inflicted’. It is not, in that if the service user’s struggle can be reasonably anticipated then placing the person in a situation where such struggles will result in pain is effectively still care giver inflicted and therefore remains deliberate....only perhaps indirectly rather than directly.*
- *The incidental infliction of a pain. A number of approaches to the management of acutely disturbed behaviour describe themselves as non-aversive. This tends to mean that they do not use procedures or methods that involve the ‘deliberate’ use of ‘unpleasant’ stimuli to control behaviour. Unfortunately this does not mean that whatever physical interventions are endorsed are experienced by the service user as non-aversive or that such interventions are perceived by the service user as better or worse than pain-based interventions”.*

6.75 In its evidence to the Review, the Department of Health stated:

*“DH believes that children and young people displaying challenging and difficult behaviour can be successfully managed without the use of restraints or methods involving pain compliance, which would be in line with the management of aggression and violence across healthcare settings”.*

6.76 We fully accept the careful thought behind this opinion, but it may not be without adverse implications itself. Evidence we heard during the Review suggested that the instruction to NHS services to cease to use pain compliance to oblige a patient to move, together with instructions that they may not lift patients, for health and safety reasons in order to prevent back injury to staff, means that:

*“A situation now exists where staff in one major secure facility have no means at all to move resistive patients. In one case a patient was restrained for 45 minutes, face down, in a public corridor and could only be moved to a safer location by the police being summoned into the unit to carry him. The staff were embarrassed that police had been called to manage a situation which they would previously have managed with out difficulty themselves and were also concerned at the safety implications of being completely unable to move the patient to a safer location.”*

6.77 **Ultimately, and having weighed the arguments carefully we conclude that pain compliance does have a role in restraint, where it can be effective in bringing to an end longer, more exhaustive restraint incidents which can compromise the safety of young people and staff. But the use of pain, like the use of any restraint method, must be restricted and managed such that its significant potential for abuse is minimised.**

## 7. THE CASE FOR A SINGLE METHOD OF RESTRAINT

### *Key messages*

- While the idea of a single restraint method for the whole secure estate is attractive in principle, uncertainties over the relative effectiveness and safety of methods make it difficult in practice to identify what that method might be.
- There was little support for the idea from the secure estate, with units preferring to keep the current diverse range of restraint systems over a 'one size fits all' approach.
- We conclude that a new system of mandatory accreditation for all restraint methods is preferable to prescription of a single method.

### **Overview**

- 7.1 As we have seen (inside front leaf), there are 10 different restraint methods operating across the secure estate. This presents a fragmented and confusing picture.
- 7.2 It seemed absurd to us that the same child may potentially move reasonably quickly between the three sectors of the estate and experience a different method of restraint in each. For example, just in the North East of England, there are different methods of restraint in Hassockfield STC (PCC), Castington YOI (C&R) and Aycliffe (PRICE), which in turn differs in its restraint method from another local SCH, Kylloe House (CALM).
- 7.3 In 2003, the YJB commissioned a report from the National Children's Bureau to examine options for a single method of restraint to be implemented across the secure estate. As a result of the report's findings, the YJB decided that the evidence did not exist to prescribe a single method of restraint and instead looked for greater consistency through shared principles of behaviour management across the secure estate. The resulting Code of Practice, published in 2006, provides a common set of practices governing the management of challenging behaviour and establishes a common framework for reporting the incidence of restrictive physical intervention.
- 7.4 In this review, we have looked afresh at the arguments for and against a single, consistent, method of restraint across all settings.

### **For a single method of restraint**

- 7.5 We recognise that this review is the perfect time for such a change. Many of those responding to consultation have argued in favour of a single method.
- 7.6 It would provide consistency and clarity. It would ensure that the young person had a clear understanding of what techniques might be deployed, irrespective of the unit in which they were placed. It would be in step with moves to bring STCs, YOIs and SCHs into a more co-ordinated secure estate.
- 7.7 More consistency might make it easier to set, monitor and enforce standards across the estate and will assist performance comparators, for example, in assessing injuries across sectors and units. It should bring economies of scale across the secure estate, with resources, skills and best practice concentrated on a common approach. It would ultimately harmonise training, and could help specialisation and free up movement of staff across the secure estate.

### **Against a single method**

- 7.8 There are, however, strong arguments against a common method of restraint. We realised that we were dealing with very different types of institutions, which makes a uniform approach

difficult. We have seen that the secure estate is diverse in terms of its values, population characteristics, culture, staffing levels, environment and regime. A “one-size-fits-all” approach might not fit comfortably with this diversity and could be difficult to apply in all settings, with their own operational difficulties. On the whole, this argument was expressed most strongly in consultation by SCHs.

7.9 Any single method, and the continuity of techniques in that method, must match the continuum of risk in all establishments in the secure estate. We have not been able to identify one method of physical intervention applicable across the secure estate due to the range in age, maturity and physical stature of the young people to which this one method would have to be applied.

7.10 Standardisation would also work against the well-established methods in SCHs, where there is no tradition of harmonisation, but where the proliferation of methods, with appropriate governance, would encourage innovation and good practice to flourish. That might be lost and there would be a danger of a lack of alternatives should any chosen method become unsafe or controversial. As John Parkes remarked of a similar position in secure mental health settings:

*“It may be argued that this range of techniques...offers opportunity. The limited central control may be seen as allowing the opportunity for innovation. It might be argued that strict adherence to one syllabus of training, mandated from the centre, would restrict progress and response to local needs.”*

7.11 There would be extensive disruption to the estate during the transition to a single system and we are concerned about the effect this would have on the safety of young people and staff. There would also be significant upfront investment needed in retraining and other costs.

## Conclusion

7.12 **These arguments, while finely balanced, ultimately do not persuade us to recommend a single system of restraint. Critically, there is no consensus about what any single method should be.** Several candidates for a single overall method have been put forward during consultation, including PRICE, CALM and C&R. But as we highlight in chapter 10, we have found no evidence on which to choose any favoured method. Selecting one without a clear basis for choice would not serve the best interests of young people or staff and may run the risk of legal challenge.

7.13 This does not mean that we are content to leave the current position undisturbed. Currently there are a number of methods in use and no single approval or accreditation body. The YJB has taken steps to address this fragmentation through the Code of Practice, but while a positive step we feel that it is not enough.

7.14 In reviewing this issue we have been helped by the recent experience of the secure mental health sector, which has wrestled with many of same problems. At the current time no single syllabus of physical restraint techniques exists within the NHS. **Our conclusion for the juvenile secure estate, like theirs for mental health, is to favour mandatory accreditation over recommending a single method of restraint.**

7.15 We set out our proposals for an Accreditation Scheme in more detail in Chapter 11.

7.16 The experience of mental health suggests that an Accreditation Scheme may take several years to establish, although we urge that it is given priority. **There are issues, however, that cannot await accreditation – most importantly the future of restraint in YOIs and STCs.** We make recommendations on these now.

## 8. THE FUTURE OF RESTRAINT IN YOUNG OFFENDER INSTITUTIONS

### *Key messages*

- It is inappropriate that C&R, a pain-compliant restraint method not designed for young people, is the main response when force is required to be used in YOIs.
- New techniques, which involve non pain-compliant holds, should be introduced into YOIs.
- Not enough has been done by the Prison Service to place any use of restraint within a proper framework system of behaviour management. This must change.
- Batons should not be routinely deployed in the young people's estate.

### Control and Restraint

- 8.1 Control and Restraint (C&R) is the only method of physical restraint approved by the Prison Service for use within their establishments. There is no restraint technique designed specifically for juveniles – the exact same C&R techniques are used on both adults and young people. As the Chief Inspector of Prison has said<sup>38</sup>:

*“Prison Service guidance on use of force does not distinguish adequately between children and adults, or take into account child protection considerations”.*

- 8.2 C&R restraint techniques rely on the use of locks on joints in order to bring control to dangerous or violent situations. These techniques employ a three officer team who may be required to use pain compliant aikido-based arm and wrist locks. When applied these locks are intended to initiate pain gradually and proportionately until compliance and control is achieved. When force is no longer necessary the locks should be released. The prisoner is then usually moved away from the scene of the incident to a “relocation area” – to their room, or segregation or another place – often in handcuffs.
- 8.3 In cases where a prisoner refuses to comply even after pain compliant locks are used, two of the three officer team may move the prisoner by lifting him or her from either side, whilst the remaining member – the “Number 1” – supports the prisoner's head from the rear.
- 8.4 During C&R incidents generally, the Number 1 is responsible for the control and protection of the prisoner's head, to maintain dialogue with the prisoner and for monitoring the prisoner's condition. There is extensive advice in the C&R Training Manual on the medical warning signs which may indicate a prisoner is in distress during restraint, with sections dealing with positional asphyxia, excited delirium, psychosis and sickle cell disease. In addition, a member of health care staff is required, “whenever reasonably practicable”, to attend every incident of restraint, which is limited in practice to those restraints incidents which are planned, in which case healthcare must be asked to provide relevant medical details (e.g. if the prisoner is pregnant).
- 8.5 While C&R envisages that the prisoner should if possible be kept standing upright while locks are applied, staff may take a prisoner to the ground if the prisoner is violent and “where there is a risk of injury to a member of the team or the prisoner”. It is acknowledged that placing a prisoner in the prone (i.e. face-down) position brings an increased risk of breathing difficulties and staff are alerted to potential warning signs and instructed to “get the prisoner to their feet as soon as possible”. For reasons which are not clear, staff in YOIs are not given the same advice as their counterparts in STCs, who are instructed to release the young person if they are on the floor after 3 minutes. Our impression from visits to YOIs, backed up by evidence from Voice, is that bringing the young person to the ground often results in their head being banged, which is clearly risky for the young person.

<sup>38</sup> HM Chief Inspector of Prisons, Annual Report 2006-07

- 8.6 C&R has “control techniques” - its own version of PCC “distraction techniques”. These are intended for use in gaining control of a prisoner when “due to the level of resistance offered by the prisoner it may at times be difficult to apply controlling locks”. The “thumb lock” (applying downwards pressure to a cocked thumb) is intended to loosen a standing prisoner’s grip from a weapon or from an officer or clothes, while there are several techniques for gaining compliance on the floor, including “nose control” in which the Number 1:

*“can apply pressure at the base of the nose, either hand will suffice. The finger will stay taut making contact beneath the nose. The officer’s fingers will be at an angle of 45° (Staying clear of the prisoner’s mouth). Pressure will be applied through the fingers underneath the nose towards the crown of the prisoner’s head”.*

- 8.7 ‘Nose control’ is no different from the nose distraction technique in PCC which was suspended by the Government in December 2007 yet unaccountably it survives in C&R.

#### **Recommendation**

The Government should remove the nose control technique in C&R. Its continued use is inconsistent with the removal of the identical nose distraction technique in PCC.

- 8.8 The C&R Training Manual stresses that C&R techniques are:

*“only one part of a range of possible responses to threatened or actual violent behaviour and that such techniques are to be used only when other methods, not involving the use of force, have been tried and failed, or are judged unlikely to succeed, and action needs to be taken to prevent injury to staff, prisoners, other persons or serious damage to property”*

- 8.9 Elsewhere in the manual there are reminders that C&R should only be used after all other means of de-escalating the incident have been deployed. But the guidance on the “other methods” to be employed, short of force, is comparatively limited (as it is the PCC manual, with which it has common parentage – the Prison Service National Tactical Response Group). The sections on ‘Communication’ and ‘Defusion Strategies’ occupy just a handful of pages in a 150 page document. In fact, we found on our visits to YOIs that staff thought of “de-escalation” principally in terms of relaxing the pain used in a C&R lock rather than avoiding restraint in the first place.

### **Planned restraint**

- 8.10 Use of C&R in YOIs fall into two main categories: planned C&R and unplanned or spontaneous C&R.
- 8.11 Planned C&R is in response to incidents which allow for a greater level of planning, for example to overcome a prisoner who has barricaded himself into a room. Planned C&R incidents are managed by a supervising officer, usually of Orderly officer or Duty Governor rank. Protective equipment – shields, helmets, shin and arm guards and gloves – may be worn, the incident may be videotaped and a member of healthcare should be present.

### **Unplanned restraint**

- 8.12 But the substantial majority of incidents in YOIs are not planned. In Lancaster Farms in 2007 for example, 85% of incidents were unplanned. These are the spontaneous restraints – often sudden, unpredictable, confusing and distressing – that can occur at any time and may be most dangerous for young people and staff. These can include violent acts – like fighting between prisoners, smashing up furniture and self-harm – to more minor incidents like prisoners refusing to move.
- 8.13 Usually, a three person team is not there to manage this under C&R, at least not initially. These require prison officers to use split-second judgement on if and how to intervene, often on their own, until assistance arrives. These are the incidents which young people most often described to us, incidents in which they said prison officers in response to alarm bells would arrive to “pile in”, in their words, to help a colleague. The Prison Service concurs that the

violence and difficulty of controlling some unplanned incidents may be compounded, if members of the team arrive at varying angles and varying times.

8.14 In unplanned restraints, the Prison Service advises officers that they:

*“may have to use whatever force is necessary to protect themselves or others until such time as sufficient members of staff arrive on scene. They must also bear in mind that any use of force must be reasonable and proportionate in the circumstances”.*

8.15 In these cases, staff may utilise orthodox C&R skills. An officer in one YOI described, for example, how, to prevent a young person kicking another in the head, he had to wrestle him to the floor alone whilst trying to support his head, for which he was punched several times. For personal safety when alone at a violent incident a prison officer is authorised to use “defensive techniques”. These include a simple “break away” from a prisoner if grabbed, to a defensive punch to the torso, a knee to the thigh or a kick to the shin. Use of these techniques is permitted on young people as on adults but striking a prisoner in this way is “an exceptional measure” and:

*“must never be regarded as anything but a means to defend themselves or a third party from an attack threatening serious injury”.*

### **Supervision of C&R**

8.16 Active supervision of C&R is strong. In planned C&R incidents, the role must be taken by officers of senior rank, often Orderly Officers or Duty Governors, who are accountable for the management of the incident until the young person is relocated. The supervisor must prior to every planned use of C&R:

- Make every reasonable effort to persuade the young person to end with incident peacefully;
- Ensure that all staff present are C&R trained and at least refreshed in the last 24 months. Staff who do not qualify are not allowed to take part in the intervention; and
- Request the attendance of healthcare staff who should provide details of any relevant medical risks to the young person.

8.17 Following the incident, the supervisor retains a key role, debriefing all staff on the reasons and circumstances of the use of force and signing off incident forms. In spontaneous incidents, the role of supervisor is taken by the number 1 until the Orderly Officer or Duty Governor takes over on arrival at the scene.

### **Use of C&R when escorting young people**

8.18 Staff escorting young people to and from YOIs are trained in the same C&R techniques employed in prisons, although the main type of restraint used is the HIATT ratchet handcuff or escort chain. The majority of the young people moved would be handcuffed sometime during the trip and moved within locked cellular vehicles. Use of handcuff on very young people (aged 10 to 14) is not allowed except if the child is thought likely to escape or is particularly violent or thought likely to harm him/her self or others, and cannot be restrained in any other way. Force is rarely needed in addition to handcuffing. In over 1500 young people escorted by one PECS provider in April 2008, force was used in only 6 cases (0.4%). The minority of these required full C&R and two of the cases were to prevent self-harm, including the removal of a ligature.

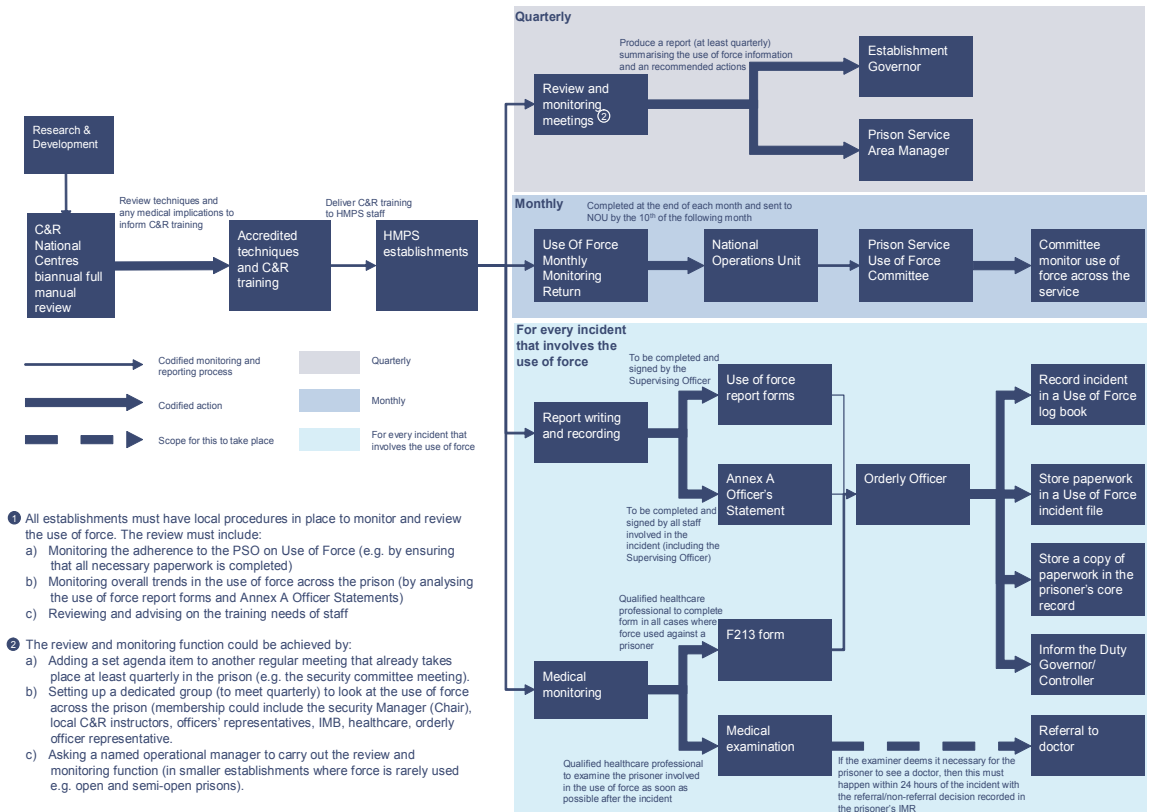
### **Medical Review of C&R**

8.19 There has been no full medical review of C&R since 1995, when the method was examined following the deaths of several prisoners whilst being restrained. Lessons learned were incorporated into C&R guidance at the time. The Prison Service point to the lack of restraint-related deaths in custody since 1995 as justification for their belief in C&R’s enduring safety.



8.20 But we are concerned that arrangements for examining the use of C&R and ensuring that its techniques are safe and refreshed with good practice fall well short of the level of scrutiny given to PCC. The following map sets out the structures set up by the Prison Service for monitoring and recording use of C&R.

**Monitoring and reporting of Prison Service use of force, including control and restraint (C&R)**<sup>1</sup> – taken from PSO 1600, HMPS Standard on use of force, HMPS use of force monthly monitoring return and HMPS use of force form



8.21 However, while the C&R manual is reviewed biannually **we could find in practice no adequate ongoing medical review process to ensure, for example, that injuries caused during C&R are systematically monitored and any resulting changes in practice are communicated back to units.** There is no equivalent of PCC Medical Panel or Management Board. There is a monthly Use of Force committee, but it has not met for several years and was concerned mainly with policy on C&R across the prison estate. It did not consider use of force data or reports on injuries.

