



Thematic report by HM Inspectorate of Prisons

# **Behaviour management and restraint of children in custody**

A review of the early implementation of MMPR

by HM Inspectorate of Prisons

**November 2015**

## **Glossary of terms**

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# Introduction

In March 2013, the House of Commons Justice Committee recommended in its report on youth justice that Her Majesty's Chief Inspector of Prisons should report on the implementation of the new system of behaviour management and restraint in young offender institutions (YOIs) and secure training centres (STCs), known as 'minimising and managing physical restraint' (MMPR). This report sets out our findings on the implementation of the new system to date.

The introduction of MMPR was the culmination of a long process initiated following the deaths of two boys in 2004. Gareth Myatt died after he became unconscious during a restraint in an STC. 'If you can talk, you can breathe', an officer told him when he complained. It was not true. Adam Rickwood, aged 14, hung himself after a 'pain compliance' technique was applied to him. This was the 'nose distraction technique', a painful jab under the base of the nose.

MMPR is intended to change the approach to behaviour management within YOIs and STCs, placing an additional emphasis on the importance of staff using their existing relationships with children to de-escalate volatile incidents, and minimising the number of children who experience restraint. MMPR also includes a comprehensive system of national governance and oversight to not only monitor the use of restraint but also improve and promote safe practice across the estate.

The implementation of MMPR is taking place against a backdrop of a substantial fall in the number of children in custody, the decommissioning of beds across both YOIs and STCs and staffing shortages across the YOI estate. This has caused significant delay in the roll out of MMPR, which is now due to be completed in July 2016 – a year behind schedule. The reduction in numbers also means that YOIs and STCs now hold an even more concentrated mix of children (almost all boys) with more challenging behaviour and complex needs than in the past. This combination of delay, resource pressures, a more complex population and concerns about overall performance means that the new MMPR system is not yet being consistently implemented or achieving the intended outcomes.

At this stage in the implementation of MMPR we welcome the significant improvements that it has brought to the national oversight of restraint and the greater focus on communication and de-escalation as part of a wider approach to behaviour management. The development of a consistent approach to restraint across all secure settings is itself an important improvement. However, some of what we have found has been too variable and sometimes very poor. Nevertheless, we have seen enough of when it does work to cautiously conclude it is an improvement on previous systems and that the foundations are there to enable further improvement still. The Youth Justice Board should continue with its implementation.

While it is sometimes necessary to restrain children we share the view of others that there is no such thing as 'entirely safe' restraint. MMPR attempts to change the culture of behaviour management across the secure estate so that effective relationships and communication are used as a basis to reduce the use of force. Effective relationships are more difficult to establish in YOIs, which are larger than STCs and have lower staffing levels. Staff in YOIs spoke of the difficulty in forming these relationships during short association periods. Staff shortages had led to many staff being cross-deployed within YOIs or sent on detached duty to work at other establishments. In contrast, STC staff felt they had the time to form positive relationships with the children living on their unit. This is supported by the perceptions of children in our annual survey of children in custody – a significantly higher proportion of children in STCs than YOIs reported that staff treated them with respect; 93% in STCs compared with 70% in YOIs.

We found that all establishments had implemented behaviour management plans for children with more challenging behaviour. This was progress. However, the criteria for implementing a behaviour management plan were not always clear and we were not satisfied that all children who needed a plan had one. Too many of the plans we saw were of a poor standard, not demonstrating adequate

assessment, relevant targets or any review of the child's progress to enable staff to manage the most challenging children expertly. Some staff also commented that if they did not have the time to get to know a particular child, a written plan was of limited use.

Children with medical or other conditions that could be affected by MMPR techniques could also have restraint handling plans put in place for them. It was positive that establishments dealing with more complex cases could now seek medical advice through the expert serious injuries and warning signs (SIWS) medical panel. However, we found potentially dangerous examples of staff not adhering to these plans during restraints. In general, staff were unfamiliar with the content of the plans; this was a serious oversight that could have led to significant injuries.

In the YOIs and STCs we visited many children were unable to identify any difference between their experience of MMPR and previous behaviour management systems in terms of attempts made to reduce the incidence of restraint or actual restraint practice. While the accounts of children varied, the experience remained, for many, painful and distressing. The evidence from interviews with staff and children, MMPR documentation and our review of CCTV footage indicates that too many of the concerns identified with the previous practice remain.

MMPR guidance outlines techniques staff can use to slow down and de-escalate a situation. Children's own experiences of de-escalation before and during restraint varied dramatically; some spoke of staff communicating throughout and making good efforts to calm them down while others reported that little effort was made before or during an incident. Despite staff recording the use of de-escalation in use of force reports, most CCTV footage we reviewed contained evidence of poor de-escalation, and some recordings showed staff intervening too quickly in response to minor incidents.

We had particular concerns about the practice relating to restraining children on the floor, the application of head holds and the use of pain-inducing techniques. MMPR does not allow staff to take children to the floor intentionally during a restraint because of the medical risks this poses to the child. In nearly half of all the incidents we reviewed however, including 70% of those in YOIs, children ended up on the floor. We also had concerns about the continued misapplication of the head hold: in addition to the incidents described in this review, the SIWS medical panel has identified the incorrect application of this technique in a significant number of incidents that have resulted in SIWS referrals. We also identified unacceptable examples of children being strip searched under restraint in YOIs. Restraint policy agreed by ministers states that staff should only use pain as a last resort to prevent an immediate risk of serious physical harm, but we found that pain-inducing techniques were used frequently in YOIs, and that in most cases staff were not compliant with this requirement. It is notable that staff in STCs dealing with similar incidents did not use these techniques. We also found underreporting of the use of pain-inducing techniques in YOIs, reducing the effectiveness of local and national safeguards. We found no evidence to justify the deliberate infliction of pain as an approved technique.