**Recommendation**

The Prison Service should ensure that it has adequate arrangements in place for regular central oversight and analysis of the use of force and reporting of injuries in YOIs.

### Restraint Review findings on C&R

8.22 There is no doubt that C&R generally has the confidence of staff in the Prison Service, from the highest level to officers on the wings. Our impression was that staff felt well-trained in C&R, were confident in using it and saw it as a much more pragmatically effective and 'clinical' means of bringing control to incidents than other restraint methods such as PCC. "It works" was the assessment we heard most often from prison officers around the country. It appears embedded in the Prison Service psychology.

8.23 The Prison Service also defends the ethical validity of C&R primarily through the recent avoidance of any restraint-related deaths in custody, and by the lower number of injuries to young people in YOIs relative to injury rates in STCs and SCHs, although we question whether this is supported by the evidence. This "success" comes, we heard, despite the fact that the Prison Service has to deal with the more dangerous and threatening young people in

the juvenile secure estate, a state of affairs compounded by the perception we encountered in YOIs that many of the most difficult to manage young people were moved quickly through the system from local authority units to STCs to YOIs, where the governor had no choice but to take them. Only in YOIs, the argument went, would the young person be properly challenged for the first time, which brought implications for the need for restraint. That, we heard, is the “brutal reality”.

- 8.24 It is important to acknowledge that the Prison Service is making some headway in reducing use of force, as has also been recognised by the Chief Inspector of Prisons. She has referred to Feltham YOI as an example, where use of force incidents over January to April 2007 had been reduced by 8% from the same period in 2006. We deal with the Prison Service’s ability to reduce use of force in more detail in Chapter 13, but one social worker we met in a YOI gave his assessment of the position in his prison:

*“There are still incidents in which force is used inappropriately, and we are dealing with that, but more staff are becoming aware of the need to negotiate and de-escalate the situation before laying on hands. That message is beginning to get across”.*

(Social Worker, YOI)

- 8.25 However, while we do not underestimate the difficulty of the Prison Service’s task nor the risks that their staff can face, it is at least arguable that C&R, with its emphasis on coercion and pain compliance, itself reinforces the very culture of danger and violence in YOIs in which it operates. C&R displays for young people an example in which overwhelming force is sanctioned by authority and in which ‘might’ is perceived to be ‘right’. It does little to break the cycle of violence which many young people in custody have known for much of their lives. No allowance is made in C&R for the fact that it has to be used on children and young people as well as adults and its use helps to import into the young person’s estate the ethos of adult prisons.
- 8.26 The perceived ‘success’ of C&R may also have led to a widespread and persistent over-reliance on physical intervention in YOIs, in which C&R is seen as a ‘stand alone’ intervention, one capable by itself of managing violence and aggressive behaviour in young people. This may have led to a relative neglect of interpersonal skills and the wider aspects of violence prevention, including helping young people to manage their own behaviour and develop pro-social skills.
- 8.27 A key problem is that while we believe pain compliance should be avoided is possible and should be employed only as a last resort, C&R currently lacks the ability to provide it. It lacks within it the holds to provide a sufficiently graded response to behaviour and offers no reasonable alternative to the use of pain. The recognition by Ministers and the Prison Service of this has led to the development of Adapted C&R.

### **Adapted Control and Restraint**

- 8.28 Adapted C&R (ACR) arose out of Ministers request in 2003 to the Prison Service to explore options for developing non-pain compliant restraint techniques for use on young people.
- 8.29 The Prison Service initially considered the possibility of replacing standard C&R in YOIs entirely with PCC techniques used in STCs, but rejected it on the grounds that PCC techniques were not applicable “because their success was heavily reliant on the relative size and strength differential between the staff and trainees”. Instead, the Prison Service developed a new system in which selected PCC holds – the Double Embrace and the Figure of 4 – were introduced into C&R. This would mean that C&R would rely on the use of holds as opposed to locks to gain compliance, but would retain pain compliance as a last resort.
- 8.30 In May 2006 the Prison Service began piloting this new restraint system, called Adapted C&R in the juvenile sites of Feltham and Cookham Wood. The Prison Service concluded from the pilots in April 2007 that ACR “showed promise but had not been used sufficiently to draw firm conclusions”. This is certainly true. In Feltham they were used in 28 incidents, 27 times in conjunction with C&R. C&R alone was used 198 times during the course of C&R there. In Cookham Wood, ACR was not used once. The Prison Service has now postponed decisions on the further development and piloting of an appropriate restraint technique for young people in YOIs until our review has reported.
- 8.31 It should perhaps not be surprising that ACR did not ‘take’. Changes to deeply-held working practices can take years to overcome, particularly so when there is no attempt to change the

prevailing culture of C&R at the same time. Against the historic reliance on C&R – one member of staff called ACR “totally alien to me” – we question whether the Prison Service did enough to champion ACR properly and to embed its use in the pilot sites (initial training was not followed up).

- 8.32 This must change. There is an opportunity in ACR to provide an effective alternative to C&R in many cases. A member of the IMB, who monitored the ACR pilots, told the Review:

*“we were very impressed with the non pain compliance techniques being taught for restraining young men. However we were disappointed that the techniques were not used as the first option of restraint as much as the prison had hoped. A combination of the techniques and C&R were frequently used with the former an effective means of de-escalation. The ability to switch from one to the other was often employed. It led to meaningful debriefs of both staff and young men after any use of force. Without doubt it has led to a general reduction in violence.”*

## Conclusion

- 8.33 We believe that the use of C&R involving pain compliant locks as the main technique when force is required for restraining young people in YOIs is inappropriate. We accept, as we propose in STCs, that it has a place in a hierarchy of use of force techniques there as a last resort, but **staff must have available effective alternative techniques which can safely restraint young people without the use of pain.**

### Recommendation

The Prison Service must provide staff with safe restraint techniques which are designed specifically for young people and which do not rely on pain-compliance. As a matter of priority it should re-introduce properly resourced and managed pilots of Adapted C&R into YOIs.

- 8.34 But simply introducing new techniques will not by itself reduce levels of restraint in YOIs – ACR is still ‘using force’ after all.
- 8.35 Any use of force by prison officers, whether it is C&R or ACR, must be fully integrated within much better arrangements for overall behaviour management. Staff in YOIs must have the range of effective, ethical interventions to respond to challenging behaviour which we have seen in SCHs and STCs.
- 8.36 This is why we propose that **ACR must be introduced with a new behaviour management system for YOIs, which will provide a new framework for preventing crises and provide prison staff with the skills to support children and young people when they are at their most destructive so the need for high risk physical interventions is reduced.**
- 8.37 We deal with this recommendation in detail in Chapter 13 on Preventing Restraint.
- 8.38 Two initiatives in YOIs which we should commend are the introduction of a social worker post to provide a service to “Looked After Children” and others with special needs such as care leavers and those suffering or likely to suffer harm, and the introduction of a Safeguarding Children Manager who is responsible, at senior management level, for championing local safeguard arrangements. We were impressed by the Safeguarding Managers we met but they face a daunting task in helping to change YOIs towards a more child-focused culture. One initiative, which we believe will bring greater scrutiny on restraint in YOIs, was at Feltham, where use of force co-ordination and monitoring has been placed within the Safeguarding Team instead of the traditional security department.

### Recommendation

Staff responsible for training and co-ordinating use of force in YOIs should be brought within the management responsibilities of the Safeguard Manager.

## Batons

- 8.39 We were asked by Ministers to take account in our report of the evidence of the Prison Service review into the case for extending the use of the baton to the young people's estate. We have carefully considered that evidence and the resulting findings, including the views of the Prison Officers Association. We share the Prison Service conclusion that the risks of batons, not least the medical evidence that the consequences of using batons on young people could involve a greater danger of significant harm to them than adults, outweigh any advantages.

**Recommendation**

Batons should not be routinely deployed in the young person's estate.

- 8.40 We accept that batons may continue to be used as part of planned interventions by C&R teams in response to very serious incidents of disorder.

## 9. THE FUTURE OF RESTRAINT IN SECURE TRAINING CENTRES

### *Key messages*

- PCC is in some disarray. It is too complex and features too many holds, many of which are being challenged by medical opinion.
- PCC is also increasingly inadequate to manage the physically stronger young people found in STCs which is compromising their safety and that of staff.
- PCC should be replaced by a new simpler, safer and more effective system of restraint.
- The new system must be built around a core of safe techniques to cover the range of risks in STCs but should incorporate wrist flexion locks to be used in exceptional circumstances and subject to strict safeguards.

### Physical Control in Care

- 9.1 STCs are required by law to use restraint methods approved by the Secretary of State. The only method approved for STCs is Physical Control in Care (PCC). PCC is also used by the Borders and Immigration Agency and by the Juvenile Justice Centre in Northern Ireland.
- 9.2 PCC was designed by the Prison Service specifically for use on younger children (12-14 year olds). It is itself a development of PRICE, which was previously devised by the Prison Service for SCHs after children had been injured through the use of Control & Restraint at the Aycliffe Centre for Children in the 1990s.
- 9.3 We have experienced the main PCC holds from instructors at the Prison Service NTRG and at our request the YJB provided us with an unredacted copy of the PCC Training Manual dated December 2005.

### PCC holds

- 9.4 The PCC Manual seeks to place the techniques within the context of the total relationship between care staff and young people and warns trainers to discourage “*any suggestion that the appropriate response to disruptive or threatening behaviour is necessarily the use of force*”.
- 9.5 PCC is based on a series of holds that rely on restricting the movements of a young person until he or she has calmed down. The holds are designed to be ‘phased’ in response to an incident so that no more force than necessary is used at any point. Systematic de-escalation of techniques is said to be central to PCC:
- Phase 1 restraints are intended to be low-key holds which can be used by a member of staff on their own. They include the ‘Single Embrace Hold’, in which a member of staff reaches behind the young person’s back and holds their far upper forearm while their other hand holds the young person’s near arm between the young person and their own body; and the ‘Side Hug Hold’ in which the young person is controlled in a hug by member of staff holding their far upper and lower arm.
  - Phase 2 restraints require two members of staff. The most frequently applied holds are the ‘Figure of Four Arm Hold’, in which staff use a hand to block the young person’s elbow while the other hand holds the forearm; and the ‘Double Embrace’, in which the staff each cross an arm behind the young person’s back to take hold and pull in the

young person's far arm while holding their near arm. Double Embrace is the recommended technique in PCC should young people need to be moved under restraint.

- Phase 3 requires a third member of staff and should be used only "if the young person is so violent that a Phase 2 hold is deemed to be inadequate". The role of the third person is "to control and protect the young person's head until de-escalation becomes possible".

## **Distraction techniques and personal protection**

- 9.6 PCC, states the Manual, "does not rely on pain compliance to regain control" (although it is acknowledged that some pain may result if the child struggles). This statement obscures the use within PCC of three 'distraction' techniques which inflict a deliberate brief sharp burst of pain to a young person's nose, rib or thumb. These are to be used to gain initial control prior to PCC holds "*in a dangerous or violent situation where a person is at serious risk of injury*" such as when one young person has grabbed hold of another or a member of staff and only as "*a last resort after other attempts to control the young person have failed*".
- 9.7 Staff are also taught a range of techniques to be used one-on-one to enable a member of staff to defend themselves from attack. The prime objective of these "breakaway" techniques is to allow the member of staff to disengage quickly and seek assistance. The techniques appear in the PCC manual under alarming headings such as "strangle against the wall", "hair grab" and "kicks" and only on close inspection does it become clear that these are not describing the breakaway techniques themselves but the violent assaults against which they might be used.

## **Use of handcuffs**

- 9.8 The use of ratchet handcuffs on young people is permitted in PCC in exceptional circumstances. These are described as:
- If there is a long or difficult route to escort the young person
  - When staff are unlikely to maintain PCC holds
  - With exceptionally strong/violent young people
  - To aid de-escalation
- 9.9 In each case, staff are expected to have attempted to de-escalate the situation and tried PCC techniques before considering handcuffs. The STC Director must approve the use of handcuffs in every instance and they must be removed as soon as the threat has receded.

## **Safety**

- 9.10 The Manual provides some advice for staff about the potential dangers and medical implications of using force:

*"A number of adverse effects are possible following the application of restraints. These include being unable to breathe, feeling sick or vomiting, developing swelling to the face and neck and development of petechiae (small blood-spots associated with asphyxiation) to the head, neck and feet).*

*A degree of positional asphyxia can result from any restraint position in which there is restriction of the neck, chest wall or diaphragm, particularly in those where the head is forced downward towards the knees. Restraints where the subject is seated require particular caution"*

- 9.11 Staff are warned that "where continued application of physical holds by staff on a trainee becomes unsafe for staff the hold(s) must be released". PCC has a Non-Decking Policy to avoid prone and supine restraint: it has "no techniques which deliberately take trainees to the floor" although that is often the outcome, not least because, from their evidence young people can take themselves to the floor deliberately when struggling against a hold. Should a young person be taken to the floor, the advice is that "the trainee will only be held on the floor for up to 3 minutes then the trainee must be released", although the Manual does not offer an

explanation for this time limit. NTRG inform us that when reviewed the PCC Manual will have references to specific time limits removed.

- 9.12 The Manual emphasises that the use of physical force to restrain a young person must always be viewed as the final option. It should not replace the ability of staff to use interpersonal skills to resolve confrontational incidents. Indeed there are sections which deal with defusion strategies and de-escalation techniques. We gather from the Prison Service that in 2003 and 2005 the PCC manual was reviewed and rewritten to place greater emphasis on the law, de-escalation techniques and communication. But the majority of the Manual concerns instruction in the various holds of PCC and the roles of those involved. Arguably, this is not surprising – this reflects its purpose. **But our perception is of a Manual that presupposes that force will be used. The sections on de-escalation and avoidance of force appear cursory in contrast to the detail, and sheer range, of techniques for physical intervention.**
- 9.13 After its inception in STCs in 1998, a commitment was made by the Home Office to review PCC after one year of operation. This did not happen. Following the transfer of responsibilities for secure facilities from the Home Office to the YJB in 2000, this commitment to review PCC was forgotten. In the event, no review of PCC took place until 2004 and before it had got properly underway, Gareth Myatt and Adam Rickwood had tragically died in STCs.

### Gareth Myatt and Adam Rickwood

#### Gareth Myatt

Gareth Myatt died on 19<sup>th</sup> April 2004, aged 15, while being restrained in Rainsbrook STC.

Officers used the Double Seated Embrace, at that time one of the PCC techniques approved by the Secretary of State under the Secure Training Centre Rules 1998.

The jury found that Gareth's death was asphyxia, probably caused during lawful restraint and was probably accidental and therefore recorded a verdict of "accidental death". But, amongst other serious concerns, the jury criticised the Home Office and YJB for not having taken account of the dangers of positional asphyxia before approving PCC and for having failed to undertake a medical review of PCC in the period between 1998 and Gareth's death in 2004.

#### Adam Rickwood

Just four months after Gareth's death, Adam Rickwood, aged 14, died at Hassockfield STC on 9 August 2004 after being found hanging in his room. He was the youngest person to die in custody in recent times.

Adam had been restrained earlier on the day of his death, when a nose distraction technique was used, causing a nosebleed.

At the inquest, the jury returned a verdict of suicide. It found that the restraint had not been a causative factor and that staff at Hassockfield had acted appropriately throughout Adam's time there. It found there were no system failures at Hassockfield that contributed to his death, but criticised Lancashire Youth Offending Team for not providing adequate information to the YJB about Adam's vulnerability.

- 9.14 The Coroner of the inquest into the death of Gareth completed his report in June 2007 with the report of the Coroner into Adam's death following a month later.

### Coroners Reports

- 9.15 The Coroners' reports made a number of wide-ranging recommendations about the safety, operation and monitoring of PCC, the training given to STC staff, referral of injuries to external scrutiny and how young people's complaints were dealt with. The Coroner of the inquest into Gareth's death, His Honour Judge Pollard, also noted in his report the prospect of our review of restraint across the juvenile secure estate but insisted that "I trust that no-one will lose sight of the particular and very immediate problems of PCC and STCs". We are pleased that the

Government has not waited for the outcome of this review before publishing its response to the Coroners' recommendations on 27 March 2008. We have taken account of the Coroners' recommendations and the Government's response in our review.

- 9.16 One key recommendation made by His Honour Mr Andrew Tweddle, the Coroner of the inquest into Adam's death, was to urge the Government to clarify the relationship between the Criminal Justice and Public Order Act 1994 (s9), the STC Rules and the STC Directors Rules "to avoid any confusion whatsoever...as to when the use of restraint or force to maintain good order and discipline or for compliance reasons is authorised". The result was the Secure Training Centre (Amendment) Rules 2007 with which we deal in chapter 13
- 9.17 Further recommendations were made in the Serious Case Panel Report into Adam's death published by Lancashire Safeguarding Children Board on 3<sup>rd</sup> September 2007. Again, we have taken on board these recommendations and by this report fulfil one of them, that "the use of restraint in the whole of the secure estate is reviewed nationally".

### Medical review of PCC

- 9.18 After Gareth and Adam's death, use of PCC rightly came under intense scrutiny, and moves were made to strip out unsafe techniques. Shortly after Gareth's death, Ministers suspended use of the Double Seated Embrace. It was permanently discontinued following a full safety review of PCC undertaken by the YJB and concluded in 2005. In 2007 the YJB began a further medical review of PCC, although a first meeting of the **PCC Medical Panel**, which included a forensic pathologist, a paediatrician, a physiotherapist, a children's orthopaedic surgeon, and a Child and Adolescent Psychiatrist, was delayed until November 2007.
- 9.19 As result of the Medical Panel's preliminary findings, Ministers, in a letter of 14 December 2007 to STCs and other main parties, took the decision to suspend use of two PCC techniques:
- a. Nose distraction, as it is unnecessarily invasive (use of the nose distraction technique had in any event been stopped locally at most STCs before it was suspended by Ministers); and
  - b. The double basket hold, due to potential respiratory difficulties.
- 9.20 In February 2008, the Medical Panel, in further advice to Ministers we have seen, concluded that PCC is over complicated and should be simplified to comprise fewer holds. The Panel also made further urgent recommendations on the safety of specific holds in PCC. In response, Ministers have:
- a. Confirmed suspension of the nose distraction technique and double basket hold pending our Review;
  - b. Asked the Prison Service, the YJB and the Department of Health to:
    - i. investigate the safety implications of disapplying the head support during 'de-escalation Option 2' because of the risk of compromising breathing;
    - ii. assess whether the head support generally should be applied differently;
    - iii. assess the suitability of seated holds. (While accepting that seated holds are more useful in de-escalation, the Panel felt that standing holds were inherently safer); and
    - iv. assess the double embrace to determine whether it is universally applicable regardless of height or weight of the young person and the members of staff applying the hold.
- 9.21 **It is right for Ministers, when faced with clear safety concerns about PCC, to act before our review reports. In the event, we consider the PCC Medical Panel's evidence to be authoritative and recommend:**



### Recommendation

The Government should permanently remove nose distraction and the double basket hold from the techniques currently used in PCC.