Within MMPR health care staff play an important role in safeguarding a child during a restraint. It was therefore unacceptable that some establishments did not call health care staff to all incidents. This undermined their role. In some cases, health care staff did not undertake a physical examination of a child after a restraint, instead carrying out this check through a locked door, which was inadequate to ensure the child's welfare.

Support for children after a restraint also required improvement; children we interviewed told us that staff did not always speak to them after an incident to ensure they were okay. Structured post-restraint debriefs with children did not always take place, and when they did they varied in quality. They did not serve the purpose of encouraging helpful discussion about the restraint or looking at ways to help the child to improve their behaviour and prevent any further incidents.

During this review we found a comprehensive system of national governance and oversight, and the introduction of dedicated MMPR coordinators to drive improvements in local practice was positive. Together they have the potential to be an effective mechanism to address the weaknesses we have

identified and introduce a level of national and local oversight and coordination to the restraint of children that has not previously existed. National systems, however, are only as good as the information provided from local level and local systems depend on MMPR coordinators being given sufficient time to do their jobs. Staffing shortages in YOIs led to the frequent redeployment of MMPR coordinators.

Poor local recording, inadequate quality assurance and inconsistent referrals undermined the improved oversight at national level. This was a particular problem in the YOIs, where we found use of force paperwork was not completed promptly and quality assurance did not always take place. CCTV did not cover all incidents and where it did it was sometimes not reviewed for months after the incident. The introduction of body-worn cameras with proper safeguards is one means to address this. Where internal procedures did identify learning points for establishments or individuals there was insufficient evidence that these were addressed. We also found evidence of underreporting of the use of pain-inducing techniques and incidents resulting in SIVS. The impact of this was that individual establishments were unable to monitor use of force accurately, referrals to the national team did not take place, and some child protection investigations could have been delayed.

Improved restraint processes, although very necessary, cannot alone reduce their use or make them safer. That depends much more on the structure of the estate, the quality and training of staff, and the culture in place. As our inspection reports on individual establishments repeatedly show, none of these are adequate to meet the needs of the children who are now in custody. In September 2015, the Justice Secretary announced a review of the youth justice system and we hope this will create the opportunity to make the wider improvements to the juvenile custodial estate that are essential if MMPR is to achieve its full potential. We recommend that the findings of this thematic inspection should inform that review. We will continue to monitor the implementation of MMPR and expect to see much greater improvement and consistency in future.

Some of what we describe in this report is deeply disturbing. Too many of our findings indicate little cultural change and, despite significant effort and some good practice, there is still much more to be done to ensure that the application locally is consistent with national policy guidance. Further progress is necessary both to ensure that past tragedies associated with the application of force by the state on children are not repeated – and to give staff the tools to better manage the behaviour of some of our most troubled and challenging children on a day-to-day basis. MMPR has the potential to deliver those improvements but that potential is not yet realised.

**Nick Hardwick**  
HM Chief Inspector of Prisons

November 2015



# Section 1. Summary

## The review of MMPR

**1.1** In March 2013, the House of Commons Justice Committee published a wide-ranging inquiry into the youth justice system in England and Wales.<sup>1</sup> The inquiry addressed a number of issues affecting children in the secure estate and raised serious concerns about the use of physical restraint on children in custody, namely the continuing rise in the number of restraint incidents and an underlying culture of managing children through physical control rather than effective relationships.

**1.2** Of particular concern to the inquiry was the direct role physical restraint had played in the tragic deaths of two children in custody, Gareth Myatt and Adam Rickwood.

**1.3** Citing the *Independent Review of Restraint in Juvenile Secure Settings (IRRJSS)*,<sup>2</sup> the inquiry highlighted the finding that restraint was ‘intrinsically unsafe’ and could be ‘profoundly damaging psychologically’. The inquiry concluded:

*‘It is matter of serious concern to us that, despite the fact that the use of force in restraining young offenders has now been definitively linked to the death of at least one young person in custody, the use of restraint rose considerably across the secure estate last year.’*

**1.4** The inquiry noted that in July 2012, in response to the publication of the IRRJSS, the government had announced the introduction of a new system of restraint in juvenile secure settings termed ‘minimising and managing physical restraint’ (MMPR). In view of the concerns about the use of physical restraint on children in custody, the Justice Committee recommended that the implementation of such a system be reviewed and reported on by the Chief Inspector of Prisons:

*‘We welcome the fact that the new policy limits the use of force against young offenders but consider a more fundamental cultural shift is required. We intend to keep a watching brief on this issue and recommend that Her Majesty’s Chief Inspector of Prisons reports on the implementation and impact of the new policy in more detail in his Annual Report to Parliament.’*

**1.5** Due to the gradual implementation schedule of MMPR, very little could be reviewed for inclusion in HM Inspectorate of Prisons’ Annual Report 2013–14. Instead, a large-scale review of the implementation and impact of MMPR was instigated, the key aims of which were:

1. to report publically on the implementation and impact of MMPR and make recommendations for improvement and ultimately to contribute to/influence the reduction of restraint on children;
2. to use the findings of the review to improve and revise inspection arrangements of young offender institutions (YOIs) and secure training centres (STCs) where necessary and ensure adequate coverage is given to restraint on all inspections.

**1.6** This report presents the findings of our initial review. HM Inspectorate of Prisons (HMI Prisons) will continue to monitor the implementation and delivery of MMPR during routine

<sup>1</sup> House of Commons Justice Committee report on Youth Justice, March 2013.

<sup>2</sup> Smallridge, P. & Williamson, A. (2008) *Independent Review of Restraint in Juvenile Secure Settings*. London.

inspections, and will consider whether a further report is necessary to revisit these objectives.