9.22 Further concerns have been recently raised about PCC after a risk assessment, by an **expert panel**, of seven restraint techniques taught within PCC. For the first time, a **Risk Assessment Tool**, developed by BILD with the support of the YJB, was used as part of a methodical process to evaluate PCC. The techniques evaluated were:

- The nose distraction
- The rib distraction
- The tantrum hold
- The Double Embrace
- The Double Embrace Lift (and escalation)
- The Single Basket Hold
- The Hair Grab Release

9.23 In their April 2008 report, commissioned by the YJB, the panel states they had:

*“identified significant concerns on the grounds of safety with three of the techniques within the PCC system; the double embrace lift, the nose distraction, and the rib distraction. The panel recommended the immediate discontinuation of all three techniques.”*

9.24 The report also claims that some of the techniques are “highly fragile” – i.e. they have a narrow tolerance and small adjustments can alter dramatically the risk of a specific physical intervention. The single basket hold is given as an example. We note, however, that the panel did not contain any expert in PCC nor a representative from NTRG. We do not endorse the panel's conclusions now, but its useful work must be taken into account in any technical review of PCC.

9.25 This recent medical evidence on the safety of PCC has been of great help to our review. In no other sector of the juvenile secure estate in England and Wales has there been a comparable recent scrutiny of restraint safety. We believe that such scrutiny must be extended to all techniques used in YOIs and SCHs and consider this in more detail in the context of Accreditation in chapter 11.

## Restraint Review findings on PCC

9.26 Much of what we found chimed with the medical opinion of PCC. In their evidence to the Review, the Prison Service NTRG, the body which originally devised PCC and still provides training for PCC instructors, stated:

*“PCC is now not fit for purpose It was written originally for STCs when they held only 12-14 year olds and it is less suitable for larger 15 to 17 year olds. It has too many outdated and complicated techniques”.*

9.27 This assessment was supported by senior management in STCs. Rebound Children's Services, which operates all STCs except Hassockfield, also referred to the problem that PCC was intended for 12-14 year olds, who were no longer representative of young people they managed:

*“the changing profiles of young people we look after both in terms of length of stay, non refusal policy, age range and the indexes offences for which they are admitted particularly violent offences...has increased the number of spontaneous violent incidents. The size and strength of many young people meant that “it is very difficult for staff to apply the holds in the first instance in accordance with the manual or their training due to the violent behaviour of many young people”.*

9.28 Rebound said that they had:

*“significant concerns about the safety of some of the key holds [in PCC], particularly phase 3 when the 'head support' is used”.*

9.29 The head support appears to be used far too often in restraint incidents in STCs. In a six month period in Hassockfield in 2007, for example, almost 60% of PCC incidents were dealt with using full Phase 3 holds, which we find troubling given that we know young people find head holds especially distressing and want them minimised. The PCC Medical Panel has noted that it has considerable medical risk if applied incorrectly, although the evidence of the Prison Service is that it has been used safely in prisons and suspending it without assessing the impact may introduce other unknown risks.

9.30 The current re-location technique is considered inadequate for staff to safely remove themselves from a bedroom when a young person has not calmed down. Generally, we found broad agreement among staff that many of the holds within PCC, including the double-embrace hold, were often inadequate and potentially unsafe when used on some of the more powerful young people:

*“With PCC the bigger lads, if you use double embrace, and you don’t have a proper hold, they can be flying around.”*

*“PCC is stuck in history. It’s hanging on, not controlling. You can be struggling with a boy for 45 minutes, sometimes an hour.”*

(STC staff)

9.31 These scenarios have resulted in more staff being required in PCC incidents, increasing the chaos, stress and potential for injury to young people. The active involvement of 5 staff or more in incidents is not unknown, with frequent changeovers of staff:

*“It needs too many people. Sometimes we are looking at 6 or 7 staff just to get from A to B”.*

(PCC trainer)

9.32 We are greatly concerned about the implications these problems are having for the duration of restraint incidents and the consequent safety of young people.

9.33 We heard consistent testimony from both young people and staff – similar to that heard by the inquests into the deaths of Gareth and Adam – of prolonged PCC incidents. Struggles of 30 to 45 minutes or more were not uncommon; the longest was almost 2 hours. Two typical examples we heard of were:

JJ was in Room 9 and had spat at a teacher. When he was informed of his sanction he refused to go back to the unit and became abusive and aggressive towards staff.

During the incident JJ swore at, punched, grabbed, took a swing at, threatened, shoved and kicked staff.

During the PCC JJ continued to be aggressive and to drop his weight. He was held in Figure of Four and Phase 3. JJ continued to struggle violently and was placed in a double embrace hold. He continued to drop his weight and continued to struggle. This meant that on several occasions he dropped his weight to the floor, was held in the prone and supine positions and then raised to his feet and attempts were made to move him to his unit. He was extremely strong and refused to calm down in spite of attempts to de-escalate him.

Seven different members of staff were involved in the PCC and were used to change over from each other due to JJ not calming down and the level of sustained aggression which he exhibited. Comments made by staff suggest that he was not able to be moved, without the use of the double embrace lift. Also that when in the double embrace his struggling caused all to fall to the floor.

Eventually he was relocated into the stairwell of his unit and he calmed enough for holds to be released and he walked to his room.

A nurse was present throughout the incident.

**Duration = 30 minutes**

TM attempted to assault another trainee and was prevented by using PCC to prevent harm to others.

He was held in Figure of Four holds and then double embrace holds, with Phase 3 and in prone when he took himself to the floor. TM took himself to the floor several times while on the Green and continued to struggle violently.

He was eventually moved inside the stairwell to his unit and remained there while staff attempted to de-escalate. He was held there for approximately 15 minutes where he continued to try to drop his weight. He also continued to threaten to assault staff if he were released. Due to the confined space in the stairwell, this increased the risk, as the hold release option was not an option.

TM was moved up the stairs in double embrace, Phase 3 and with two members of staff as anchors. He was moved to his bedroom where he was de-escalated.

In total ten members of staff were involved in this incident due to the duration and fatigue.

A nurse was present throughout the incident.

**Duration = 50 minutes**

- 9.34 Staff agreed with the Medical Panel assessment that PCC was over complicated and should be simplified down to fewer holds. Staff in Medway STC used 15 different PCC techniques in September 2007 – six of them just once. This might show that PCC is able to provide a range of responses depending on the young person, the circumstance and the risk, but staff are confused by the sheer breadth of options and are unlikely to safely retain expertise in all of them. Instructors at the Juvenile Justice Centre said that of all the PCC holds, the Figure of Four and the Double Embrace were most effective and used most often (despite reservations noted with Double Embrace elsewhere).
- 9.35 PCC is also raising health and safety concerns with staff. Rebound reported that the removal of the double seated embrace had increased impact injuries and sprains to staff by 50% and other injuries, such as stamping on feet and injuries to feet by 60%. Their evidence concluded that:
- “The current system of physically restraining young people [in STCs] is inadequate and should serious injury occur to staff the Health and Safety Executive would determine the system is unsafe for use.”*
- 9.36 In his evidence to the Review the Director of Hassockfield STC also concluded:
- “It is the view of the Senior Team that the effectiveness of PCC has reduced considerably since the removal of the seated double embrace technique approximately 3 years ago”.*
- 9.37 There is no consistent approach across STCs to using handcuffs to manage exceptional incidents. Medway and Rainsbrook never use handcuffs amidst concerns that they run contrary to a ‘child centered ethos’ and are difficult to apply safely to young people. They are also said to be of use to staff only after they have gained control of a situation. Hassockfield has no prohibition against handcuff but did not use them between October and December 2007, while Oakhill used them just once in that period. The Woodlands Justice Centre do use handcuffs, seeing it as an aid to de-escalation. We note that the PCC Medical Panel have recently advised the Government to examine the efficacy of handcuffing young people.
- 9.38 A further outcome of the increasing difficulty with PCC may be the growth of unauthorised and untrained restraint techniques in STCs:
- “You can’t PCC a 16 year old. They C&R them here. When you’re not here they don’t give a shit how they do it”.*

(Shaz)

We have no evidence to suggest that this is widespread, but descriptions we heard from STC staff about some of the adapted ‘holds’ they sounded much like C&R-style wrist locks, although STC senior management were quick to make clear to us that such locks, if they existed, were neither trained nor condoned.

## Conclusion

- 9.39 The current approach to PCC cannot continue. Concerns about the safety of PCC in the light of the deaths of Gareth Myatt and Adam Rickwood have seen the Government take action to remove unsafe techniques without specifying replacements. This is potentially damaging PCC as withdrawing techniques piecemeal is affecting the coherence of the system as a whole.
- 9.40 PCC does retain strengths. Where force has to be used, PCC remains capable of dealing safely with younger people. We are reassured that at the heart of the system are techniques which are not pain-compliant, although they are over-complex and need rationalising. But increasingly as a response to managing the older, more powerful young people increasingly found in STCs – for whom it was not originally designed – PCC is inadequate.
- 9.41 We have considered the options for the future of PCC. We could leave PCC undisturbed and entrust changes to the outcome of independent accreditation proposed elsewhere in this report. This would not only be evading our responsibilities but ignoring the pressing need for a solution to the problems in PCC. We could recommend the replacement of PCC wholesale with one of the other existing methods in the secure estate or in other settings – Price, Calm, etc – but we have not seen conclusive evidence that any existing method is in itself adequate to respond to the range of challenges in which force might be used in STC.
- 9.42 Instead we favour the replacement of PCC with a new system which takes account of emerging medical evidence, to protect the safety of young people, and an up-to-date assessment of the risks in STCs to which restraint techniques, and the skills of staff, are expected to respond.

### Recommendation

The Government should commission the Prison Service NTRG to devise a new simpler, safer and more effective system of restraint to replace PCC in STCs.

### Recommendation

The new system must be built around a smaller core of safe techniques to cover the range of risks in STCs. Its development should be informed by latest medical evidence, including the PCC Medical Panel's conclusions on the safety and suitability of the head support, seated holds and the double embrace, and where appropriate by the evidence of the BILD expert panel.

### Recommendation

The new system should be based primarily on holds which avoid pain but should incorporate wrist flexion locks, as a Phase 4 technique, to be used in exceptional circumstances and subject to strict safeguards.

- 9.43 We are acutely aware that our final recommendation means that pain-compliant techniques will be part of the future restraint system in STCs. But the circumstances which shaped the development of PCC have changed. Young people are being exposed to the risks of prolonged, exhausting and potentially life-threatening restraint, and staff are being denied workable means to manage violent incidents. This demands a fundamental reassessment of PCC.
- 9.44 We do not wish use of wrist locks to become commonplace. We do not favour the use of pain as the main response when force has to be used. It would be clearly disproportionate for large, strong staff to use pain compliance to control a mildly resistive small child. But a fully grown and seriously violent late teenager may well justify such techniques.
- 9.45 But there must be strict **safeguards** on its use. We seek to restrict the circumstances in which staff could use wrist locks. Risk assessment will be critical. We believe the safeguards to be so important that we make them explicit recommendations:

**Recommendation**

Staff in STCs should be prohibited from using wrist locks on a young person unless:

- Use has been approved in a prior individual risk assessment authorised personally by the STC Director/Duty Director and signed off by healthcare or
- The safety of any young person or staff member during a restraint incident requires it to be brought to an end quickly. Authority to use wrist locks in these circumstances must be given following risk assessment by the Duty Manager or in emergency situations by the team leader present.

In all cases, de-escalation and other permitted, non-pain techniques should have been tried first before the use of wrist flexion is considered.

**Recommendation**

The risk assessment of young people should be reviewed weekly to determine whether prior authority for the use of wrist locks can be withdrawn.

**Recommendation**

The STC should report all incidents of restraint requiring wrist flexion to the YJB monitor and Local Safeguarding Children Board for external scrutiny. Examination of the use of pain compliance in STCs should be on the agenda for each STC's LSCB meeting

**Recommendation**

Ofsted should review the use of pain compliance in STCs as part of their announced and unannounced inspection.

**Escorting young people**

- 9.46 Staff who provide escorts for young people in STCs, to enable visits to court, hospital or other necessary journeys, also have concerns about PCC. No specific techniques have been designed for the restraint of young persons under escort. Staff have to use the figure of four, which is conspicuous and undignified for the young person in public as it requires crowding them in from either side as they are moved, especially distressing for vulnerable young people who do not like being touched. The removal of the 'double seated embrace' without the addition of other techniques has caused acute difficulties during some escorts:

*"exposing both young persons and escort officers to increased risk of injury as they grapple in what amounts to an unsophisticated tussle."*

**Recommendation**

The review of PCC should consider the provision of specific techniques suitable for vehicles to allow escort staff to move young people safely and effectively.

## 10. THE FUTURE OF RESTRAINT IN SECURE CHILDREN'S HOMES

### *Key messages*

- There are eight different restraint systems being used in the 19 SCHs. Each local authority with a SCH takes its own decisions on the methods needed and none are centrally approved.
- Taken as a whole, there are a diverse range of techniques in SCH restraint methods, including prone restraint. SCHs methods generally avoid pain compliance although some do feature distraction techniques.
- There is no accreditation of the safety of SCH techniques, although the training and trainers of some methods are accredited through the British Institute of Learning Disabilities' voluntary scheme.

### Overview

- 10.1 There is considerable diversity and inconsistency in restraint methods and training in SCHs. There is no central mandating of restraint methods or training – each local authority (or other provider) may take their own decisions. None of the methods are subject to Secretary of State approval.
- 10.2 The National Minimum Standards for Children's Homes state that measures to manage behaviour must be "*consistent with any relevant guidance on approved methods*" but we have been unable to find any such guidance. In an attempt to ensure that SCHs are acting within their policy, YJB contracts with the local authorities that SCHs include a generic service specification that is common to all and which includes detail on the use of restraint. This service specification requires that SCHs comply with the *Guidance on Permissible forms of Control* published by the Department of Health in 1993, but more specifically it stipulates that,
- 'physical restraint must be used only as a last resort and then following approved, accredited methods. The minimum necessary force must be applied and incidents documented, recorded and audited. Staff using force must have had appropriate up to date training.*
- 10.3 But there is no accreditation system for SCH methods, and the main accreditation for SCH training, run by the British Institute for Learning Disability, is voluntary and not taken up by all SCH restraint training organisations. There are no standard requirements to assure the safety of techniques, and review processes vary according to the restraint method (see below). There is no formal governance system which brings together all SCH methods.
- 10.4 In most cases, it is unclear why a particular method of restraint has been chosen by individual homes. Reasons for choosing methods vary, and include for example a desire to use an accredited training provider, or a wish to avoid techniques which include the use of pain or prone restraint. Managers of some homes have clearly taken the initiative to research methods, sometimes involving other staff. Generally, methods are not selected as the result of a clear procurement process, and there tend not to be service level agreements or formal reviews of the decision to use a particular method. Within a specific method, not all the techniques will necessarily be used, or even taught. The roles of individuals within SCHs also vary; in some, in-house instructors are involved in determining the techniques of restraint suitable for individual children, in others the provider takes such decisions.
- 10.5 None of the methods being used in SCHs have been designed specifically for use on children, although tailored packages may be developed for individual settings. All methods claim not to deliberately inflict pain to gain control, although some SCH methods do use an element of pain distraction for use in specified and high-risk circumstances only.
- 10.6 A summary of the methods of restraint being used by individual SCH is set out below.

## **PRICE (Physical Rights in a Caring Environment) *BILD Accredited***

- 10.7 PRICE is the most commonly used method of restraint within SCHs, being used in five of the 19 SCHs. It was commissioned and developed in the early 1990s under the guidance of the Home Office following concerns that children had been injured through the use of restraint in the Aycliffe Secure Unit. It has evolved since then with more emphasis on de-escalation and general behaviour management skills as opposed to purely physical intervention techniques.
- 10.8 Basic PRICE holds are designed to hold children without putting pressure on their joints and do not take children to the floor, although safe ways of holding them if they end up on the floor are taught. The aim would be to move them to a seated or supine position as soon as possible. PRICE does have a Phase 4 package that will be taught if organisations request it but this would have to be on the basis that they are dealing with particularly challenging situations. It contains some pain compliant techniques and the expectation is that it would be used: only in the short-term with specified individuals and reviewed daily; on the basis of a risk assessment; as part of a multi-disciplinary plan.
- 10.9 PRICE does also teach some pain distraction techniques for use in escape situations, including one to be used when the person is biting (requiring two people) and another involving the knuckle to get someone to release their grip. PRICE techniques have been independently risk assessed by a medical practitioner and occupational physiotherapist, although there is acknowledgement that it is difficult for risk assessments to take into account the fluid nature of movement in real life situations rather than the static nature of a training course.
- 10.10 SCHs using PRICE are generally happy with the physical intervention aspects of the method but have tended to supplement it by commissioning other training on the wider aspects of behaviour management

## **GSA (General Services Association)**

- 10.11 GSA is used in four SCHs. It was previously known as C&R (General Services) and some staff still refer to it as C&R. It is an association of trainers who are not directly employed but are self-employed or work for other organisations.
- 10.12 Originally the techniques were adapted for use in special hospitals from C&R method used in prisons and have been in use for 14 years. The techniques are said to have moved away from the reliance on pain compliance and locks on joints that remain an essential element of C&R itself.
- 10.13 The techniques themselves are designed not to cause pain or injury, or to go against the principles of dignity and respect for service users. They are phased, from a 'friendly come along' to techniques for use only in extreme situations. These more restrictive techniques include one pain distraction that puts pressure below the ear for use when someone is being bitten. There is a finger and thumb hold but the most commonly used hold is a Figure of Four. There are also techniques for taking children to the floor in a prone or supine position because this is considered to be safer than the alternatives when someone is being extremely violent.
- 10.14 The techniques are regularly reviewed by a Consultant in Emergency Medicine with particular expertise in trauma who gives an opinion on the level of risk they pose to staff and subjects, categorised as likely, possible or remote risk, and describes what the possible adverse consequences could be of each technique. The medical review makes it clear that particular health problems of staff or subjects, and operational factors may have an impact on safety in practice. If any new techniques are developed in-between these regular reviews, course participants will be warned that they have not yet been subjected to medical evaluation. A recent review has just been done, so all techniques within the current core curriculum have been medically assessed. GSA receive information on injuries caused during training but not those caused operationally.
- 10.15 The establishments that use GSA are reasonably happy with it. There is also some confusion about whether it does contain some pain compliant techniques or pressure on joints or not, and the large number of different holds that need to be remembered. It was generally acknowledged that it is primarily about physical skills and that other training or strategies are needed to ensure staff are skilled in holistic approaches to behaviour management.

### **MAPA (Management of Actual or Potential Aggression) *BILD Accredited***

- 10.16 MAPA was developed by staff working in the health service in the 1980s. They had initially welcomed C&R training because, before that, there had been no taught methods of restraint and the response to challenging behaviour had been a 'free for all' or seclusion and medication. There was an increasing concern that C&R was too complicated so that staff had not grasped the techniques and were misapplying them, and too harsh.
- 10.17 MAPA was developed based on the practice experience of its founders, and has been continually refined since. MAPA has set strong ethical standards, rejecting the use of pain and pressure on joints. The organisation that has developed MAPA is called Positive Options to reflect their overall approach: MAPA is the name of the physical intervention curriculum. Their approach is that physical intervention is about supporting people in crisis rather than enforcing compliance.
- 10.18 The MAPA techniques themselves are designed to be simple. There are three levels of intervention. The first is holding to keep people safe, the second and third level are for disengaging from incidents. Level three contains two techniques involving pain stimulus at the base of the nose or sternum for use only in the case of violent assault. The use of the techniques must be agreed at the commissioning stage, there is an expectation that the use of pain stimulus must only be used if a manager is present and must be written into individual behaviour management plans. The same applies to prone restraint. It may be taught if it is indicated by a training needs analysis. Positive Options have undertaken research to find the position that causes the least reduction in oxygen levels.
- 10.19 MAPA does not teach methods for moving a child because they do not support the use of force to make people go somewhere they do not want to go, seeing this as enforcing compliance rather than supporting people in crisis. All methods have been independently assessed by a consultant physiotherapist and are reviewed when they reapply for BILD accreditation. There is a risk matrix used within the health service and now adopted by NICE which is also used. Positive Options ask all the centres they have accredited to send in a quarterly return on the training they provide, relevant injuries and complaints.

### **CALM (Crisis, Aggression, Limitation and Management) *BILD Accredited***

- 10.20 CALM takes what is described as a public health approach to challenging behaviour, seeing it as a phenomenon that can only be understood in the context of organisational culture rather than individual pathology or a failure of staff skills. Events before, during and after incidents must be taken into consideration. The response must extend beyond training as a quick fix, and it is CALM's view that training on physical intervention skills in isolation can make situations worse.
- 10.21 The techniques themselves are 'non-aversive' and do not cause pain or flex the joints beyond their middle-range or take the body outside its natural alignment. They have been assessed by bio-mechanical experts. There are five levels of response to challenging behaviour within CALM. The first two do not involve laying hands on the child, the third contains strategies such as an arm round the shoulder and levels four and five are more restrictive. Prone restraint can be used but only exceptionally and there would need to be a prior letter from the organisation's chief executive endorsing it and stating why other methods are insufficient. There would also need to be a guarantee that it would only be used on the basis of a risk assessment, and with identified individuals. The particular method of prone restraint does not put pressure on the torso and has not caused injuries.
- 10.22 CALM requires organisations to submit data on the numbers of injuries and undertakes a regular analysis. They have also been involved in various research studies that confirm a low injury rate.

### **Team-Teach *BILD Accredited***

- 10.23 Team-Teach was developed from GSA but has removed all elements that it considered to be painful. It is used in a large number of educational settings but expects each setting that intends to use Team-Teach to undertake an analysis of their specific needs and a package of behaviour management techniques and training is then developed to meet those needs.



Courses will include both theoretical and practical elements and it is Team-Teach's view that it is essential to integrate these elements in order to ensure a holistic approach to behaviour management.

- 10.24 The theoretical element contains information that will support staff in their thinking about the 'before, during and after' of incidents of restraint. It includes understanding the origins and types of challenging behaviour, listening skills, de-escalation skills and underlying values.
- 10.25 Team-Teach does not use pain compliant or pain distraction techniques and, in ten years, has not felt that they would have been needed. Team-Teach does use prone, supine and side restraint in the belief that these are safer than some of the alternatives as long as safeguards are in place. These include ensuring that no pressure is placed on the torso. They consider 'ground restraint' to be more likely to bring an incident to a close and to avoid the need for prolonged, and therefore risky, restraint.
- 10.26 The techniques themselves, because they originate in GSA, were developed within health care settings but additional opinions about their safety have been sought from a panel of experienced trainers and a back care specialist. They also request information from organisations that use Team-Teach about injuries, including an evaluation form for 'high risk' techniques.
- 10.27 From the data they have collected over the years, including 3000 instances of prone restraint, only three have needed hospital attention although the figures have not been independently verified. There have been some minor fractures to the forearm but these have usually been a feature of the environment rather than the hold itself. Team-Teach insist on all staff who will be using their techniques being trained in First Aid.
- 10.28 Establishments that use Team-Teach were happy with its ethos although there were some concerns that training was too short. The decision not to use prone restraints on the basis of the DCSF advice (see paragraph 6.25) had recently reduced the repertoire of techniques available to staff and some concern was expressed about the adequacy of the remaining techniques, with children having got out of holds and a lack of techniques for moving children.

### **ECC&R (UK) (Ethical Care Control and Restraint UK)**

- 10.29 The founder of ECC&R (UK) developed C&R for use in the prison service. When he left in the late 1980s, he adapted the method for use in other settings, including psychiatric and children's services. ECC&R (UK) is used in one SCH.
- 10.30 The physical techniques offer a phased response but do not include techniques that take children to the floor or routinely use pain. If children do end up on the floor, it offers techniques to turn them onto their back so that they can be monitored more effectively. No pressure is applied to the neck, throat, chest, abdomen, upper or lower back, sexual area or fingers. The aim is to support people and follow the natural movement of joints. There are advanced techniques for use with particularly challenging service users, and a recognition that it may be necessary to cause discomfort in extreme situations. There is one technique called a 'thumb release' but it is not designed to be the same as a thumb lock.
- 10.31 ECC&R (UK) encourage feedback from establishments about injuries but do not have a formal system for this. ECC&R (UK) is not BILD accredited and, again, expressed doubts about the validity of the scheme. The Open College Network or Anglia Ruskin University can accredit their courses.

### **DIVERT (De-escalation In Various Environments using Realistic Training)**

- 10.32 DIVERT has been developed within one SCH but is now also used in other children's homes across the local authority. The SCH previously used PRICE but the managers became concerned about the lack of theoretical underpinning, such as the antecedents to challenging behaviour, and the fact that it did not pay any attention to emotional well-being. Two senior managers adapted and simplified the PRICE techniques and have developed their own training programme consisting of a one-day theory course and four days on responding to challenging behaviour, including physical intervention.
- 10.33 The techniques are primarily based on a Figure of Four hold, which is used in most circumstances and is thought to be more effective than the wide range of techniques

previously taught. The holds are not pain compliant and there are no pain distraction techniques on the basis that once staff are trained in them, they will use them. Staff are told that they can cause discomfort if necessary in situations where they were being assaulted but the view expressed by others is endorsed: it is a mistake to teach skills based on worst case scenarios rather than typical events.

- 10.34 Restraints are said to have reduced by 60% under the new approach. DIVERT is not accredited but the managers responsible ensure that they attend external courses and continue to develop their skills and knowledge.

### **SCAPE (Safe Care And Protection in Essex)**

- 10.35 SCAPE was devised by one of the people who developed PRICE, and who still provided consultancy and trained the in-house instructors. It uses the same basic techniques although there may now be some divergence as the methods have developed separately.
- 10.36 As with PRICE, SCAPE has a Phase 4 that is not taught as a matter of routine. It is developed only if and when there is particular young person who presents an additional challenge. If there is a problem, in-house SCAPE instructors would be asked to develop an individualised package of holds. A decision has been taken within Essex not to use the pain compliant elements of PRICE and there is no prone restraint. There is a regular review process whereby the training department ask operational managers about the usefulness of the training.
- 10.37 Instructors have regular meetings with SCAPE and there are problem-solving meetings every two months and development days of all the instructors in Essex. They can approach the consultants for advice if needed. A decision has been taken not to seek BILD accreditation because of the costly nature of the process and a feeling that it would not add value. There is a plan, however, to present the SCAPE package to Essex LSCB.

### **Restraint Review findings on SCH restraint methods**

- 10.38 Although they appear to be used very rarely and with safeguards we are opposed to the presence of nose distraction techniques in several SCH systems as unnecessarily invasive. We also repeat our recommendation on double basket holds in line with STCs.

#### **Recommendation**

SCHs should remove the nose distraction technique and double basket hold where they are used as part of their restraint method.

- 10.39 We have no other specific recommendations on the SCH restraint methods themselves. All methods provided techniques which did not rely on pain compliance. Generally, we found that many methods had been progressively adapted to fit in with the ethos of the SCH and use was well-integrated within behaviour management.
- 10.40 However, as much as PCC and C&R there needs to be consistent independent review of the safety of SCH techniques and of the training and trainers used by SCHs. The BILD accreditation system does not adequately fill that gap. As Ofsted has remarked of SCHs:
- “there are no restrictions in legislation to stop anyone describing themselves as a trainer, or to prevent them introducing their own type of restraint”.*
- 10.41 These anomalies must be addressed. All SCH restraint techniques, training and trainers must be assured in future through the system of mandatory accreditation we recommend.

## 11. ACCREDITATION AND REGULATION

### *Key messages*

- There should be a new mandatory Accreditation Scheme for all restraint methods, training and trainers in the juvenile secure estate.
- The accreditation panel should be independent and feature medical expertise and operational experience of restraint techniques. A consistent objective risk assessment tool will be essential.
- Regulation should be strengthened across the secure estate through a Restraint Management Board, chaired at Ministerial level.

### **Overview**

- 11.1 There is currently no overall central regulatory framework for assessing the safety of restraint methods and the effectiveness of training and trainers in the secure estate.
- 11.2 Where bodies do exist, like the PCC Medical Panel and PCC Management Board, they are ad hoc and looking at only one sector of the estate. We believe that there is scope for a wider and stronger regulation of restraint in the secure estate and consider that this can be best delivered through a mandatory accreditation scheme.

### **Recommendation**

To provide transparency and reassurance on the safety, effectiveness and ethical validity of restraint methods, the Government should establish a mandatory Accreditation Scheme for all restraint techniques, training and trainers in the secure estate.

- 11.3 During consultation, we found widespread support, including from many restraint providers themselves, for an accreditation scheme. Under such a scheme, as we see it, an accreditation body would be responsible for assessing the risks of a restraint method against a sound evidence base. Should the method be considered safe and effective then the provider and its trainers would be assessed against a range of criteria to demonstrate that they are fit for purpose. Critically, only those methods and organisations receiving accreditation would be able to offer their services to the juvenile secure estate.
- 11.4 Two models of an accreditation scheme show how this might work; an established voluntary system run by the British Institute of Learning Disabilities (BILD) and a new system being developed by the National Institute for Mental Health in England (NIMHE) and the Care Services Improvement Partnership (CSIP) for mental health services.

### **The BILD scheme**

- 11.5 The BILD Physical Interventions Accreditation Scheme (PIAS) offers voluntary accreditation for organisations providing training in the management of violence and aggression and physical intervention techniques for services educating or caring for adults or children with learning disabilities and/or autistic spectrum disorder and/or emotional and behavioural difficulties and/or special educational needs in general.
- 11.6 PIAS does not extend to accrediting the actual techniques and holds used but accredits the organisation and trainers involved in delivering the training in a restraint method.
- 11.7 The basis of PIAS is BILD's Code of Practice in Physical Interventions. For admission to the scheme, all organisations must have formally adopted the Code and the training they offer

must reflect its standards. This requires a formal commitment to abide by the standards of the Code and to come forward for accreditation within two years.

- 11.8 In brief, accreditation is by evidence-backed written submission – which should include an external independent risk assessment of the physical techniques taught – and presentation to an accreditation panel comprising experts in physical interventions and professional and national organisations, including those with an interest in learning disabilities. Training organisations applying must also receive at least one pre-assessment panel visit to observe training in action and to assess procedures and processes.
- 11.9 Assessment is scored against 8 criteria:
- The organisation’s physical intervention policies, including its values base;
  - ‘Best interest’ which covers risk assessment, monitoring of physical well-being during restraint, post-incident support and review of outcomes;
  - Physical intervention techniques, including whether any techniques appear to impede breathing or otherwise are associated with elevated risk, or apply pain as an “effective component”. Techniques need to comply with the law and relevant sector specific guidance;
  - Health and Safety;
  - Course organisation and training;
  - Monitoring performance;
  - Evaluation and record keeping; and
  - Professional conduct
- 11.10 The assessment criteria requires that the principles of any physical intervention should be:
- considered only when all other methods have been examined and judged effective;
  - used as a last resort;
  - employing the minimum reasonable amount of force;
  - be used for the shortest possible time; and
  - part of a individual care and support plan.
- 11.11 Training organisations assessed as suitable by the panel receive PIAS accreditation for 3 years. Organisations failing to meet the assessment criteria may appeal or re-submit their application within 12 months. There is quality assurance built into the scheme, as accreditation may be withdrawn from organisations which fail to maintain standards.
- 11.12 There are 23 organisations currently accredited under the BILD scheme, including a number also currently providing restraint training in SCHs: CALM, PRICE, TCI and Team Teach. **Accreditation to the BILD scheme is voluntary. This is its acknowledged weakness.** The guidance published by DH/DfES in 2002 states that organisations *should* use training organisations accredited by BILD. This lack of mandate means that organisations not wishing to subject themselves to accreditation may simply ignore it without ramifications.

## The mental health scheme

- 11.13 The impetus for a focus on establishing a system for the accreditation and regulation of trainers and training, in the prevention and management of aggression and violence in mental health services in England, was the 2004 inquiry report into the death of David Bennett, who died at the Norvic Clinic following an incident of restraint.
- 11.14 The NIMHE/CSIP scheme for accreditation is based on the BILD model, but with a key difference:
- “if a system is to be introduced experience from the introduction of national training into learning disabilities services by BILD strongly indicates to have any meaningful impact the system should be mandatory”.*
- (NIMHE/CSIP draft accreditation and regulation proposal)
- 11.15 Under the NIMHE/CSIP scheme, any provider applying for accreditation should be able to demonstrate that its policies and procedures define its philosophy and values, and set out a framework of practice within which staff must operate. These policies and procedures should cover areas such as:

- Recognition, prevention and de-escalation strategies.
- Risk assessment and management.
- Approaches for the actual management of aggression and violence.
- Physical care and observation during and post restraint.
- Basic life support.
- Post incident support, review and reconciliation.
- Root cause analysis and sharing lessons learned.
- A robust monitoring and audit system to ensure action in response to recommendations occurs.
- The use of seclusion.

11.16 Organisations must also ensure that they have reporting systems which cover:

- Number and type of injury.
- Techniques associated with the injury.
- 'Near miss' situations.
- Review and follow up of the incident to conclusion.
- Key themes.
- Lessons to be learned.
- Proposed local strategies to minimise future re-occurrence.

11.17 Accreditation will be time limited and reviewed after an agreed period, for example 3 years, to ensure that the course content is regularly reviewed in light of any emerging research or practice guidance. Failure to meet accreditation standards means that the applicant will need to re-apply and be subjected to a new full accreditation. This system also does not appear to accredit particular techniques and holds.

### **An accreditation scheme for the juvenile secure estate**

11.18 We recommend a similar scheme for all restraint methods in the secure estate. No method should be exempt from accreditation. To be credible the accreditation scheme will need the endorsement and support of Government and the YJB.

#### **Recommendation**

The Government should direct that only accredited restraint techniques, training and trainers will be permitted in the secure estate.

11.19 We do not envisage this being simply an accreditation scheme for training and trainers. **For it to be effective, and to play a role in protecting the safety of young people, it must take into account the relative risks of the physical intervention itself.** The questions that Professor David Allen has posed in relation to risk and prone restraint apply equally, we feel, to all restraint methods:

- How effective is the technique in question? What degree of control does it offer over very disturbed behaviour?
- How technically complex is the procedure to execute? How many separate steps does it involve? How many steps require staff to make a sophisticated judgement (e.g. how much pressure to exert)?
- What is the potential harm to young people (in terms of physical pain, muscular-skeletal damage, respiratory distress, emotional distress etc)?
- What is the potential harm for staff (e.g. back injury)?
- What is the margin for error? To what extent are inherent risks exacerbated if the technique is performed incorrectly?

11.20 This may potentially place the accreditation scheme under the difficulty we have outlined in section 12: the absence of a proper evidence base against which to take judgements. As the NCB report commented on a review done for the Welsh Assembly:

*“The Welsh Review noted that, valuable as it is, even much of BILD’s own Code of Practice and Policy Framework is based on opinion and professional belief rather than empirical evidence”.*

(NCB, 2003, p55)

11.21 **In looking at the safety of restraint, we have identified a clear weakness in the lack of any systematic attempt to evaluate the risks of all the restraint techniques in the juvenile secure estate. We are not aware, in fact, that a workable tool currently even exists for doing so. This must change, not least because it is fundamental for underpinning a national accreditation scheme.**

11.22 So we welcome the work that the YJB has been doing with BILD to develop, for the first time, a Risk Assessment Tool for the juvenile secure estate.

**Recommendation**

The YJB should give priority to completing the development of a new Risk Assessment Tool to be used to provide consistent, objective evaluation of the safety of restraint techniques as part of the proposed Accreditation Scheme.

**Recommendation**

To underpin the Accreditation Scheme, the YJB should develop and maintain an evidence base of the relative risk and safety of all restraint techniques used in the secure estate, to include data on injuries or warning signs associated with use.

11.23 Under the BILD scheme all organisations seeking accreditation should have formally adopted the BILD Code of Practice. We consider that the creation of a similar value base for those seeking accreditation in the secure estate should be considered and suggest that the YJB’s Code of Practice on Behaviour Management is considered for this purpose [the Code will need to be reviewed and made more robust].

11.24 To prevent duplication, the Government might consider how in practice an Accreditation Scheme for the secure estate should fit in with the schemes currently operating in learning disability services and proposed for mental health. There may be scope to forge a common accreditation system. If not, thought should be given as to how those organisations whose training methods have already been scrutinised under the BILD scheme might get a head start in accreditation under the secure estate scheme.

11.25 We would not wish to be prescriptive about the composition of the accreditation panel but it should have wide representation to provide a rounded view of the safety, effectiveness and ethical efficacy of restraint techniques.

**Recommendation**

Membership of the Accreditation Panel should include experts drawn from physiotherapy, paediatrics, child psychiatry, orthopaedics, PTSD and other disciplines, together with those with operational knowledge of restraint techniques.

11.26 Preserving the independence of the Accreditation Panel will be imperative and we advise that to avoid conflicts of interest it should be independent from the main statutory bodies and providers in the secure estate.

## **Regulating restraint**

11.27 The Accreditation Scheme must be given oversight by a body that can bring together Government, providers, inspectors and other interests across the secure estate. The PCC Management Board – which it should replace – provides a good model. We believe that a similar body, **a Restraint Management Board extended to cover restraint in YOIs and SCHs and not just STCs**, should have a major role in not only managing the Accreditation Scheme but driving down the use of force.

### **Recommendation**

The Government should establish a Restraint Management Board, chaired at Ministerial level, to provide better regulation, give oversight to the Accreditation Scheme and help drive down the use of restraint across the secure estate.

- 11.28 As a minimum, the Restraint Management Board should:
- Oversee and direct the accreditation of restraint methods, training and trainers across the estate – including ensuring the Accreditation Panel contains the appropriate membership and consideration of how to make the process as objective as possible, e.g. through the risk assessment tool.
  - Champion restraint reduction strategies.
  - Consider the role of restraint in an overall behaviour management approach.
  - Develop a core body of knowledge for behaviour management and restraint practices and methods.
  - Review data and trends on restraint from across relevant sectors.
  - Identify and share good practice – providing a co-ordination mechanism to ensure information is shared between appropriate bodies such as the police, allowing for experience across the board to be shared and drawn upon.
  - Identify and commission research projects into areas in which more evidence is required.
  - Cover restraint not just in secure establishments but its use by escort providers.
- 11.29 **The Board must be the authority to ensure that change is made, is chaired at Ministerial level by the Ministry of Justice and the Department for Children, Schools and Families**, and should include representatives from:
- YJB
  - Prison Service / NOMS
  - STCs
  - SCHs – possibly Chair of the Secure Accommodation Network
  - Escort providers
  - Borders and Immigration Agency
  - Northern Ireland Youth Justice Agency
  - OFSTED
  - HM Inspectorate of Prisons
  - Department of Health
- 11.30 The Board must have the authority to ensure changes are made across the estate including in SCHs through the accreditation process, backed by OFSTED.