- 1.7** To inform this report, the HMI Prisons review team conducted fieldwork in six establishments: pre-implementation fieldwork in one YOI and one STC, and post-implementation fieldwork in two YOIs and two STCs. As part of the fieldwork, we interviewed children who had experienced restraint, staff who had experience of applying MMPR and the restraint systems which preceded it (physical control in care, PCC, and control and restraint, C&R), members of establishment health care teams, and representatives from local authorities with safeguarding responsibilities in secure establishments. Group discussions were held with establishment senior managers and MMPR coordinators responsible for MMPR training and monitoring at a local level. In addition, use of force documents, behaviour management plans and CCTV of restraint incidents were also reviewed. Further detail about the methodology is in Appendix I.

## Key findings

- 1.8 It is sometimes necessary to restrain children physically in secure settings but there are no completely safe restraint methods. Overall, the development of MMPR is a clear improvement on the previous systems.** The restraint-related deaths of 15-year-old Gareth Myatt and 14-year-old Adam Rickwood in 2004 initiated a lengthy process of review, which culminated in the development of MMPR in 2009. The risks that children in secure settings sometimes pose to themselves and others mean that it is sometimes necessary to restrain them physically and this is accepted, with strict caveats, in international human rights standards. Nevertheless, we agree with the conclusion of the 2008 *Independent Review of Restraint in Juvenile Secure Settings*, to which MMPR was the direct response, that 'there is no such thing as "entirely safe" restraint', and children have continued to suffer restraint-related injuries in establishments that have implemented MMPR. The principles behind MMPR, which emphasise one consistent system of behaviour management, de-escalation and minimising the use of force required, and the establishment of effective local and national supervision and governance systems, are a clear improvement on the different and limited systems that existed before. (See paragraphs 2.8 to 2.10, 2.20 to 2.21, 2.23 to 2.28, 2.31 to 3.31, and Section 6.)
- 1.9 Resource pressures, the contraction of the juvenile estate and the need for cultural change have delayed the implementation of MMPR. This has inhibited the development of consistent good practice and needs to be addressed.** The training, supervisory and implementation costs of MMPR are significant. Staffing shortages across some parts of the juvenile estate and the contraction of the estate mean that implementation has fallen behind the original schedule and is not yet complete. At an early stage in the development of MMPR it was recognised that its successful implementation depended on cultural change. The difference in the application of MMPR between STCs and YOIs and the concerns set out below indicate this cultural change has not yet occurred. The Youth Justice Review announced by the Justice Secretary in September 2015 provides an opportunity to address the wider structural, staffing and cultural issues on which the fully successful implementation of MMPR depends. (See paragraphs 2.12, Section 4 and paragraphs 5.1 to 5.5.)
- 1.10 A national training resource is still required to meet significant training needs.** National inconsistencies between and within establishments that have already implemented MMPR mean that national governance and training functions remain necessary. In its final report, the independent restraint advisory panel (IRAP) recommended that a dedicated MMPR training team remains in place. This recommendation remains valid and we welcome the commitment of the Youth Justice Board (YJB) and National Offender Management

Service (NOMS) to maintaining this resource. Despite the development of a bespoke MMPR course for health and local authority staff, we found many had not attended adequate training to understand their roles in MMPR. (See paragraphs 2.50, 4.11 to 4.18, and 6.36 to 6.37.)

- 1.11 Behaviour management processes required improvement to ensure the safe and effective management of children within secure settings.** Not enough emphasis was placed on behaviour management as a means to reduce the incidence of restraint of children in fieldwork sites. Behaviour management plans (BMPs) were not always used proactively for children who exhibited challenging behaviour, often only being established once a child had already been restrained. Behaviour management was not always effective; BMPs did not always evidence effective engagement with a child's individual assessed needs, or identify clear behavioural targets for children. Within plans there was also little evidence of staff assisting children to address their objectives, recording a child's progress or reviewing a child's progress at all. This lack of effective behaviour management could have been a contributing factor to the number of restraint incidents. (See paragraphs 5.7 to 5.14.)
- 1.12 More can and should be done to de-escalate incidents and avoid the use of physical restraint.** We found that not enough was being done to de-escalate incidents and prevent restraints taking place, particularly for cases of restraint to prevent self-harm and strip searching under restraint. More effort should be made, and documented, to reduce the need to restrain children who are at risk of self-harm, and reduce the need to strip search children under restraint. Lower staff:child ratios in YOIs and inconsistent staff deployment limits the ability of staff to get to know the children under their care. This affects their ability to avoid incidents by effectively managing behaviour and to de-escalate incidents to reduce the likelihood that restraint will be required. Children reported that staff across both YOIs and STCs did not give them enough opportunity to 'back down' or modify their behaviour before they were restrained. (See paragraphs 5.15 to 5.28 and 5.91 to 5.104.)
- 1.13 Restraint hurt and sometimes caused injury to children. Techniques were not always applied correctly or informed by the known medical conditions of individual children.** Restraint using MMPR was not always conducted safely. Within STCs restraint handling plans (RHPs) were put in place to inform staff about how a child could be safely restrained based on any known medical conditions. While some plans were comprehensive too many were of poor quality, not providing any specific information about the particular child, and in some instances where they were put in place instructions were not always followed by all staff involved in the restraint. (See paragraphs 5.34 to 5.39.)
- 1.14 Children who were not known to each other and in different establishments gave us consistent accounts of staff sometimes using excessive force, for example using a higher level hold than was required, not releasing holds when they had calmed down sufficiently to do so, or not verbally trying to de-escalate the incident.** Not releasing holds could result in some children being moved long distances in high level MMPR holds, increasing the likelihood of injury to children, or indeed staff, as a result. Records we reviewed supported children's reports that they were regularly 'taken to the floor', despite the known dangers in doing so. (See paragraphs 5.71 to 5.84.)
- 1.15 Many children still reported that restraint was a painful and distressing experience.** Despite MMPR being designed to be safer than previous methods of restraint, such as PCC and C&R, children still reported that restraint, and some holds in particular, which are not intended to cause pain, caused them significant discomfort and pain, and that staff did not always respond appropriately by checking the hold(s) were being applied properly and readjusting them to avoid injuries. In the six months to September 2014, of the 462 incidents of restraint in STCs, 11 minor injuries were sustained that required medical treatment, with eight such cases out of the 764 incidents in YOIs – two involving serious injuries that required hospital treatment. Some incidents we reviewed or were told about

would have required investigation as potential staff misconduct. (See paragraphs 5.49 to 5.121.)

- I.16 Children were not always monitored when it was possible to do so for serious injuries and warning signs (SIWS) during restraint.** Not all uses of restraint were attended by a member of health care staff for the specific purpose of monitoring the child for SIWS. This was sometimes as a result of the incident concluding before they had time to attend, but in a minority of cases they were not told of an incident taking place. Children told us how they sometimes experienced difficulty breathing and other SIWS during a restraint, and staff did not always take action to address these. This highlights the importance of a member of health care staff being in attendance to assist the MMPR supervisor in monitoring for SIWS and intervene to prevent serious harm to the child. (See paragraphs 5.40 to 5.48.)
- I.17 There was inappropriate use of pain-inducing techniques and they were not always used as a last resort to protect a child or other from immediate risk of serious physical harm.** Not all uses of pain met the very specific criteria within which pain can be applied, instead being used to ‘continue with the regime’. In YOIs, not all incidents of the use of pain were appropriately recorded with the justification for this provided. We did not find any evidence to justify the use of pain compliance as an approved technique. It was of note that similar incidents in STCs were resolved without the use of these techniques. (See paragraphs 5.105 to 5.121.)
- I.18 Staff and children involved in a restraint were not always medically assessed as soon after the incident as was practicable, and opportunities to improve the behaviour of children and the practice of staff were missed because they did not always receive a structured debriefing.** Health care staff did not medically assess all children, or staff, after an incident. In some cases, they would ‘check on’ the child through the hatch on their door rather than carry out a full assessment. This could lead to restraint-related injuries going unchecked. Effective debriefs did not always take place with children following an incident of restraint, and this was more pronounced in YOIs. In these circumstances, there was little opportunity for children to discuss the restraint itself, their actions that led to the restraint taking place, and how to prevent a restraint in the future – a key feature of effective behaviour management. Staff in YOIs were less likely to receive a medical assessment or participate in a structured debrief than their counterparts in STCs. A lack of reflection following an incident meant that staff could not modify or improve their own MMPR practice. (See paragraphs 5.126 to 5.144.)
- I.19 Governance has transformed but both national and local processes required accurate recording by staff, which was sometime inaccurate or delayed. Not all serious injuries and warning signs were recorded, which prevented thorough investigations.** Internal governance processes were not always effective, particularly in YOIs where significant delays in the completion of use of force documentation and the absence of CCTV coverage, coupled with inadequate quality assurance by MMPR coordinators, limited the ability of some establishments to monitor and analyse their own restraint-related data meaningfully. National structures have been established to provide a level of external oversight that did not exist under previous systems, but these remain dependent on establishments’ own internal analysis and monitoring. Body-worn cameras with audio can help address this, and initial feedback on their use has been positive, but they should not be allowed to inhibit normal staff-child interaction. (See Section 6.)
- I.20 The implementation of an obligation on all establishments to report SIWS that occur during a restraint is welcome. However, not all SIWS were recorded and referred appropriately, either as a result of inadequate local monitoring or inappropriate decision making by senior staff.** Without appropriate referral, full and thorough investigation cannot take place. (See paragraphs 6.36 and 6.37.)

- 1.21 Local safeguarding children boards (LSCBs) did not adequately scrutinise their establishments' use of restraint.** LSCBs were not scrutinising their establishments' use of restraint, instead dealing with specific child protection or safeguarding referrals made by the establishment. No LSCB staff we spoke to had undertaken any MMPR training, which hindered their effectiveness to review restraint, as they did not fully understand the system. (See paragraphs 6.33 to 6.35.)

## Recommendations

1. The findings of this report should inform the Youth Justice Review announced by the Justice Secretary in September 2015. All efforts should be made to ensure that the structure, culture and staffing of the secure juvenile estate enable staff to manage challenging behaviour effectively and de-escalate incidents of the use of force.
2. The findings of this report should inform any decisions by the YJB about the future roll out of MMPR. There should be a clear plan for the future implementation of MMPR with sustained efforts to roll it out in full across the children's estate, including to escort providers. National governance and training structures should remain in place.
3. Restraint should not be used for reasons relating to good order or security, and children should not be strip searched under restraint.
4. There should be restraint handling plans for all children with a medical condition that may be adversely affected by restraint. All staff should be aware of their contents and use the information during restraint.
5. All staff should be able to identify serious injuries and warning signs (SIWS) when they occur, make appropriate adjustments to the restraints, and report all SIWS to the national team.
6. Pain-inducing techniques should not be used on children and, until this is agreed, all incidents of pain compliance should be reviewed by the MMPR national team.
7. Health care staff should be included on first response calls in all establishments to assist with MMPR situations and monitor for serious injury warning signs. Health care staff should always physically examine a child after a restraint, and establishments should facilitate face-to-face contact.
8. All incidents where force is used should be recorded, including by audio and, once appropriate safeguards and procedures have been put in place, body-worn cameras should be used to achieve this. Staff should complete accurate and detailed use of force reports within 24 hours of an incident, which should detail all holds applied, including use of pain. MMPR coordinators should review reports and recordings and address any concerns with the staff involved. All incidents should be reviewed by a senior manager within seven days.
9. MMPR coordinators should have guaranteed hours and support to undertake their responsibilities, and commissioners should ensure these are delivered.
10. LSCBs and local authorities should ensure that they have sufficient expertise to enable effective independent oversight of restraint.