## 12. WHEN CAN RESTRAINT BE USED?

### *Key messages*

- Restraint in the secure estate should be used only for preventing the risk of harm. This would include risk of physical or psychological harm and risk of harm to a safe environment.
- Restraint should not be used simply to secure compliance with an instruction from a member of staff.
- In all cases, restraint should be subject to risk assessment and debriefing with young people and staff.

### **Overview**

12.1 We have felt a clear duty to provide guidance about when force might be necessary. Meeting this challenge has not been easy. During consultation we found widespread acceptance that it is sometimes necessary to use force to restrain children where their behaviour poses a high degree of risk to themselves or others. Beyond this, however, the circumstances in which it is appropriate to use restraint are less clear cut. As we shall see, not only are there differing approaches between secure settings to the question of when force can be used but, in the case of SCHs, inconsistencies within the setting.

12.2 First, we had to confront two immediate questions

#### *Is using restraint an admission of failure?*

12.3 Put another way, is the answer to the title of this chapter: 'never'. It might be argued that all restraint incidents should be viewed by establishments as an operational failure; that there should be a 'zero tolerance' approach to use of force. We understand these sentiments and wish to see restraint minimised where possible. But physically restraining a young person does not always mean you have failed. In some circumstances, it must be acceptable, even desirable, to use restraint; where the greater failure would be to place a child or others in danger.

12.4 Although staff universally acknowledge the importance of prevention, they regard the notion that restraint can be entirely avoided as naive and therefore ask for clear and sensible guidance on how to minimise the risk to those young people who must still be restrained. We have tried to bear this in mind in framing our recommendations.

#### *Is guidance needed at all?*

12.5 Some of those who responded to consultation thought that we should not seek to define the powers of restraint for staff in the secure estate. The Children are Unbeatable Alliance said:

*"It must be remembered that there are common law defences available for those who, in emergency or extreme situations, have to use necessary force to protect life and prevent injury. It is not necessary or useful to try to set out in statute particular rights to use force in relation to children, or to children in particular types of institution"*

12.6 We understand the thinking behind this view but believe that it would be worse to leave staff without explicit guidance, and therefore without any limitations, on when and how they can use force on young people.



## Current powers to use restraint in the secure estate

### STCs

12.7 Under Rule 38 of the STC Rules, as amended by the STC Rules (Amendment) 2007, no young person shall be physically restrained save where necessary for the purpose of ensuring good order and discipline or for the purpose of preventing him from:

- a) *escaping from custody;*
- b) *injuring themselves or others;*
- c) *damaging property;*
- d) *inciting another trainee to do anything specified in paragraph (b) or (c) above*

12.8 Even then staff should not use restraint if an alternative to force is available.

12.9 Rule 37 of the STC Rules states that *“an officer dealing with a trainee shall not use force unnecessarily and, when the application of force is necessary, no more force than is necessary shall be used”*.

### YOIs

12.10 The rules on use of force in YOIs, contained in Prison Service Order 1600, are those which apply to the adult prison estate. The use of force by staff in YOIs is deemed to be unlawful unless it is justified as:

- *reasonable in the circumstances;*
- *necessary;*
- *no more force than is necessary is used;*
- *proportionate to the seriousness of the circumstances*

12.11 What is reasonable in the circumstances is:

*a matter of fact to be decided in each individual case. Each set of circumstances are unique and are to be judged on their own merits.*

12.12 The use of force is explicitly linked in YOIs to the prevention of harm:

*It is important to take into account the type of harm that the member of staff is trying to prevent – 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:*

- a) *Risk to life*
- b) *Risk to limb*
- c) *Risk to property*
- d) *Risk to the good order of the establishment*

12.13 Prison staff are also given guidance that:

*“Force must only be used as a last resort and no more force than is necessary may be used.”*

### SCHs

12.14 The circumstances in which restraint can be used in SCHs differ from STCs and YOIs in that restraint is not allowed for preserving good order and discipline. The guidance for SCHs has been refined and adjusted over the years but the Children Act 1989 Guidance & Regulations on Residential Care state that restraint may only be used:

*to prevent a child harming himself or others or from damaging property. Force should not be used for any other purpose, nor simply to secure compliance with staff instructions.*

12.15 Guidance on ‘Permissible Forms of Control in Children’s Residential Care’ (Department of Health 1993) sets out seven guiding principles relating to the use of physical restraint in all children’s homes:

- a) *Staff have good grounds for believing immediate action is necessary to prevent*

*significant injury to the child or others or serious damage to property*

- b) *Staff should take pre-emptive steps to avoid the need for restraint (dialogue and diversion)*
- c) *Only the minimum force necessary to be effective should be used*
- d) *Every effort should be made to secure the presence of other staff before applying – as assistants or witnesses*
- e) *As soon as it is safe restraint should be relaxed to allow child to regain control*
- f) *Restraint should be an act of care and control, not punishment*
- g) *Restraint should not be used purely to force compliance with staff instruction when there is no immediate risk to people or property.*

12.16 Restraint in SCHs is allowed in cases when a child attempts to run away but here there are different criteria:

- a) *The staff member must have reason to believe that the attempt to escape has a realistic chance of success unless some sort of intervention is made.*
- b) *Physical restraint should be attempted only where there is sufficient staff at hand to ensure it can be achieved safely.*
- c) *Physical intervention should not be substituted for waiting patiently when, for example, a child has got onto a roof and, although in some danger, is unlikely to escape further; physical intervention could create greater danger.*

12.17 The Secure Accommodation Network seeks to provide SCHs with advice on “Restrictive Physical Interventions” through its Code of Practice (2005), by which RPI may be used to prevent children from:

- a) *Harming themselves or others*
- b) *Causing significant damage to property*
- c) *Inciting other young people to cause physical harm or damage to property.*
- d) *Abducting both from within and outside of the Unit.*

12.18 As has been noted elsewhere<sup>39</sup>, the inclusion of incitement of a justification for use of force is a criterion taken from the STC Rules and may have questionable validity for SCHs.

12.19 There is an anomaly in SCHs caused by the fact that different legal provisions apply to the use of force in education than in the rest of secure settings. Amongst the criteria for the use of force in the Education and Inspections Act 1996<sup>40</sup>, school staff may use reasonable force to prevent a pupil:

*Prejudicing the maintenance of good order and discipline at the school or among any pupils receiving education at the school, whether during a teaching session or otherwise.*

12.20 While this appears to enable teaching staff to use force in circumstances that care staff cannot, in practice, most SCHs do not allow the difference, because although they provide full-time education they see themselves as primarily social care settings and therefore bound by the Children’s Homes regulations.

### **The YJB’s Code of Practice**

12.21 For all secure settings, the YJB’s Code of Practice says that physical restraint must only be used:

- as the result of a risk assessment;
- not as a punishment, or merely to secure compliance with staff instructions;

<sup>39</sup> Hart D *Restrictive Physical Intervention in Secure Children’s Homes*

<sup>40</sup> DCSF *The Use of Force to Control or Restrain Pupils* (2007)

- only as a last resort, when there is no alternative available or other options have been exhausted;
- with the minimum force and for the shortest possible period of time; and must be
- proportionate to the assessed risk.

## 6 principles for the use of restraint

- 12.22 We believe that the Government needs to rethink the approach to using restraint in the secure estate. We believe that the criteria by which restraint may be used should be consistent across the settings. We think it would be helpful, when considering how this can be achieved, to focus on the need to create a safe environment for young people and staff. The phrase ‘good order and discipline’, may be acceptable for legislative purposes – as non-lawyers we do not offer a view about that - but in more general use, and particularly in guidance to staff, there is a risk of its being misunderstood as meaning simple compliance with staff wishes.
- 12.23 We present our proposals in the form of a framework of 6 principles. We are grateful to the National Children’s Bureau, whose approach, put forward during consultation, contained within it the key elements we wish to see for determining whether restraint is justified.

### Recommendation

To ensure a consistent approach to the use of force across the young people’s estate, the Government should re-examine the legislation and guidance on restraint against the principles.

#### Principle 1: Force should be used only as a last resort.

- 12.24 ‘Last resort’ is not defined in law, but we understand it to mean that if alternatives for managing the young person’s behaviour – other than force – have a realistic chance of success, their use is preferable. The critical need is for staff to have credible, effective alternative strategies.
- 12.25 Staff should be required to demonstrate in all but the most exceptional circumstances that they had attempted to defuse a situation first.
- 12.26 But ‘last resort’ does not necessarily mean that all the other low level alternatives *must* be tried and seen to fail before force can be considered. There are occasions in which the immediate use of force is essential to prevent the level of risk rising. The Children’s Rights Director of England has made this point well:

*“Within safeguarding practice there may be exceptional circumstances in which to keep a child safe from imminent danger (e.g. from an attack or impending attack) restraint can, at times, reasonably be a measure of the first resort”.*

#### Principle 2: Force should be used only to prevent the risk of harm.

- 12.27 We propose that this should be the sole overriding criterion when staff are judging whether to use force. It would be the responsibility of staff to exercise a judgment about whether that risk is present or not and if restraint is the only way of dealing with it.
- 12.28 We see the ‘risk of harm’ falling into two categories:
- a) ***The risk of physical or psychological harm to a young person or another person, which would include staff.***
- 12.29 Physical harm would include injury, assaults, bullying and self-harm.

12.30 The introduction of the prevention of psychological harm we consider to be important, although we accept that assessing the potential risk here may be more difficult than physical harm. The sort of scenario we have in mind would be where a young person was on the point of impulsively destroying all the family letters belonging to another child. If staff determined that to do so would risk psychologically damaging that child and there were no alternatives for avoiding that risk, then restraint might be justified against the young person.

**b) The risk of harm to a safe environment.**

12.31 Preventing the risk of harm to a safe environment may appear, on the face of it, to be compatible with ensuring 'good order and discipline' or risks to the 'good order of the establishment', by which STCs and YOIs can currently justify the use of force.

12.32 To a degree, we accept that some force permitted under the existing law may also be justified under our proposal. Any secure unit operates in what is by definition a closed environment, and managers must ensure that it is run safely for the benefit of all children and that its practices and processes are carried out in an orderly fashion. Indiscipline, to such a degree that it threatens harm to the safe environment has to be addressed. Lack of discipline at Oakhill STC, left unchecked, led to the creation of an unsafe environment which generated high levels of restraint.

12.33 But we do not equate preserving a safe environment with automatic use of restraint in all situations where good order and discipline might appear to be at risk. It is not, as good order and discipline can become, "do as I say", where force is used to reinforce staff wishes. We are against restraint being used for mere compliance. Instead, staff must have a reasonable belief that the level of safety in an establishment would be undermined if they did not use force.

12.34 To illustrate this we would point to an example of indiscipline raised often during our review – when a child refuses to go to bed. In these circumstances, staff should employ normal de-escalation and defusion skills to deal with the situation. However, staff would have to assess the risk of either physical or psychological harm to an individual or to the safe environment if the situation continued. If, for example:

- Staying with the young person would leave a vulnerable young person at risk of self – harm unchecked in their bedroom then restraint to bring the incident to an end might be justified under preventing the risk of physical harm; or
- Staying with the young person looked likely to provoke concerted indiscipline from other young people present, and there was no way of removing them from the scene, then using restraint to end the situation might be justified under preventing harm to a safe environment.

12.35 But if there is neither a risk of physical or psychological harm, nor a risk to a safe environment then staff should avoid restraint. It is critical that staff are trained to balance genuine risks, to look at environmental factors, rather than take a predetermined course to respond to an incident by force. It would not be justified to end the incident for its own sake or to enable the member of staff to end their shift. They should continue to use alternative strategies. We know that, often, something has happened for the young person to behave in this way - a phone call from home, a call from a lawyer with bad news, or an element of loss or perceived loss.

12.36 To use another example, a child may be damaging property. If in damaging the property a child is putting themselves or others at risk of physical or psychological harm – smashing furniture to use as a weapon – then based on the risk, force may be justified. But if the damage is just to their own possessions, in a way that is not harmful, staff may be justified in using alternative skills or leaving them.

12.37 It is important to say that in all cases:

- Force may be justified even if the harm is not imminent. Staff have a duty to intervene immediately to prevent children putting themselves or others at risk or seriously damaging property, and it is the *action* that needed to be immediate – not the *risk*.
- There are no absolutes. The restraint itself may cause harm. Staff need to balance the harm, both short-term and long-term, both physical and psychological, that might result

from a young person being restrained against the harm of doing nothing or taking another course of action. All options may have adverse consequences.<sup>41</sup>

- Although it is a good guiding principle that the force used must never lead to greater harm than it is seeking to prevent, this is not always self-evident at the time. There are often fine judgements to be made. Staff cannot be expected to know what ultimate harm they are seeking to prevent, but through good dynamic risk management they can assess the risks of using force against the risks of inaction or another form of intervention.
- This makes good risk assessment critical. Not only does this mean that risks must be identified in a child's personal behaviour plan but that staff should be able to undertake risk assessments in each separate incident, not just in relation to the child concerned but in relation to the risk to and from others. We consider Holding Safely's guidance on the question to be asked on individual risk assessments as good practice and worth repeating here:

<b>Holding Safely – Risk Assessment and Care Planning</b>
<p><b>Assessing risk</b></p> <p><b>Risk assessment – each event</b></p> <p>Although it may not be clearly stated, you are carrying out a risk assessment each time you think about restraining a child. The assessment will usually include considering the following:</p> <ul style="list-style-type: none"> <li>• Who is at risk of harm and what is the nature of the risk?</li> <li>• How likely is the harm and how serious will it be?</li> <li>• Would restraining this young person really be about safety, or is it about my own feelings of powerlessness and frustration?</li> <li>• Will the consequences of restraining the child be less or more harmful than the behaviour itself?</li> <li>• What will be the effect on the rest of the group of restraining the child?</li> <li>• What would the consequence be of not restraining the child?</li> <li>• Are there alternatives that I could use?</li> <li>• Are there enough staff with the right skills to restrain the child safely and effectively?</li> <li>• What is the least restrictive and most respectful way of restraining the child to prevent harm?</li> <li>• What is the plan if the young person cannot be restrained appropriately?</li> </ul> <p>The outcome of this rapid assessment should be in line with the child's care plan unless there are clear reasons based on the risk of harm that justify overriding it.</p>

**Principle 3: The criteria for using force should be consistent across settings.**

12.38 The reasons why children might need to be restrained should be the same across the secure estate. We can see no justification for different treatment. The Government should make it clear especially that the same criteria for use of force should apply in SCHs including education and should review existing guidance in the light of this.

**Principle 4: The minimum force necessary should be used, and this is proportionate to the identified risk.**

12.39 The degree of force used must demonstrably be in proportion to the circumstances of the incident and the seriousness of the behaviour or consequences it is intended to prevent

**Principle 5: Only approved restraint techniques should be used.**

12.40 The Accreditation Scheme we propose in this report should be adopted: only techniques accredited for their safety, efficacy and effectiveness will be permitted in the secure estate.

<sup>41</sup> Allen B *Safeguarding Children, Safeguarding Staff* (2008)

**Principle 6: Force should only be used in the context of an overall approach to behaviour management, including de-escalation and de-briefing, in which children and young people are actively involved.**

- 12.41 Good debriefing with children and staff is also essential. Staff will need to justify their reasons in the event of force being used and demonstrate the harm they were seeking to prevent. We believe that systems of debriefing, together with risk assessment of young people and their changing circumstances, mean that over time, practice will improve and the incidence of using restraint in these circumstances will reduce. We deal in more detail with reducing restraint and recommendations for debriefing in Chapters 13 and 15.

## 13. PREVENTING RESTRAINT

### *Key messages*

- All establishments must take a holistic approach to promoting positive behaviour by young people where the need for restraint is just one rarely-used element.
- The Prison Service has not matched STCs and SCHs in placing any use of force within a full behaviour management approach and need to take positive action to address this.
- All units in the secure estate must have an auditable Restraint Reduction Strategy to make explicit what they are doing to minimise use of force.

### Overview

13.1 So much of our report has had to deal with restraining young people. But we would miss an opportunity if we did not set out factors which we see as key to avoiding the need to use force. That should be a shared ambition for everyone working in the secure estate. These factors are:

- The place of restraint within Behaviour Management
- Restraint Reduction Strategies
- Leadership
- Ethos and culture
- Management arrangements
- Staffing
- Training
- Environment
- Contractual arrangements

### The place of restraint within Behaviour Management

13.2 The YJB has sought consistency since 2006 on the practices adopted throughout the secure estate in behaviour management by a Code of Practice, underpinned by ten principles:

- The responsibilities of managers are clearly set out
- There is a clear statement of acceptable behaviour
- There is a coherent system of rewards and sanctions
- There is a planned approach to managing behaviour
- There is a process for consulting young people
- There is an independent advocacy service
- There is a clear complaints procedure
- There is a process for diversion, de-escalation and defusion
- There is a clear system for removal from normal location
- There is a system for restrictive physical intervention.

13.3 It was not part of our brief to review behaviour management arrangements in the light of this Code of Practice but restraint cannot be properly understood, nor successfully reduced, when it is considered in isolation. In the event, some of our conclusions echo the Code of Practice, but we feel them so important we make them specific recommendations in this report.

### **Recommendation**

All units should ensure that any use of restraint is placed within an overall behaviour management strategy.

- 13.4 **Overall, we found that both SCHs and STCs are taking a more holistic approach to promoting positive behaviour and the use of restraint is just one element of managing challenging behaviour among young people.**
- 13.5 The National Minimum Standards for Children's Homes require every SCH to have a behaviour management policy, specifying the measures of control, restraint and discipline that may be used. Of the 16 SCHs that provided copies of their policies to Di Hart, all were compliant with this requirement although their quality and range was variable.
- 13.6 All but two had integrated restraint into their overall guidance on behaviour management in order to emphasise that it was part of an overall repertoire of techniques required to manage children's behaviour and must not be seen in isolation. Most of the policies were needs-led, which involved the children to a greater or lesser extent in a partnership approach with staff to understand and overcome their behavioural problems. In some, children were active in devising and reviewing their own behaviour management plan. This would include the situations that caused them stress, the behaviours that might ensue and the best way of managing those behaviours. Children may be invited to express a view on the types of physical intervention that they would prefer. For example, children may find it distressing to have people approaching them from behind or to be held face down on the floor.
- 13.7 STCs have also made strides in the direction of better behaviour management, although the recent HMIP report on Oakhill has remarked on improvements needed there. Rainsbrook for example, has impressive strategies for young people which seek to reinforce and reward positive behaviour and reduce the need for sanction. Rainsbrook feature a range of Tailored Individual Plans for children to identify triggers to unacceptable behaviour and tactics for avoiding or defusing them. There is a good incentive bonus scheme, which rewards young people for positive behaviour. There is ongoing consultation with the young people about the effectiveness of behaviour management strategies during their stay and thorough exit interviews. Rainsbrook has also introduced voluntary 'restorative justice' meetings with its young people, to help them resolve any differences they may have with other young people or staff members.
- 13.8 Hassockfield STC is using, as part of a pilot with the YJB, a crisis prevention and intervention model called 'Therapeutic Crisis Intervention' (TCI) which assists organisations in de-escalating potential and actual injury to children and staff, and teaching young people adaptive coping skills (TCI is also used in four SCHs). TCI provides a consistent template for the conduct of staff and young people which is easily understood and applied.
- 13.9 The key elements of TCI are:
- An Acceptable Behaviour Contract, which the young person should discuss and sign as part of induction. The contract sets out what is expected of a young person and what rights they will have in return, such as being treated to respect and dignity and being rewarded with incentives for positive behaviour and achievements.
  - Behaviour Support Plans for all young people to be completed after discussion with the young person within 24 hours of admission and updated weekly.
  - Individual Crisis Management Plan (ICMP) for those young people with behaviour assessed as representing a significant risk of harm to other young people, to themselves or to staff, or who have been involved in multiple incidents. For these young people, the personalised plan aims to ask:
    - When is the young person likely to engage in the behaviour?*
    - What function does the behaviour serve?*
    - What is the young person trying to communicate through the behaviour?*
    - What other factors are contributing?*
- The ICMP responds to this crisis behaviour with a plan to eliminate the need for external controls, by helping the young person develop replacement behaviours and more appropriate coping skills. The Plan should also include specific intervention strategies, including physical intervention if necessary.
- To support these intervention strategies, the ICMP requires details on:
- Health issues, e.g. any medical complaint such as asthma, heart problems, etc that would exclude or limit the use of restraint;



- Dangerous behaviours, e.g. self-harm, violence, damaging property, and whether behaviours are planned or reactive;
- Pre-crisis usual behaviours, e.g. whether the young person has been diagnosed with ADD/ADHD, Aspergers's syndrome;
- Crisis triggers for the young person and what makes the situation worse;
- The de-escalation techniques that work best to manage the behaviour; and
- If restraint is required, what techniques can be used.