## Section 2. Background

### Context

- 2.1** To explain the context for the introduction of MMPR, and to provide a backdrop to the concerns expressed by the Justice Committee, this section sets out the composition of the children's secure estate and a brief recent history of restraint in establishments holding children.

### Youth justice secure estate

- 2.2** There are three types of secure establishment in England and Wales that hold children:

**Secure training centres (STCs)** were originally intended to hold children (boys and girls) aged 12 to 15 years old; however, with the introduction of detention and training orders (DTOs)<sup>3</sup> in 2000, the age range was extended to 18. Since their inception in 1998, there have been four privately-run STCs; in December 2014 the closure of Hassockfield STC, operated by Serco, was announced, leaving the G4S-run Medway, Oakhill and Rainsbrook STCs from January 2015.

**Young offender institutions (YOIs)** hold boys<sup>4</sup> aged 15 to 18 years old. A steady decline in the number of children in the secure children's estate has seen the closure of all of the girls' YOI units, as well as a reduction in the number of YOIs holding boys. At the time of writing in September 2015, there are currently five YOIs: Cookham Wood, Feltham, Parc, Werrington, and Wetherby. Parc is the only YOI that is privately run, and is operated by G4S.

**Secure children's homes (SCHs)** are run by local authorities or other providers and can hold children from the age of 10 to 17 on either criminal justice or welfare orders. In September 2015 there were 15 SCHs in England and Wales.

### Children in YOIs and STCs

- 2.3** Over the last decade, the number of children in YOIs and STCs in England and Wales has fallen by approximately two-thirds, from 2,817 in April 2005 to 981 in April 2015.<sup>5</sup>
- 2.4** Reductions in numbers led the Youth Justice Board (YJB) to decommission seven sites where children could be detained. In 2012 there were 15 establishments (11 YOIs and four STCs). By 2014 this had reduced to 10 establishments (six YOIs and four STCs)<sup>6</sup> and at the beginning of 2015 this fell to eight (five YOIs and three STCs).<sup>7</sup>

<sup>3</sup> A detention and training order (DTO) is a custodial sentence for 12-17 year olds that combines detention with training. A DTO lasts for between four months and two years and is given to children who commit a serious offence or a number of offences.

<sup>4</sup> Boys only since the closure of girls' units in 2013.

<sup>5</sup> Youth Justice Board (2015) *Youth custody report: May 2015*. Available: <https://www.gov.uk/government/statistics/youth-custody-data>. Note: This data includes people aged 18 who were held in the children's secure estate but excludes those held in secure children's homes.

<sup>6</sup> The girls' units at HMYOIs Eastwood Park, Downview and New Hall closed and Ashfield re-roled to an adult establishment.

<sup>7</sup> Warren Hill has re-roled to hold adults and Hindley has re-roled to hold young adults and adults.

- 2.5** While this is a welcome reduction, the children who remain in secure accommodation are likely to have committed serious and/or repeat offences, exhibit very challenging behaviour and have a high level of complex needs.
- 2.6** *A profile of children in custody*<sup>8</sup> published in 2010 found that two-fifths of children had been on the child protection register or had experienced abuse and neglect, a quarter had witnessed domestic violence, and more children in custody than in the community had experienced loss or bereavement. Current evidence continues to identify high levels of need.
- 2.7** Findings from our own annual survey of children and young people<sup>9</sup> support much of the existing research: over a third of boys in YOIs reported having been in local authority care at some point (38%), 18% considered themselves to have a disability, and 24% said that they had an emotional or mental health problem. Thirty-six per cent of boys told us they had problems with drugs on arrival into custody, and 7% reported a problem with alcohol. Almost nine in 10 boys (85%) said that they had been excluded from school, and 75% reported having truanted.
- 2.8** In 2013–14 there were almost 3,000 assault incidents in the children’s secure estate, a 7% increase on 2012–13, even though the number of children in custody had fallen by 20%. There were 14.6 assaults per 100 children in 2013–14 compared with 10.1 in 2012–13.<sup>10</sup>
- 2.9** There were over 1,300 incidents of self-harm in 2013–14.<sup>11</sup> The number of incidents of self-harm increased from 5.2 per 100 children in 2012–13 to 6.6 per 100 children in 2013–14.<sup>12</sup>
- 2.10** Given the difficult and sometimes harmful behaviour of some children in custody, those caring for or supervising them in secure settings will, on occasion, need to restrain them in order to prevent them from causing harm to themselves or others. Across the children’s secure estate in 2013–14 there were 5,714 incidents of restrictive physical intervention (RPI). Although this was a decrease on previous years, the reduction in the size of the children’s secure estate meant that the number of RPIs per 100 children actually increased from 23.8 in 2012–13 to 28.4 in 2013–14.
- 2.11** The profile of those held in custody has also changed during the last decade. The number of children on DTOs and on remand has fallen by two-thirds in the last 10 years. In contrast, the number of children in YOIs and STCs who are serving longer sentences, which by their nature are given to those who have committed more serious offences, has not fallen as dramatically.<sup>13</sup> This has led to a greater concentration of those convicted of serious crimes being held in YOIs and STCs.

## Youth Justice Review

- 2.12** In September 2015, the Justice Secretary announced a review of the youth justice system. The terms of reference of the review included:

*‘the delivery models for detaining young people remanded or sentenced to custody and for supervising and rehabilitating young offenders in the community. This includes the interventions and support provided by these services and the co-ordination and integration between custodial and community youth offending services, and the interaction with wider services for children and*

<sup>8</sup> <http://www.prisonreformtrust.org.uk/portals/0/documents/punishingdisadvantage.pdf>

<sup>9</sup> Redmond, A. (2015) *Children in Custody 2014–15*. London

<sup>10</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/399379/youth-justice-annual-stats-13-14.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/399379/youth-justice-annual-stats-13-14.pdf)

<sup>11</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/399379/youth-justice-annual-stats-13-14.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/399379/youth-justice-annual-stats-13-14.pdf)

<sup>12</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/399379/youth-justice-annual-stats-13-14.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/399379/youth-justice-annual-stats-13-14.pdf)

<sup>13</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/434378/youth-custody-report-april-2015.xls](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/434378/youth-custody-report-april-2015.xls)

*young people. In respect of custody, this also includes the arrangements to safeguard young people.'*

The review provides the opportunity to address the development of MMPR in the context of structural and staffing changes necessary to create the culture required for its fully successful implementation.

## Systems of restraint prior to MMPR

**2.13** Prior to the development of MMPR, a range of different restraint methods were in operation across the children's secure estate.

**2.14** **Control and restraint (C&R)** was introduced in 1983 as the approved method for physical restraint in both adult prisons and YOIs holding boys and girls aged 15 to 18. It continues to be in use in adult prisons and in YOIs holding boys that have not yet implemented MMPR. C&R does not distinguish between adults and children in the techniques used. The basic principles of C&R are outlined in this description provided in the *Independent Review of Restraint in Juvenile Secure Settings (IRRJSS)*:<sup>14</sup>

*'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.'*

**2.15** **Physical control in care (PCC)** was a new form of restraint developed by the National Offender Management Service (NOMS) and the national tactical response group (NTRG) in 1998 specifically for use with children held in STCs, and was governed by the Secure Training Centre Rules 1998.<sup>15</sup>

**2.16** PCC was originally designed for use on children aged 12 to 14 and was a development of 'protecting rights in the care environment' (PRICE), a method of restraint devised by the Prison Service and which had come into use in some SCHs.

**2.17** The PCC system is based on a series of holds intended to restrict the movement of a child, suitable for use by one, two, or three staff. Holds are graded according to the level of resistance of the child. PCC holds are intended to maintain the child in a standing or sitting position; the system does not include techniques that deliberately take the child to the floor, but a child under PCC restraint may be placed on their knees if their safety or the safety of others is considered at risk. PCC includes a hold release option when it is considered that the continued application of physical holds by staff on the child becomes unsafe. In those circumstances the child must be released. Distraction techniques, which involve inflicting pain to thumb or ribs, are permitted as a last resort to prevent a child from causing serious injury to themselves or others and when other PCC techniques have been unsuccessful or are inappropriate.

**2.18** Since the introduction of MMPR, PCC is no longer used in any STCs but it is still used by escort providers and for children in immigration detention, despite significant concerns regarding its safety.

<sup>14</sup> Smallridge, P. & Williamson, A. (2008) *Independent Review of Restraint in Juvenile Secure Settings*. London.

<sup>15</sup> Available at: <http://www.legislation.gov.uk/ukSI/1998/472/made>

**2.19** In **secure children homes** a range of different restraint methods are in use, with each local authority (or other provider) making its own decision about the system employed. There is no central mandating or accreditation of the safety of the techniques. No SCHs use C&R, PCC or MMPR. SCHs do not fall within the inspection remit of HMI Prisons, and are therefore excluded from the scope of this review.

## Human rights standards relevant to restraint

**2.20** Under the UN Convention on the Rights of the Child, ratified by the UK in 1991, restraint or force should only be used when a child poses an imminent threat of injury to him or herself or others, and only when all other means of control have been exhausted. The principle of the minimum necessary use of force for the shortest necessary period of time must always apply.<sup>16</sup>

**2.21** Human rights bodies have consistently opposed the deliberate infliction of pain as a form of control, and in 2009 the European Committee for the Prevention of Torture recommended that the UK discontinue the use of 'manual restraint based upon pain compliant methods' and that only specifically designed non-compliant manual restraint techniques, combined with better risk assessment of young people and enhanced staffing skills, should be used in juvenile establishments.<sup>17</sup>

## The development of MMPR

**2.22** The timeline below sets out the key stages in the development of MMPR, with more detail provided on each of the stages in the following section.

Date	Detail
2004	The restraint-related deaths of Gareth Myatt and Adam Rickwood raise serious concerns about the safety and efficacy of PCC.
2005	The YJB commissions a review of potentially unsafe holds in PCC to be undertaken by a specialist medical panel; the seated double embrace (which had been suspended shortly after Gareth Myatt's death) is permanently discontinued.
November 2007 – February 2008	A further review into PCC is commissioned by the YJB and undertaken by a specialist medical panel.  Following preliminary findings, the nose distraction technique and the double basket hold are suspended. The medical panel conclude that PCC is overly complicated.
April 2008	An expert panel is commissioned by the YJB to risk assess seven restraint techniques taught within PCC. Significant concerns are raised with the nose distraction technique, rib distraction technique and the double embrace lift, and the panel recommends their immediate discontinuation.
December 2008	Report of the <i>Independent Review of Restraint in Juvenile Secure Settings (IRRJSS)</i> makes 58 recommendations.

<sup>16</sup> UN Committee on the Rights of the Child, *General Comment 8, The right of the child to protection from corporal punishment and other cruel or degrading forms of punishment* (2006), para 15 and *General Comment 10, Children's rights in juvenile justice* (2007), para 89.

<sup>17</sup> *Ibid* UN Committee on the Rights of the Child 2007, Council of Europe Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), *Report to the Government of the UK on the visit to the UK from 18 November to 1 December 2008* (2009) para.107.