13.10 A Life Space Interview debrief takes place following any incident to help young people understand their behaviour and address their needs.

13.11 **This approach is not unique to TCI. There are a number of behaviour management models in the secure estate which include similar elements. But we have been particularly impressed by the effect TCI has had in helping to reduce use of force where it has been used in the secure estate.** With the help of TCI, Hassockfield STC has reduced use of PCC by 32.8% in 2007. Woodlands Justice Centre in Northern Ireland has recorded only two episodes of restraint in the three months between 1 February and 30 April 2008. Other schemes where TCI is used have also reported success.

13.12 **In YOIs, we found much less evidence of comprehensive behaviour management than in SCHs and STCS, with good examples in individual establishments being the exception.** Wetherby YOI is one, having developed its own behaviour management policy, which will be implemented in June 2008. The policy aims to provide tools to help staff provide emotional and environmental support to young people to reduce stress and risk and to teach them more constructive ways of dealing with feelings. Such initiatives are often the result of energetic initiatives by Governors and Safeguard managers in YOIs. There is little sense of a positive co-ordinated approach to behaviour management across YOIs and consequently Prison Service efforts to reduce restraint appear disjointed and half-hearted.

13.13 **As a result we take the positive step of recommending a specific behaviour management approach for the whole YOI estate.** We propose TCI, although accept there may be other suitable approaches – they key thing is that they should contain the core elements of TCI.

#### Recommendation

The Prison Service should adopt Therapeutic Crisis Intervention or a similar effective behaviour management approach in all YOIs.

13.14 We do not accept any suggestion that approaches like TCI are somehow uniquely suitable for smaller care settings and cannot work in larger establishments like YOIs. Proactively preventing and/or de-escalating a potential crisis situation with a child or young person, managing crisis situations in a therapeutic manner and helping children and young people to help improve their coping strategies afterwards are skills which should be universal across the secure estate. And we note that for its behaviour management strategy, Wetherby YOI, a pathfinder in these matters, has chosen a method based on TCI.

13.15 Should the Prison Service choose TCI as its behaviour management approach, we suggest:

- The Prison Service may wish to learn the lessons of the Hassockfield pilot before implementing TCI.
- It need not introduce TCI's stand-alone physical restraint system, which uses prone restraint. Units in the secure estate which use TCI have dispensed with its physical system in favour of their own methods.
- TCI must be fully integrated within YOI safeguarding, violence reduction and anti-bullying strategies, which currently lack adequate reference to use of force.

### *Compliance with the YJB's Behaviour Management Code of Practice*

- 13.17 So far the compliance of secure units with the Code of Practice has been measured on the basis of individual self-assessment to the YJB. This has weaknesses, because units can over-report achievement and see the process as a 'tick-box' primarily for the benefit of the YJB. This needs to change. Establishments must own the Code of Practice as part of their business and embed it within their policies and procedures on restraint.

#### **Recommendation**

The YJB should proactively monitor compliance with the Behaviour Management Code of Practice to ensure establishments are using it for continuous improvement in managing restraint.

### **Restraint Reduction Strategies**

- 13.18 We met many in the secure estate who are dedicated to driving down use of restraint. But in very few units have we seen that intent backed by a clear statement of concrete actions and a commitment to devote resources to the goal of minimising restraint. We wish to see positive action in this direction.

#### **Recommendation**

Every STC, YOI and SCH should be required to produce, publish and report against a Restraint Reduction Strategy setting out how they propose to reduce the use of force on children and young people.

- 13.19 There are a number of toolkits to measure restraint reduction but little use has been made of them so far. An audit tool developed by Dr David Colton<sup>42</sup> is one of the best known. The audit tool provides a 'road map' for restraint reduction and enables an organisation's progress to be measured against essential themes required for effective restraint reduction: Leadership Orientation & training; Staffing; Environmental Factors; Programmatic Structure; Timely and responsive treatment; Planning; Processing after the event. This tool, or a similar one, could provide the basis for independent auditing of the effect of Restraint Reduction Strategies.

#### **Recommendation**

The YJB should commission regular independent audit of the progress of establishments against their Restraint Reduction Strategies.

### **Leadership**

- 13.20 We have observed in the course of our visits that the propensity for using restraint is significantly influenced by the attitude towards children which managers instil in their staff and by the methods they choose to run their regimes. Leaders within a closed environment provide a reference point for the behaviour of all staff and young people within the establishment. This establishes the 'culture' of the organisation which is fundamental to the adoption of a professional and appropriate attitude to the management of challenging behaviour and therefore to the use of restraint.

### **Ethos and culture**

- 13.21 Nothing influences an establishment's readiness to use force more fundamentally than its ethos and culture. Every culture should aim to make an establishment as restraint-proof as possible. The units which have been most successful in driving down the use of force are

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<sup>42</sup> Colton D (2004) *Checklist for assessing your organization's readiness for reducing seclusion and restraint*

those with a culture which sends strong messages to staff that they must act reasonably at all times in the best interests of the child; and that if they do so they will be supported.

13.22 We heard much about the need for staff to develop therapeutic relationships with children. While this finds expression most obviously in health settings, such as St Andrew's hospital in Northampton, we understand it in the context of the secure estate to mean trusting, two-way relationships between staff and children, which encourage young people to develop and find alternatives to violent and challenging behaviour. For this to be effective, staff need the time and skills to engage in the right ways with young people. SCHs and increasingly STCs appear to us more successful at this than YOIs.

13.23 We do not doubt that the Prison Service takes seriously its duty to safeguard and promote the welfare of young people. Its Order 4950 on the 'Care and Management of Young People' acknowledges that:

*"every care must be taken to ensure that both the conditions of custody and regime activities promote their well-being and healthy growth".*

13.24 Some YOIs are delivering specific offender behaviour programmes for young people. We met a number of thoughtful prison officers who appeared good role models for young people. But the culture and regimes of YOIs as a whole fail to meet the aspiration of the PSO that "custody cannot just be about containment".

#### *Admission and induction of young people*

13.25 A young person's admission to a place of custody is a crucial time, when the responses of staff and the process of admission set the tone for the relationship the young person is likely to have in the establishment. It is also frightening for the young person, none more so than when they experience or witness restraint for the first time.

#### **Recommendation**

Establishments should inform children and their parents or carers, of their restraint policy, methods used and safeguards in place.

13.26 We also wish to say something about full, or strip-searches. Policy in most parts of the secure estate is to subject every young person to an undignified and distressing strip search or "full search" on arrival, even if this is late at night (the young person having been transported often for many hours from court) and irrespective of whether the young person has suffered physical or sexual abuse in the past.

13.27 We can see no justification for full searches on all young people on admission. The need to balance child protection with the need for security can be met by making any full search subject to prior risk assessment. The provision of better information about a young person – background, offences, sentences, vulnerability, any history of drugs or violence etc – seems a basic requirement of the system.

13.28 We urge a review of the policies and practices in place on full-searching across the estate as a matter of urgency.

#### **Environment**

13.29 All STCs were purpose built in the last 20 years. However we saw many of the buildings as being poorly designed for the purpose they serve and some simply not 'fit for purpose' – rooms and corridors were cramped, bedrooms and bathing facilities which prevented subtle observation and increased the risk of self harm. This will come as no surprise to those working in the STCs.

13.30 We do not conclude that the design of the building is the only factor influencing this outcome, however there is no doubt that it is of crucial importance and seen as highly significant by staff and young people. Well designed, maintained and cared for buildings inspire respect and are less likely to be vandalised than those where graffiti covered walls (including in some cells) and poorly maintained toilet facilities are the norm.

- 13.31 Little attempt seems to have been made when undertaking new projects to learn from the experience and design of the other STCs and avoid repeating previous mistakes. Where lessons have been learned, the design of the building and its 'fitness for purpose' is evident. Good design:

- removes the need for fences and keys, but maintains security
- enables a variety of activities to take place involving substantial numbers of young people within the establishment, without a high risk of group disturbances and
- appears to give rise to a high degree of safety for all

#### **Recommendation**

Future design and construction of STCs should build on the successes of some of the more recently built units such as Woodlands in Northern Ireland, which was the best designed we saw and in which restraint is being successfully minimised.

### **Management arrangements**

- 13.32 There is general consensus among those working in custodial environments that the management of young people within secure settings is one of the most difficult custodial tasks. It requires a degree of dedication and commitment which is different from, and often more demanding than the custody of adults. This is particularly important in YOIs, where the rules, regulations and restraint techniques which are designed to be applied to adults, are also applied to juveniles. As a result, the 'adult' culture dominates.

- 13.33 We believe that it is simply not possible to provide a 'child centred' environment on sites shared with adults (split sites). The problem is compounded where staff are required to move from one site to the other when called upon to deal with violent or high risk incidents and where they are called to assist when a planned restraint is to take place. Moreover staff and managers consider that their experience of working with young people places them at a disadvantage when it comes to promotion, if they stay too long. For wider operational reasons, all Prison Service staff are deployable across the estate and turnover of governors and managers in YOIs can be high.

- 13.34 The Prison Service should seriously consider specialisation for managers and staff in order to ensure that only the best trained people deal with the most challenging group of prisoners:

#### **Recommendation**

YOIs should be designated a specialist system within the Prison Service with their management a discrete specialism. Career opportunities should be created for managers and staff which reward their expertise in working with young people.

- 13.35 We believe that the majority of staff who obtain satisfaction from working with young people, and those managers and Governors who have developed valuable expertise in this work, would welcome such a change.

- 13.36 **We believe this to be so important for the management of the custody of juveniles – particularly since such a high proportion of them are held in YOIs – and so fundamental to the incidence and the nature of restraint that we urge that serious consideration be given to this matter and for Ministers to require a response from the Prison Service within a specified timescale.**

### **Training**

- 13.37 We believe that the training of staff is fundamental and underpins professional practice in relation to the care and custody provided and particularly in the use of restraint. We have therefore included a chapter in this report specifically on training (see Chapter 17).

## Contractual Arrangements

- 13.38 We have not been shown the detail of the contractual arrangements between the YJB and the STCs for reasons of commercial confidentiality. However, in the course of our wide-ranging discussions, it has been suggested that the contracts – and in particular the penalty clauses in the contracts – should be more concerned with the standards of care and custody provided, than technical specifications and concerns about the buildings etc. This would enable the YJB to be able to exert greater influence, than at present, over the practice standards in STCs, including the use of restraint.

### **Recommendation**

The focus of YJB monitoring should be on qualitative treatment of children not contract compliance. Monitoring must be timely, effective, noted and acted upon.

## 14. RECORDING AND MONITORING RESTRAINT

### *Key messages*

- There is a need for better, more consistent reporting, monitoring and analysis of information on restraint by units across the estate.
- Young people should be able to give their own views and to report any injuries as part of standard restraint incident reporting in all units.
- The YJB through its new Assurance Monitoring regime should hold establishments to account for their use of force including the reliability of their restraint data.

### **Overview**

- 14.1 In order for us all to be sure that restraint is used appropriately, a robust system for recording and monitoring the use of restraint must be developed. Proper recording and monitoring of information underpins a process of quality assurance and review of individual practice, allowing deficiencies to be identified and remedial action to be taken where necessary. While the YJB and others have an important monitoring role here, fundamental responsibility lies with establishments themselves. The whole process must therefore be supported by a coherent framework of independent reporting and inspection.
- 14.2 The current arrangements for recording information about restraint in the different secure settings are set out below.

### **STCs**

- 14.3 When a young person in a STC has been subject to any PCC hold, staff involved should complete an incident report immediately afterwards setting out why the action was necessary and providing details of the force used. This is signed by the unit manager, duty operations manager and duty director and copied to the YJB monitor within 12 hours. It is evident from our visits and from previous inspections that the completion of incident forms varies in quality and it is not always clear when de-escalation techniques have been used.
- 14.4 The STC Director is responsible for reviewing PCC incidents to ensure that restraint was used within the rules, and to learn any lessons which could prevent similar situations from arising. The YJB monitor checks that this has been carried out by reviewing incident reports. The monitor can raise issues with the Director or refer concerns to local child protection agencies where appropriate. Monitors told us that there are still problems with correlation of Use of Force forms, with discrepancies on the types of holds used. Any incident is logged in the STC's physical restraint care log book. Records are checked weekly by a nominated head of department and audited.
- 14.5 The monitoring and analysis of PCC in STCs tends to be detailed. We saw examples of the monitoring of overall incidents, reason for force, the location and time of incidents, average use per young person, the type of hold used and injuries. PCC is raised at the daily briefing meetings, the weekly SASH/anti-bullying and Trainee Monitoring meetings and at monthly strategic meetings. The monthly PCC summary is submitted to the YJB monitor locally and the YJB centrally, along with exception reports on injuries. STCs also hold regular safeguarding children panels to assess PCC use, involving external agencies such as child protection social workers, police, healthcare staff and advocates.

### *Recording restraint used for good order and discipline*

- 14.6 Since the Secure Training Centre (Amendment) Rules 2007 were passed STCs have reported very few instances of restraint being used for "good order and discipline". From our review of recording of restraint in STCs this does not surprise us. This is because the use of force forms we saw did not even allow it as a possibility. Use of Force forms completed at

Hassockfield in November 2007, for example, asked staff to select the criteria under which PCC was used, from among the following:

- Prevention of self harm
- Preventing harm to others
- Preventing significant damage to property

14.7 There was no mention of “good order and discipline” as a potential reason for use of force. There was a similar absence in the Use of Force form used in Rainsbrook. This appears an unacceptable omission in the circumstances and it should be rectified.

#### **YOIs**

14.8 All YOI officers involved in restraint must complete a Use of Force form, on which should be recorded details of the incident, the staff involved, the circumstances which required the use of force and the nature of that force – if it was C&R, the officer must state whether the restraint was standing, supine, prone or seated. Staff make a statement about the incident in an Annex to the form and are prompted to give details, including whether de-escalation techniques were used, where the young person was relocated and whether injuries were sustained. Healthcare staff report on any injuries on separate medical sheet.

14.9 Minutes of Use of Force committees can reveal problems with incomplete forms, errors and missing data. When they are completed, Use of Force forms can be of poor quality, which is perhaps accounted for by the feeling amongst some prison staff that completing the forms is a burden which can impact on the running of the regime. In one YOI, officers described having to shut down a wing for 2 hours, with the young people kept to their rooms and denied association, because the few staff were required to complete a Use of Force form on an earlier incident.

14.10 All C&R reports are reported to healthcare and security department, with reports reviewed by the Deputy or Duty Governor and Head of Safeguarding, who makes the decision whether to refer the incident to external agencies. If there is cause for concern about the frequency of restraints by any officer, the Safeguarding Team takes it up with the Governor.

14.11 Safeguarding Committees in YOIs provide the main forum for external scrutiny of use of force, bringing together local agencies such as the Local Safeguarding Children Board, advocacy services and the police child protection officer (although attendance can be patchy – in one YOI the YOT representative had attended just once in four months). The level of scrutiny varies and not all Committees go beyond looking at simple levels of force used into trend analysis and the examination of injuries and complaints arising from C&R.

#### **SCHs**

14.12 Recording arrangements in SCHs tend to be rigorous. All the SCHs appear to monitor their practice in restraint on case-by-case basis. Managers see individual records of restraint, and discuss any queries or concerns with staff before signing them.

14.13 SCHs have to comply with the National Minimum Standards on the recording of restraint, although there is no single format on which records should be made, with establishments being responsible for devising their own. Records are kept in a separate dedicated bound and numbered book, and include the name of the child, the date, time and location, details of the behaviour requiring restraint, the nature of the restraint used, the duration of the restraint, the name of the staff member using restraint, the name(s) of any other staff, children or other people present, the effectiveness and any consequences of the restraint, any injuries caused or reported by the child or any other person, and the signature of a person authorised by the registered person to make the record. Many forms go beyond the minimum to include details of de-escalation used and how the incident was resolved.

14.14 This book should then be regularly monitored by the registered person (i.e. person responsible for the home) to ensure compliance with policy and identify any patterns which require intervention – either amongst specific staff or children or practice in general. The registered person must record their comments about the appropriateness of each restraint and any subsequent actions and sign the record to indicate that the monitoring is taking place.

- 14.15 Practice in all children's homes is regularly scrutinised by Regulation 33 visitors<sup>43</sup> who have access to the records of restraint and other behaviour management measures. They also have an opportunity to talk to children. This role is undertaken differently in different local authorities and the level of skill and knowledge of the visitors varies widely. Other local monitoring seems to be minimal. Some SCHs regularly send their data to external managers within the local authority or to the safeguarding team but there is rarely any formal process for reviewing the information.
- 14.16 An additional level of scrutiny is provided by some of the training providers, who actively request regular reports from the establishments that use their method of restraint. All SCHs taking children through the criminal justice system also receive visits from YJB monitors but we gained an inconsistent picture about their role.
- 14.17 There is no standard approach to the notification of incidents of restraint to their professional network and parents/carers. Some establishments routinely send copies of all incident reports to the child's Youth Offending Team and/ or social worker; some will include the information in a regular update report whereas others will only notify external people if requested or there is a particular reason to do so, such as a complaint or an injury. Parents are less likely to be informed as a matter of routine.

*Reporting restraint on welfare placements in SCHs*

- 14.18 Currently there are differences in the central reporting arrangements for children placed by the YJB and those placed under section 25 of the Children Act 1989 on welfare grounds. There is no requirement to report to the YJB incidents of restraint, or injuries, on welfare placements. Where SCHs have YJB beds they sometimes include this data in their monthly briefing but it is not collated or analysed. There should be more consistency in the reporting of incidents of restraint and injuries to all children in secure settings, but we accept that because of their lack of relationship or agreements with SCHs holding only welfare young people this is not a role for the YJB.