	The government response to the IRRJSS accepts the majority of recommendations and concludes that a single system of restraint should be developed for use in YOIs and STCs.
2009	The National Offender Management Service (NOMS) and the national tactical response group (NTRG) are commissioned to develop a new restraint system for children in YOIs and STCs.
2009	<b>Restraint management board (RMB)</b> established as the senior decision making body overseeing restraint policy, practice and evaluation processes during the development phase of MMPR.
June 2010	<b>Restraint accreditation board</b> , subsequently designated the <b>restraint advisory board (RAB)</b> , established to make recommendations to ministers about the safety and efficacy of the new system of restraint and report to the RMB.
August 2011	RAB publishes its report to government on its assessment of MMPR. A total of 37 recommendations are made, including the removal or adaptation of some techniques.
February 2012	RAB dissolved and succeeded by the <b>independent restraint advisory panel (IRAP)</b> . The IRAP's objective is to offer independent advice to the RMB on progress with the implementation of MMPR and review restraints systems in SCHs.  The IRAP goes on to create a medical sub-panel.
2012	<b>MMPR national team</b> is established within NOMS and works closely with the YJB MMPR team. It is tasked with developing and maintaining the safety and effectiveness of the MMPR syllabus, as well as overseeing the roll out of MMPR and delivering training to local MMPR coordinators and staff.  The national team is overseen by the <b>senior programme board (SPB)</b> , which reports directly to the RMB and is responsible for coordinating and reviewing the work of the national team.
September 2012	MMPR training commences at Rainsbrook STC, the first STC to implement MMPR.
March 2013	MMPR goes live at Rainsbrook STC.
March 2013	Justice Committee review of the youth justice system published and recommends that HM Chief Inspector of Prisons reports on the impact and implementation of MMPR.
April 2013	MMPR training commences at Wetherby, the first YOI to implement MMPR.
June 2013	HMI Prisons review of MMPR commences.
October 2013	MMPR goes live at HMYOI Wetherby.
June 2014	The IRAP publishes a report that makes recommendations about the governance of MMPR and certain techniques, for example the head hold. The report also recommends that HMI Prisons continues to monitor MMPR over a longer period to assess whether MMPR is sustainable.
July 2014	The IRAP is disbanded, along with the medical sub-panel, and the <b>serious injuries and warning signs (SIWS)</b> medical panel is created to review SIWS cases and continue to advise the governing body of MMPR.
December 2014	RMB and SPB are formally dissolved and replaced with one governing body, the <b>behaviour management and restraint governance board (BMRGB)</b> and a working group that sits underneath it, the <b>behaviour management and restraint working group (BMRWG)</b> .

## Deaths of two children in secure training centres in 2004

**2.23** The origins of MMPR lie in the aftermath of the tragic deaths of two boys in STCs. Gareth Myatt and Adam Rickwood died within four months of each other in 2004.

**On 19 April 2004, Gareth Myatt** died as a consequence of physical restraint at Rainsbrook STC where he was three days into a 12-month sentence.<sup>18</sup>

After refusing to clean a sandwich toaster one evening, Gareth was sent to his cell and locked in; officers subsequently entered and decided to place Gareth into 'single separation', which consists of removing a child from association as a way of giving them 'time out' and time to calm down. Officers then started to remove his possessions from his room; these included a piece of paper with his mother's telephone number on it. Gareth became angry that this paper was removed and is reported to have swung a clenched fist at the officer and was subsequently restrained.

Gareth was restrained using a 'seated double embrace', a technique that involves two officers either side of the person locking the arms and legs and leaning the body forward with a third officer in control of the head. During the restraint Gareth stated that he could not breathe. The officer's response was *'if you can talk, you can breathe'*.

The restraint continued even after Gareth slumped forward. When the restraint was finally stopped Gareth was found to be unconscious; efforts to resuscitate him failed.

The cause of Gareth's death was recorded as 'asphyxia resulting from a combination of inhalation of gastric content and his body position during physical restraint'. The coroner gave a verdict of accidental death.

The jury concluded that there had been no adequate assessment of the safety of PCC, in particular the seated double embrace, and that this inadequate assessment had directly contributed to the death of this child. Shortly after Gareth's death, the seated double embrace was removed from the list of approved PCC holds.

Gareth was 15 years old when he died.

**On 9 August 2004, Adam Rickwood** was found hanging in his cell at Hassockfield STC. Adam had been restrained earlier that day and a pain-inducing technique, the nose distraction technique, had been applied.

The initial inquest found that Adam had taken his own life; the restraint incident had not directly contributed to his death and staff had behaved appropriately. However, the coroner had refused to rule on the legality of the force used against Adam<sup>19</sup> and following an application for judicial review by Adam's mother, a second inquest<sup>20</sup> was opened.

The second inquest concluded that there was 'a serious system failure in relation to the use of physical control in care at Hassockfield, giving rise to an unlawful regime' whereby Adam was restrained for non-compliance (failure to obey orders) against the STC rules. Contrary to the initial

<sup>18</sup>

[http://www.howardleague.org/fileadmin/howard\\_league/user/pdf/Events/INQUEST\\_submission\\_to\\_the\\_Restraint\\_review\\_appendix.doc](http://www.howardleague.org/fileadmin/howard_league/user/pdf/Events/INQUEST_submission_to_the_Restraint_review_appendix.doc)

<sup>19</sup> [2009] EWHC (76) Admin

<sup>20</sup> Second inquest into the death of Adam Rickwood, January 2011, jury verdict.

ruling, the use of force was deemed unlawful and furthermore, this and the use of the nose distraction technique had 'more than minimally' contributed to Adam's death.

The narrative verdict also recorded that PCC instructors at Hassockfield were not adequately trained in PCC by the Prison Service, and that the staff on duty were not sufficiently trained in high risk assessment, suicide awareness or behaviour management/de-escalation, which shaped the subsequent recommendations made by the inquest.