**Recommendation**

To help provide an accurate picture of their use of force, SCHs should record, and report to Department for Children, Schools and Families for collation and analysis, incidents of restraint and restraint injuries to young people placed on welfare grounds.

**Inspections**

- 14.19 All YOIs within England and Wales which are monitored by the YJB are also inspected by HMIP at least every five years and may be on a full announced, or unannounced follow-up basis. HMIP inspections assess how 'healthy' a prison is considering the four themes of safety, respect, purposeful activity and resettlement.
- 14.20 Since April 2007, Ofsted has been conducting regular inspections of STCs and SCHs. Ofsted follows a common inspection framework specifically amended for use in STCs and SCHs which takes into account the contribution made to the five outcomes of Every Child Matters. Ofsted have access to the records of restraint and other relevant documents, such as complaints, as well as talking to children and staff.
- 14.21 While valued, the specialist inspectors in Ofsted were felt to be less experienced in knowing what they were looking for in relation to restraint. We were impressed by the joint Ofsted/HMCIP inspection report on Oakhill STC published in 2008 which we feel might be a template for inspections across the secure estate.

**Recommendation**

Ofsted and HMIP should consider establishing a joint unit which should specialise in the inspection of restraint regimes and practices.

<sup>43</sup> Representatives from the local authority required by the National Minimum Standard to visit residential children's homes on a regular basis.



## Conclusion

- 14.22 In looking at the evidence on the reporting and monitoring of restraint use and, from Chapter 6, injuries, we have been struck by some weaknesses in the system. **Secure establishments have not been sufficiently accountable for the use of restraint and the accuracy of the restraint data they provide.** From our perspective the situation is improving, with HMCIP for instance recently remarking that prisons are improving at recording all uses of force. But the recording systems of all units in the secure estate must be open and transparent to avoid any suspicions of under or partial reporting. Incident reports must be comprehensive and provide management with all the information they need for an accurate picture of restraint. We make the following recommendation:

### Recommendation

All establishments should record all incidents involving RPI within 24 hours. All records should contain as a minimum:

- The young person's details
- Staff involved in the restraint
- Description of build-up, incident and resolution
- The reason for the restraint
- Clear evidence of de-escalation techniques used to avoid use of force
- Description of holds used during the restraint
- Record of injury to the young person and any medical attention given
- Confirmation of debriefing for staff and the young person

- 14.23 We are concerned that there is still insufficient input by children into the reporting system – a failing in STCs noted by the Coroner in the inquest into Gareth Myatt's death but one which applies to the whole estate. Although many SCHs and restorative justice and TCI initiatives in STCs, for example, have brought the young person more into the learning process following restraint, it is not commonplace across the estate to include a place in incident reporting for young people to give their views.

### Recommendation

STCs, YOIs and SCHs should include in their reporting of restraint an opportunity for the young person to give their own views of the incident and to report any injuries.

- 14.24 Establishments have a responsibility to satisfy themselves that they are using restraint methods correctly and justifiably. Analysis of restraint information must be improved - only by fully understanding the extent and nature of how they use force can establishments successfully reduce it. We have seen impressive examples – including in Felton YOI, Rainsbrook STC and East Moor SCH – of in-depth analysis which should be commonplace:

### Recommendation

All establishments should produce analysis reports of restraint incidents at least monthly, focusing on continual improvement in reducing restraint. As a minimum they should examine:

- The reasons for restraints
- What patterns of restraint emerge
- Restraint 'hotspots' - which locations predominate
- The time restraint incidents occur
- Which staff, or groups of staff, have been involved
- Risks in restraint techniques
- Training gaps identified

- 14.25 Outside independent scrutiny has in the past been inadequate, with the YJB not doing enough to critically challenge the restraint data they receive. Reasons given by establishments that sudden surges in use of force are the result of individual problem children or 'seasonal fluctuations' have been too readily accepted at face value. Quality assurance of restraint figures has been lacking and 'spot checks' rare.

- 14.26 Whilst acknowledging the complexity of the task, it is not before time that **the YJB has recently strengthened its monitoring of restraint**. As part of its **new quality based Assurance Monitoring**, all establishments will undergo a regular Performance Risk and Review. Should the YJB have doubts about the reliability of a unit's restraint data, or concerns about particular incidents or patterns of restraint, it will address its concerns with the provider. If necessary, it will launch a Focused Review where YJB monitors can investigate the underlying issues.
- 14.27 It is too early to judge the success of this new system, which will not be fully in place until June 2009, but we are encouraged that the YJB has sponsored around 12 Focused Reviews so far, with one recent Review on Wetherby YOI confirming YJB concerns about the unit's restraint information. Whilst accepting that units are responsible for the safe operation of their service, it will be vital that the YJB backs up its Assurance Monitoring with firm corrective action.

**Recommendation**

The YJB should have in place a range of effective support and sanctions to back its Assurance Monitoring of restraint in the secure estate, including reporting concerns to Local Safeguarding Children Boards.

## 15. PROTECTING YOUNG PEOPLE AFTER RESTRAINT

### *Key messages*

- There should be consistent, high standards of medical examination of young people across the secure estate following restraint.
- There should be an enhanced role for independent advocates to support young people.
- LSCBs with a secure unit(s) in its area should report on its use of restraint annually to the YJB or more frequently if they have concerns. They should also report to HMCIP or Ofsted as appropriate to inform inspections.

### **Medical examination**

- 15.1 Young people deserve to have exemplary standards of medical and psychological care after being restrained. We believe that all young people should have early access to medical assessment and receive swift treatment for injuries.
- 15.2 Within STCs and YOIs, medical screening after restraint is automatic. In fact, in STCs, it is a contractual requirement after every episode of PCC for a nurse to see the young person within 30 minutes and conduct a body map of any injuries found where appropriate, although despite this at Rainsbrook and Medway STC nursing cover is not 24 hours; only one nurse is on duty from 7.30am to 9.30pm and another nurse on duty from 9.00am to 5.00pm. But in SCHs, while children have a right to be examined by a registered nurse or medical practitioner within 24 hours following physical restraint, the lack of on-site health practitioners makes this difficult to fulfill. As Ofsted have confirmed, it can be several days before a young person sees a GP or a nurse after suffering restraint in a SCH. We see no reason why children across the estate should be denied the level of medical care given in STCs.

#### **Recommendation**

All establishments in secure estate should ensure that any restrained YP is seen by a registered nurse or medical practitioner within 30 minutes of an incident.

#### **Recommendation**

All injuries should be photographed, recorded on a body map and given the appropriate level of treatment.

- 15.3 In making this recommendation we recognise the potential resource implications for SCHs in particular.

### **CCTV and video evidence**

- 15.4 It is an operational requirement in STCs, but not in YOIs and SCHs, that all planned restraint interventions are video recorded. But the majority of incidents are unplanned, which go unrecorded. For the protection of both young people and staff we believe that video recording of restraint incidents is essential. Many establishments have a CCTV system but the 'jump' in the time frame between pictures often renders the records inadequate as evidence in child protection investigations. But we saw an example of good practice at Hassockfield STC, where there is 'real-time' recordable CCTV in all common areas, footage of which is checked daily and any incidents of use of force referred to the Duty Manager to check for assurance that staff restrained correctly, child protection concerns and learning points.
- 15.5 We appreciate that this has significant resource implications but we believe that similar systems should be in place across the secure estate.

**Recommendation**

All establishments should have recordable 'real time' CCTV in common areas to help monitor the use of restraint and assist decisions on safeguarding and child protection interventions.

**Recommendation**

All incidents of planned restraint in the secure estate must be recorded on video.

- 15.6 As good practice, all units, as part of their safeguarding procedures, should allow appropriate external agencies to see CCTV and video footage to evaluate incidents of restraint.

**Debriefing**

*Debriefing of children*

- 15.7 Good practice cultures develop as a result of discussions between staff and children which focus on what action staff need to take in the best interests of the children concerned. This is nowhere more important than when a child has been restrained. It is important for a young person to be seen soon after being involved in restraint, so their recollection of the event is clear and their feelings are not clouded by the opinions of staff or young people or subsequent events such as the punishment which followed the incident. Done well, debriefing is fundamental to successful strategies to reduce use of force. It is critical in helping to expose concerns about restraint and the actions of staff. We particularly believe that the involvement of advocates in debriefing is essential to supporting young people, for example in helping them to articulate complaints about restraint.
- 15.8 The YJB's Code of Practice requires that after any physical intervention the young person must have the opportunity to debrief with a suitable member of staff, with the support of an advocate if requested. We do not consider it adequate for formal debriefs to be undertaken by an establishment's staff alone and certainly not by staff involved in the incident. In YOIs, for example, we consider it best practice for debriefs to be led by a member of the safeguarding team or a social worker.
- 15.9 While debriefing is improving across the secure estate, and an advocacy service should be available within every SCH, STC and YOI, practice can vary widely. The National Youth Advocacy Service claimed that their advocates in YOIs are often denied access to young people immediately following restraint and may only get feedback from them when the advocate is requested to provide support at the subsequent adjudication. Although children in SCHs have access to advocates and can raise any issues of concern, they do not have a formal role following incidents of restraint except in two establishments, where an advocate or children's rights officer is routinely informed of all incidents.
- 15.10 We would like to build good practice where it is developing in the secure estate by making specific recommendations:

**Recommendation**

Establishments must have a formal debriefing with every young person subject to restraint within 48 hours of the incident, with a written record of conclusions and actions taken. The debrief should be done by a member of staff who was not involved in the incident.

**Recommendation**

If the young person wishes it, an independent advocate should be present at the child's formal debrief. To help this, establishments must notify an independent advocate of every restraint within 24 hours of the incident, which should then determine whether the young person wishes an advocate to be present at the debrief.

- 15.11 The advocacy service in YOIs, STCs and SCHs can also play an important role in bringing independent scrutiny to overall use of force in a unit.

**Recommendation**

Independent advocates should keep confidential records of its debrief interviews with young people and should use them to report on an establishment's use of restraint annually to the YJB or more frequently if they have concerns. The advocacy service should also report to HMCIP or Ofsted as appropriate to inform inspections.

*Debrief of staff*

- 15.12 We strongly believe that the process of debriefing staff is at least as important as it is for children. Debriefing provides the opportunity for supervisors to question those involved in restraint in order that their intervention can be justified and lessons learned for application more widely.

**Recommendation**

All staff in the secure estate must have the opportunity after a restraint incident to debrief with their manager.

**Complaints**

- 15.13 Complaints by young people about restraint need to be dealt with in an effective, rigorous, fair and transparent manner. All establishments in the secure estate are expected to have complaints procedures in place which is clear, published and free of discrimination, and which the young people may use to make complaints about the establishment. This expectation is set out in National Standards for Youth Justice and the National Minimum Standards for Children's Homes. It is reinforced through the operating specifications for the establishments set out in contracts and service level agreements. Complaints that identify any child protection complaints should be referred immediately to senior managers.
- 15.14 The processes for dealing with complaints about restraint in the secure estate appear mixed. Some are overly bureaucratic and lengthy and had only recently introduced a way for young people to complain directly rather than going through staff. In STCs, complaints procedure appear robust, with the exception of Oakhill, where HMCIP noted in its latest report that there is "no evidence that children and young people were routinely advised of their rights to complain about any aspect of PCC". In Lancaster Farms in 2007, there was just one reported complaint against the use of C&R.
- 15.15 Many young people are not used to making complaints and fear reprisals if they do. Even where the young person made a complaint, we found that resolution of the incident often took so long that the young person no longer cared about the outcome. It was not uncommon for young people *never* to learn the outcome of their complaint. This is unacceptable.

**Recommendation**

Young people making a complaint about restraint should be given a target by which they should expect to hear of the outcome of their complaint and all complaint resolution forms should be signed off by the young person at the end.

**Child Protection Referrals**

- 15.16 Concerns about use of force is the largest single reason for establishments to make child protection referrals under section 47 of the Children Act 1989. They can account for more than 75% of referrals. There does not appear to be consistent criteria for referrals to child protection across the secure estate. One STC accepts that its referrals are high but believe it can be explained by its broad and transparent referral policy, including self-referring swearing by staff.

- 15.17 We have seen no evidence that child protection referrals are not being investigated appropriately in any sector of the secure estate, although we note concern from evidence submitted to the review that too many referrals do not meet the section 47 threshold – or that the section 47 threshold is being set too high – and generally result in no further action or a recommendation that the staff members concerned require further training. In one YOI, of the 117 child protection referrals in 2007 for which an outcome was known, the police and social services decided on no further action in 82% of cases. In an STC, no complaint was upheld in all 30 child protection complaints in one year. Some referrals to social services departments are handed back for investigation by the establishment.
- 15.18 Whatever the outcome, the young person making the complaint does not always hear formally of the outcome of the referral, and this may add to the perception among young people that their complaint is disregarded: that ‘nothing happens’. Where there is no further action, the managers need to explain the reasons to the young person and the relevant agencies.

**Recommendation**

It should be mandatory for the establishment to put in writing to the young person affected, and their parent(s)/guardian, the outcome of every child protection referral on use of force grounds

**Recommendation**

To help scrutiny of restraint incidents, including CCTV footage, staff from LSCBs and local child protection committees responsible for investigating child protection referrals should be trained in the relevant restraint methods used by their area’s secure units.

## Role of Local Safeguarding Children Boards

- 15.19 Every local area is required by the Children Act 2004 to have a Local Safeguarding Children Board (LSCB) to bring together key agencies to coordinate the safeguarding activity of their members and ensure its effectiveness. Every local area with a SCH, STC or YOI has that establishment as a statutory partner on its LSCB. Even where they do not have a secure unit, LSCBs should be aware of restraint issues in relation to young people placed out of area.

### *LSCBs with a secure unit in their area*

- 15.20 Where there is a secure unit in a local authority area, it is important that the LSCB plays a key role in scrutinising use of force and monitoring trends and patterns. This information should be provided by the unit’s Safeguarding Committee to the LSCB. Some LSCBs, for example Lancashire, which conducted the Serious Case Review into the death of Adam Rickwood, are taking an energetic lead but we were otherwise surprised how relatively few LSCBs responded to our approach for evidence.
- 15.21 Where there is a relationship with the secure unit, its quality is mixed. We saw examples of excellent close co-operation between units and LSCBs, and others where they were characterised as ‘pretend’ and even ‘downright suspicious’. Relations between YOIs and LSCBs were in their infancy but we saw evidence that this had begun to improve, certainly helped within YOIs by the advent of designated safeguard managers there. Some establishments, for example, Castington YOI, had been proactive in creating a good relationship with its LSCBs.
- 15.22 But involvement with LSCBs can be patchy. At Hassockfield STC, the LSCB attends meetings monthly, whilst at Medway it is six-monthly but at Rainsbrook we understand that the LSCB does not have the resources to attend at all. LSCB’s primary role is to coordinate and ensure the effectiveness of the safeguarding activity of its members. In SCHs:

*“Local Safeguarding Children Boards currently have little involvement with issues of restraint other than those that lead to a child protection referral or allegation against staff and are dealt with by the Local Authority Designated Officer.”<sup>44</sup>*

<sup>44</sup> Hart D *Restrictive Physical Intervention in Secure Children’s Homes*

- 15.23 Where LSCBs do take an active role there is a dislocation between their scrutiny and how, in reality, they can impact on practice. We believe this would be helped by strengthening links between LSCBs and the YJB and inspectorates, and by strengthening secure unit's own commitment to engagement in LSCB arrangements:

**Recommendation**

LSCBs must be properly linked in with any secure setting in its area and should be able to scrutinise restraint techniques, the policies and protocols which surround the use of restraint, and incidents and injuries.

**Recommendation**

LSCBs with a secure unit(s) in its area should report on its use of restraint annually to the YJB or more frequently if they have concerns. They should also report to HMCIP or Ofsted as appropriate to inform inspections.

*LSCBs without a secure setting in their area*

- 15.24 Most LSCBs do not have a secure unit in their area. But even then, LSCBs should ensure that the needs of their young people in custody outside their area are being met, including that any restraint is used safely and appropriately. As a placing authority, the local authority needs to be confident that the use of restraint is shared with their staff and patterns in the use of restraint and behaviour management are the subject of regular and prompt discussion between the establishment and staff. As Derby SCB said,

*"it is harder to safeguard and promote the welfare of young people at a distance"*

**Recommendation**

Establishments should inform the Local Authority, themselves members of the LSCB, in which the young person originates when they have been subject to restraint.

## 16. TRAINING

### *Key messages*

- Training for the use of force should reflect the model of care and custody provided, and should be seen as part of a continuum of training within a broad curriculum of personal preparation and development for work with young offenders.
- The broad curriculum should include specific preparatory core training, such as the Prison Service's Juvenile Staff Awareness Programme, which should be completed by the staff member before they are permitted to practise.
- There should be a specific NVQ3 level qualification in the custodial care of young people for all staff in the secure estate.

### **Overview**

- 16.1 The custodial care of young people is one of the most difficult roles for anyone to fulfil in society and we owe it to the staff to ensure they are as fully prepared as possible to undertake the task effectively and appropriately. Training is essential.
- 16.2 When and how force is used is as much to do with the quality and preparedness of the staff employed in the secure estate, as it is to do with policies and procedures. It is the staff who are faced with the incident and who have to make instant decisions on what action to take.
- 16.3 The ability to make these judgements depends upon individual staff understanding of:-
- the child and their behaviour;
  - their role;
  - the management arrangements which apply in respect of their supervision, appraisal or performance review; and
  - the training and support they receive to prepare them for these eventualities.
- 16.4 The requirements and expectations of staff across the estate differ widely, owing to differences in policy and practice, which in turn depends on the objective of the establishment concerned and can be influenced by practical factors such as the ratio of staff to young people. The differences in role are best summed up by the dichotomy between "custody" and "care" which is reflected in job titles - "Custody Officers" in YOIs and STCs, (the description used, at least, in the PCC Training manual,) and "Care Staff" in SCHs.
- 16.5 We have looked at training against the YJB's Behaviour Management Code of Practice which, despite the differences in badging above, sets common aims in this area for all three settings:
- 1) *any intervention must be in compliance with the relevant rules and regulations for the establishment, and carried out in accordance with methods in which the member of staff has received training.*
  - 2) *every relevant member of staff receives appropriate training for all aspects of managing behaviour.*
  - 3) *diversion, de-escalation and defusing potential conflict or violent situations, using restorative justice principles where possible, must be reflected in the establishment's training strategy.*
- 16.6 To set the context for our proposals, we outline on the following pages, our understanding of the arrangements which currently apply for training across the estate and the YJB's expectations of each organisation in training to manage challenging behaviour.



## Training in YOIs

- 16.7 All new prison officer staff are trained in C&R via the Prison Officer Entry Level Training (POELT). This is a generic course for officers across the main prison estate which, while featuring modules to cover issues such as managing challenging behaviour, does not deal explicitly with young people.
- 16.8 POELT requires staff to undertake a minimum of 32 hours of training in the use of force. This training may only be provided by an approved C&R instructor, who are accredited by the Prison Service NTRG instructors. The training provides officers with an understanding of the law surrounding the use of force and C&R basic techniques. Upon completion of their training, staff are assessed as to whether they are deemed 'competent'. Staff who have passed the use of force training course are issued with a log book certifying their competency in the required techniques. Those not meeting the required standard may not continue employment as prison officers. Staff in YOIs had a high opinion of the quality of C&R training, feeling knowledgeable and competent in using C&R.
- 16.9 All prison officers are required to undergo annual refresher training in use of force of around 8 hours per year. This is the responsibility of local YOIs; we are not aware of any central Prison Service performance target against which to monitor achievement.

### *Child focused training for prison staff*

- 16.10 According to Prison Service policies once they have completed their POELT training, staff assigned to young people's establishments participate as early as possible in a Juvenile Awareness Staff Programme (JASP) to prepare them for working with young people. JASP was introduced only in 2004 and is a 7 day course:

#### Module 1

- Child protection (1 day)
- Understanding and working with children and young people in custody (2 days, designed by the Trust for the Study of Adolescents)

#### Module 2

- Mental health awareness (1/2 day)
  - Substance misuse (1/2 day)
  - Vulnerability Assessment (1 day)
  - Training planning and resettlement (1 day)
  - Managing difficult behaviour (1/2 day)
  - Safeguarding children (1/2 day)
- 16.11 We heard evidence that many considered JASP training to be rudimentary and insufficient. The management of one YOI, for example, said that it needed to focus more on improving skills in relationship-building with young people. The Prison Officers Association thought JASP was good, but was not thorough enough. It also surprised us that JASP **is not compulsory and there is no refresher training**. Our impression was that uptake of JASP varies significantly across the YOI estate. The Prison Service were not able to provide information on take-up but the YJB thought that as few as 60% of staff in some YOIs had completed it. We met one member of staff who had managed to work in YOIs for 9 years without ever taking JASP. Overall, our impression matched that of one organisation which gave evidence to the review:

*"Prison officers receive far more training on control and restraint than in pro-social techniques"*

Prison Reform Trust

#### **Recommendation**

The Prison Service's Juvenile Staff Awareness Programme should be made mandatory for all custody staff working in YOIs and should be refreshed at regular intervals.

## Training in STCs

- 16.12 All new STC staff must receive a minimum of 7 weeks training which includes modules on child protection, child development, vulnerability, adolescent behaviour, inter-personal skills and techniques for managing challenging behaviour. Training in skills through TCI or restorative justice systems is additional.
- 16.13 All staff are trained in the use of PCC during their initial induction training prior to being allowed to work with young people. Training in PCC was developed and is delivered initially by Prison Service NTRG instructors to nominated staff selected as PCC Trainers by the STCs. The PCC Trainers then cascade the training to STC staff locally, by means of a 5 day course. The PCC trainers are reassessed annually.
- 16.14 Upon the successful completion of the course the member of staff will be authorised to use PCC in the approved manner, following the guidelines for use of force set out in STC Rules. The YJB is given responsibility in law to certify custody officers for which one of the criteria is the competent completion of PCC training.
- 16.15 All staff must receive a minimum of one refresher training course per year in order for them to be validated to continue to be authorised to use PCC techniques, although it is practice in some STCs for refresher training to be once every 6 months.
- 16.16 The PCC Management Board has re-examined the provision of PCC training in the light of the report of the Coroner of the inquest into the death of Gareth Myatt. The report recommended that teaching PCC at national level by national instructors would be preferable to the 'cascade' method, under which NTRG currently trained local instructors, who then trained custody officers at their establishments. As a result **a better quality assurance system for PCC training has been implemented by means of follow-up audits which will examine the actual use of the techniques in the STCs.** We support this approach, which will help to ensure that force is used safely and unauthorised techniques do not take root. We urge that NTRG is given adequate resources to carry out this vital role.

## Training in SCHs

- 16.17 Each SCH is responsible independently for procuring training in restraint techniques, usually from commercial providers. As a consequence little information is held centrally about the detail of training within SCHs.
- 16.18 In relation to training in restraint techniques, the Children's Homes National Minimum Standards require all staff to be:
- ...aware of, trained in, and follow in practice the registered person's policy. Training covers reducing or avoiding the need for physical restraint. All staff have a signed copy of the policy and evidence of this is retained on their personnel file (22.8)*
- 16.19 As far as we can determine, SCHs do not use accredited suppliers from an approved list and we are not aware of any system for assuring the quality of the training across the sector. Indeed, homes themselves have expressed concerns about the difficulty of selecting an appropriate method – and of evaluating information about methods – because of the commercially competitive nature of most of the providers.
- 16.20 The length of initial training in physical intervention delivered in SCHs varies considerably, from two to ten days. The precise nature and content of the training depends on the individual home's policy and the methods of restraint it uses. In some cases, different aspects of behaviour management – including physical restraint – are covered by different modules. In others, a single integrated course is delivered. There are mixed views among SCHs regarding whether training in general behaviour management skills should be integrated with training on physical interventions: whilst some see this as contributing to a coherent approach, others are concerned that restraint inevitably dominates and feel, as a result, that it is more appropriate to teach de-escalation and other methods separately.
- 16.21 The contract between the YJB and the Local Authority operating an SCH requires refresher training in physical restraint techniques to be given to all staff at regular intervals, not exceeding three years. There is evidence that homes are taking steps to keep the skills of their staff up to date by arranging sessions in between formal refresher courses.

## **Summary of training in methods of restraint used by SCHs**

### **PRICE**

- 16.22 Individual programmes are developed based on the needs of the organisation. Different training modules are offered, from a one-day de-escalation course to an eight-day instructors' course. People can fail the course. PRICE encourages the use of individualised behaviour management plans and will provide consultancy on the best methods to support particular children. New instructors are visited within 12 weeks and their training observed. Certificated instructors have access to network meetings and are encouraged to keep in touch with PRICE and to provide feedback 'from the shop floor'.

### **GSA**

- 16.23 GSA have developed a core curriculum that provides the basis for two levels of tutor training: basic and senior. The core curriculum is primarily concerned with physical intervention skills but a theoretical curriculum is being developed. The expectation is that tutors would identify the elements of the core curriculum that are suitable for inclusion in the training courses they develop. Courses range from three to five days. To become a basic GSA tutor, participants undertake a three-week intensive course. They practise the techniques, then practise teaching them. All tutors are expected to attend annual updates; and must attend at least every two years to continue practicing. After three years, tutors could apply to become senior tutors. GSA monitors their approved tutors through an external moderator.

### **MAPA**

- 16.24 Programmes are developed based on the needs of the individual settings, then piloted, adapted if necessary and rolled out. The modular approach includes three-day person centred courses with managers, courses on positive decision making and the basic MAPA skills themselves. The latter courses can vary from one to ten days. Staff must have annual refreshers and be fully retrained every three years. Participants do not to pass or fail the course. Instead, the trainer provides feedback and makes it clear that it is the manager's responsibility to evaluate that information and decide whether they are equipped to practise. Instructors' courses are available and also require annual updates of at least three days. They vary in terms of curriculum and are linked to a degree programme.

### **CALM**

- 16.25 CALM examines the organisation's policies, feeds back about their deficits and then agrees practical training. The two day theory courses must be completed prior to the five day physical intervention courses. While they would prefer to deliver all training directly, in response to demand they do provide instructors' courses so that training can be delivered within organisations. The instructors' training involves undertake presentations on the law, followed by assignments and the development of teaching plans. They must also submit a portfolio within two years, including a critical analysis of the literature underpinning the CALM modules. Participants can fail the courses, which are externally validated.

### **Team-Teach**

- 16.26 Team-Teach provides training for in-house instructors who will then train staff in their own establishment or authority. This has the advantage of having expertise available locally to sustain and refresh staff skills. Team-Teach training on physical intervention itself is relatively short, with a minimum of six hours in low risk settings and 12 hours for medium-risk, with additional modules available. Course participants are tested on the theoretic elements of the courses. Instructors' training is for four days with two day refreshers.

### **ECC&R (UK)**

- 16.27 The focus of training is on practical skills but these are taught within the context of legal accountability, particular behavioural challenges and medical risks. Courses are adapted to the needs of commissioners and basic training can be delivered in four days as long as people also do homework. Participants do not pass or fail, unless requested.. Instructors' courses run for ten days with an annual refresher of one week. Instructors must be qualified in first aid, CRB checked and have some teaching experience, and can fail the course.

### **DIVERT**

- 16.28 Course content includes the legal context, reasons for challenging behaviour, types of aggression and effective responses including active listening, establishing rapport and de-

escalation strategies. All participants get a certificate of attendance and individual feedback is given to line managers. Refreshers are undertaken every two years but skills can be supported in between.

### **SCAPE**

16.29 SCAPE uses in-house instructors at basic and senior level. Instructors receive 10 days initial training and five day refreshers annually. They are expected to demonstrate not only physical skills but an ethos of care and there are written papers. All staff are expected to be trained and refreshed at least every two years although it is sometimes a struggle to achieve this. Basic courses contain two days input on conflict management and at least two days on physical skills. Staff can fail the courses. At least one instructor would be from outside the home where courses are delivered. Quality assurance involves two independent consultants in addition to those responsible within Essex.

### **Conclusions**

16.30 We have tried to take account all of the representations we have received on the matter of training and we have sought to synthesise them in the following set of recommendations.

16.31 We believe that the Accreditation Scheme, which we outline in chapter 11, will provide reassurance of the quality of training organisations and trainers in all restraint methods across the secure estate. But we wish to make some specific recommendations in the interim:

#### *Restraint training*

##### **Recommendation**

All staff in the secure estate should have received a core module of training, which must include training in use of restraint, before they are permitted to work with young people.

##### **Recommendation**

There should be a requirement for more frequent refresher training in restraint. Ideally this should be on a 6 monthly basis, to enable staff to ensure that their skills are refreshed and assured for safety by qualified instructors.

##### **Recommendation**

All organisations providing restraint training in the secure estate should ensure that they have quality assurance processes to audit locally provided 'cascaded' training.

#### *NVQ for staff in the juvenile estate*

16.32 Taking a wider view, we believe that this group of staff are dealing with the most damaged, and sometimes dangerous young people in society. We owe it to them and to the young people concerned to equip them as professionally as possible, in order to ensure they are equipped to undertake their most difficult of roles effectively.

16.33 We consider that a radical rethink is required about the training currently available to staff in the secure estate which should start from the premise that to practise effectively requires an understanding of:-

- child protection issues;
- building relationships;
- an understanding of adolescent behaviour;
- the management of challenging behaviour, with an emphasis upon prevention, defusion, de-escalation and debriefing

16.34 We have identified that there are currently no National Vocational Qualifications specifically developed for staff working in juvenile secure settings. There are three sets of National Occupational Standards relating to the training of staff in the use of restraint, all of which are generic:

- CC018 Maintain Security and Order in the Custodial Environment
- STL37 Prevention and management of Challenging Behaviour in Children and Young People (HSC326)
- PCP 9 Use Control and Restraint to Support Close Protection

16.35 No one lead body appears to assume responsibility for developing staff in juvenile secure settings which seem to fall between Skills for Justice, Skills for Security, Training and Development Agency for Schools, Children's Workforce Development Council and the YJB.

**Recommendation**

A National Vocational Qualification (Level 3) should be specifically developed for staff working in juvenile secure settings. The three current sets of National Occupational Standards relating to the training of staff in the use of restraint should be brought together under one body. Skills for Justice, Skills for Care, Skills for Security should be asked to address this matter, in conjunction with the Children's Workforce Development Council and the YJB.

16.36 In making the above recommendations we are acutely aware of the difficulties they are likely to pose for the various organisations involved in the provision of secure accommodation for young people. We recognise that in the Prison Service, especially, the major issue is releasing staff for training and the impact in regimes given the current low staffing ratios. STCs and SCHs will need to ensure that staff undertake at the minimum, a basic training module before being allowed to practise within the secure estate.

16.37 We recognise that the current staff working within the juvenile secure estate, provide care under very difficult circumstances, to the very best of their ability. However we believe that they deserve the opportunity to develop and improve their skills in order to perform their duties to the highest standard possible.

## **ANNEX A. VISITS, MEETINGS AND CONTRIBUTORS**

### **Visits to secure establishments**

#### STCs

Hassockfield, Co Durham  
Medway, Kent  
Rainsbrook, Northants  
Oakhill, Milton Keynes

#### YOIs

Castington, Northumberland  
Cookham Wood, Kent  
Feltham, London  
Lancaster Farms, Lancaster  
Werrington, Stoke-on-Trent

#### SCHs

Atkinson Unit, Exeter  
East Moor, Leeds  
Lincolnshire, Spalding  
Newton Aycliffe, Durham (off site visit to managers)  
Swanwick Lodge, Southampton  
Vinney Green, Bristol

#### Other units

St Andrews Secure Hospital, Northants  
St Mary Kenmure Children's Unit, Edinburgh  
Woodlands Juvenile Justice Centre, Northern Ireland

### **Meetings**

Young People in STCs, YOIs and SCHs  
Staff in STCs, YOIs and SCHs  
Association of Directors of Children's Services  
Barnardo's  
Baroness Linklater  
Baroness Stern  
Borders and Immigration Agency  
British Institute of Learning Disabilities  
Children's Rights Alliance for England  
Children's Rights Director for England  
Children's Society  
Department of Health  
Durham Local Safeguarding Children Board  
Earl Listowel  
11 Million  
Forum for Preventing Deaths in Custody  
HM Chief Inspector of Prisons  
HMPS Training Centre, Kidlington  
Howard League  
Inquest  
Sally Keeble MP  
Lancashire Safeguarding Children Board  
NACRO  
National Association for Youth Justice  
National Children's Bureau  
National Institute for Mental Health in England  
NSPCC  
PCC Management Board  
Lord Carlile  
Lord Laming  
Lord Ramsbotham  
Lord Warner

Ofsted  
POA  
Carol Pounder, mother of Adam Rickwood  
Secure Accommodation Network  
Phil Wheatley, Director General HM Prison Service  
Pamela Wilton, mother of Gareth Myatt  
Youth Justice Board

**Other contributors of evidence**

ACPO  
Professor Sue Bailey, Consultant Adolescent Forensic Psychiatrist  
Richard Barnett, School of Health and Rehabilitation, University of Keele  
Dr Anthony Bleetman, Consultant in Emergency Medicine, Heart of England NHS Foundation Trust  
Bournemouth Safeguarding Children Board  
CALM (David Leadbetter)  
Children are Unbeatable Alliance!  
Children's Commissioner for Wales  
Clare Lodge SCH  
Derby Safeguarding Children Board  
Derbyshire Safeguarding Children Board  
Department for Children, Schools and Families  
Disley Quaker Meeting  
Ethical Care Control & Restraint (UK) Ltd (Tom Starling)  
Equality and Human Rights Commission  
Essex Youth Offending Service  
Gateshead Safeguarding Children Board  
Professor Barry Goldson, School of Sociology and Social Policy, University of Liverpool  
Halton Safeguarding Children Board  
Hillside SCH  
Knowlsey Safeguarding Children Board  
Kyloe House SCH  
Ministry of Justice  
National Youth Advocacy Service  
Nottinghamshire Safeguarding Children Board  
John Parkes, Senior Lecturer, Coventry University  
Dr Brodie Paterson Department of Nursing and Midwifery, University of Stirling  
Prisons and Probation Ombudsman  
Prison Reform Trust  
Rebound  
Reliance Custodial Services  
Salford Safeguarding Children Board  
SERCO  
South Tees Safeguarding Children Board  
Standing Committee for Youth Justice  
Team Teach (George Matthews)  
VOICE  
Warwickshire Safeguarding Children Board  
Willowgrave House NHS Therapeutic Community  
YOT Managers Cymru  
Several other individuals

## ANNEX B. LEGAL AND STATUTORY FRAMEWORK

In examining the issues surrounding the use of restraint we have had regard to the following documents which provided the legal and statutory framework for our review:

- The United Nations Convention on the Rights of the Child
- European Convention on Human Rights
- 1989 Children Act
- 2004 Children Act
- Every Child Matters, 2003
- Youth Matters, 2005
- Working Together to Safeguard Children 2006
- Care Matters: Time for Change 2007
- The Children's Plan 2007

### The UN Convention on the Rights of the Child (UNCRC)

#### Article 3

In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.

States Parties undertake to ensure the child such protection and care as is necessary for his or her well being

States parties shall ensure that the institutions responsible for the care and protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number of and suitability of their staff, as well as competent supervision

#### Article 6

States parties recognize that every child has the inherent right to life. States parties shall ensure to the maximum extent possible the survival and development of the child

#### Article 12

States parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child

#### Article 19

States parties shall take all appropriate measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation

#### Article 20

A child temporarily or permanently deprived of his or her family environment shall be entitled to special protection and assistance provided

#### Article 37

No child shall be subjected to torture or other cruel, inhuman or degrading treatment

In July 2007, the UK Government made its latest periodic report to the **UN Committee on the Rights of the Child** on how it is fulfilling its obligations to comply with the Convention. In response to the Committee's urging that State parties should review the use of restraints and solitary confinement in custody, the Government set out its position as:

*"The UK has reviewed the use of restraints and solitary confinement to ensure they are not used unless absolutely necessary. In 2006, the Youth Justice Board for England and Wales issued a code of practice on Managing Children and Young People's Behaviour in the Secure Estate. This made clear that young people should be removed from their normal location only if their continued presence would be a threat to the good order or discipline of an establishment or if the removal would benefit the young person in bringing their behaviour under control. Under the Code, restrictive physical intervention may only be used as a last*



*resort, carried out with minimum force for the shortest duration possible; there must be clear links between physical intervention policy and child protection procedures.”*

The Government went on, however, to acknowledge, in the case of restraint, a “key competing tension” in the area:

“minimising the use of restraint in secure settings, but keeping it as a measure of last resort for the safety of children and those around them”.

### **The European Convention on Human Rights (ECHR):**

#### *Article 3*

No one shall be subjected to torture or other cruel, inhuman or degrading treatment.

#### *Article 8*

Everyone has the right to respect for his private and family life, his home and his correspondence.

There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

#### *Article 13*

Everyone whose rights and freedoms as set forth in this Convention are violated shall have an effective remedy before a national authority notwithstanding that the violation has been committed by persons acting in an official capacity.

The Government’s **‘Every Child Matters’** programme, underpinned by the Children Act 2004, aims to improve five key outcomes for children and young people, whatever their background or circumstances: being healthy, staying safe, enjoying and achieving, making a positive contribution and achieving economic well-being.

The **National Service Framework for Children, Young People and Maternity Services** sets out a 10-year change programme across health and social care services aimed at designing and delivering services around the needs of the child. It sets standards including:

Standard 3: “Children and young people and families receive high quality services which are co-ordinated around their individual and family needs and take account of their views”.

Standard 5: “All agencies to work to prevent children suffering harm and to promote their welfare, provide them with the services they require to address their identified needs and safeguard children who are being or who are likely to be harmed.”

Standard 9: “All children and young people, from birth to their eighteenth birthday, who have mental health problems and disorders should have access to timely, integrated and high-quality multi-disciplinary mental health services to ensure effective assessment, treatment and support, for them, and their families.”

We have also had regard to the Chief Inspectors joint reports on **Safeguarding Children** published in 2002 and 2005, together with the Government’s 2006 guide to inter-agency working: **Working Together to Safeguard Children**.

The 2007 White Paper **‘Care Matters: Time for Change’** set out the steps the Government, together with local delivery partners, are taking to improve outcomes for children and young people in care.

The 2007 **Children’s Plan: Building a Brighter Future** laid out the Government’s measures “to put the needs of families, children and young people at the centre of everything we do” and highlighted this review of restraint as a component of plans to ensure rigorous safeguarding for young people in custody.

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