Adam's vulnerabilities were known to staff before his death, he had a history of self-harm and suicide attempts and he was placed a very long way from home. Following the incident, Adam's distress was evident in the statement he had written about the restraint he had experienced earlier that day:

*'What gives them the right to hit a 14-year-old child in the nose?'*<sup>21</sup>

Adam was 14 when he died, the youngest person to die in custody in the UK in recent times.

## Responses to the deaths (2004–08)

**2.24** In the months and years immediately following these deaths, various reports, inquiries and reviews reflected a growing concern about safety in relation to the restraint of children. These reports led to a number of piecemeal changes to restraint methods and their governance.

### Review of PCC holds

**2.25** The holds used in PCC came into question in 2004 following the deaths of Gareth and Adam, who were both restrained using PCC techniques. Several reviews into the holds used in PCC were conducted over the following three years.

**2.26** In 2005 a medical review panel was assembled by the YJB to review the potentially unsafe holds in PCC and recommendations for immediate implementation were made; these included the permanent suspension of the use of the seated double embrace,<sup>22</sup> a decision that was included in the revised training programme for PCC and rolled out to all STCs by April 2006.

**2.27** The medical panel conducted a further review of PCC in November 2007. Following its preliminary findings, the nose distraction technique was suspended from use in STCs in December 2007 until further notice on the grounds that it was unnecessarily invasive. The double-basket hold was also removed from PCC because of the risk of respiratory difficulties. The panel's report, published in February 2008, concluded that PCC was over-complicated and included too many holds.<sup>23</sup> In April 2008, an expert panel was commissioned by the YJB to further risk assess the nose distraction technique along with a further six techniques taught within PCC:

- the rib distraction
- the tantrum hold
- the double embrace

<sup>21</sup> Inquest's briefing on the Secure Training Centre (Amendment) Rules 2007.

<sup>22</sup> Joint Committee on Human Rights (2008) *The Use of Restraint in Secure Training Centres*. Eleventh Report of Session 2007–08

<sup>23</sup> Findings available at:

<http://webarchive.nationalarchives.gov.uk/20130401151715/http://www.education.gov.uk/publications/eOrderingDownload/Review%20of%20restraint.pdf>

- the double embrace lift (and escalation)
- the single basket hold
- the hair grab release.

**2.28** The panel raised significant concerns with three of these techniques – nose distraction, rib distraction and double embrace lift – and recommended that they be discontinued immediately.

### ***Independent Review of Restraint in Juvenile Secure Settings (IRRJSS)***

**2.29** The work described above had begun to tackle important issues about the safety and legitimacy of the restraint of children. However, in focusing on specific techniques or circumstances the reviews did not address broader or more fundamental issues related to the use of restraint, such as behaviour management, ethical practices or the use of pain. The serious case review following Adam Rickwood's death recommended a national review of restraint. This led to the government commissioning an Independent Review of Restraint in Juvenile Secure Settings (IRRJSS),<sup>24</sup> which was carried out by Peter Smallridge and Andrew Williamson, both trained social workers and previous directors of social services. At the time of conducting the IRRJSS, both authors were chairs of NHS organisations.

**2.30** The review was published in December 2008, together with the government's response, which set out acceptance in full, or in principle, of almost all the review's 58 recommendations. The review's introduction stated the following, which provides a useful backdrop for the recommendations made:

*'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.'*

**2.31** The review found that while there had been substantial scrutiny of restraint in STCs, little attention had been given to the safety of C&R for children detained in YOIs who, at the time, comprised 85% of the youth custody estate. It recommended that the Prison Service provide staff with restraint techniques suitable for use on children that were not reliant on pain compliance, and that an effective overall approach to behaviour management should be in place.

**2.32** The review concluded that PCC was not fit for purpose, was too complicated and, having been designed for use on 12–14-year-olds, was unsuitable for use with the older, bigger children now held in STCs; these issues had led to unacceptably lengthy periods of restraint for some children – up to two hours in extreme cases. Furthermore, the gradual withdrawal of PCC techniques described above had affected the coherence of the system as a whole; the review recommended that a new method of restraint should be commissioned for STCs.

**2.33** The use of pain compliance against children was also addressed in the review, which concluded that 'a degree of pain compliance may be necessary in exceptional circumstances', while acknowledging that this was irreconcilable with the UN Convention on the Rights of the Child, and contrary to the views of the Children's Commissioner, the Parliamentary Joint Committee on Human Rights and others, including inspectorates of the secure estate.

**2.34** When considering the future of restraint, the review recommended that:

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<sup>24</sup> Smallridge, P. & Williamson, A. (2008) *Independent Review of Restraint in Juvenile Secure Settings*. London.

*'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 of restraint against these principles:*

- *Force should be used only as a last resort*
  - *Force should only be used 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.'*

**2.35** A mandatory accreditation scheme for all staff was proposed, assessed by an independent accreditation panel. In recognition that an accreditation system would take some time to set up, other recommendations focused on changes that could be implemented incrementally, such as better training, improved risk assessment, more robust reporting and monitoring of restraint, and measures to protect children following restraint.

**2.36** The recommendations in the review highlighted the need for improved governance, including the establishment of a restraint management board to be chaired at ministerial level. A role was also specified for local safeguarding children boards (LSCBS) in overseeing and reporting to the YJB on restraint in secure settings in their area.

**2.37** The IRRJSS included an examination of the arguments for and against a single consistent method of restraint across the secure estate and concluded that the existing diversity of restraint methods was justified, although greater consistency across the estate was necessary. Despite no specific recommendation to this effect, in the government's response to the review, ministers concluded that a single system of restraint across YOIs and STCs should be developed.

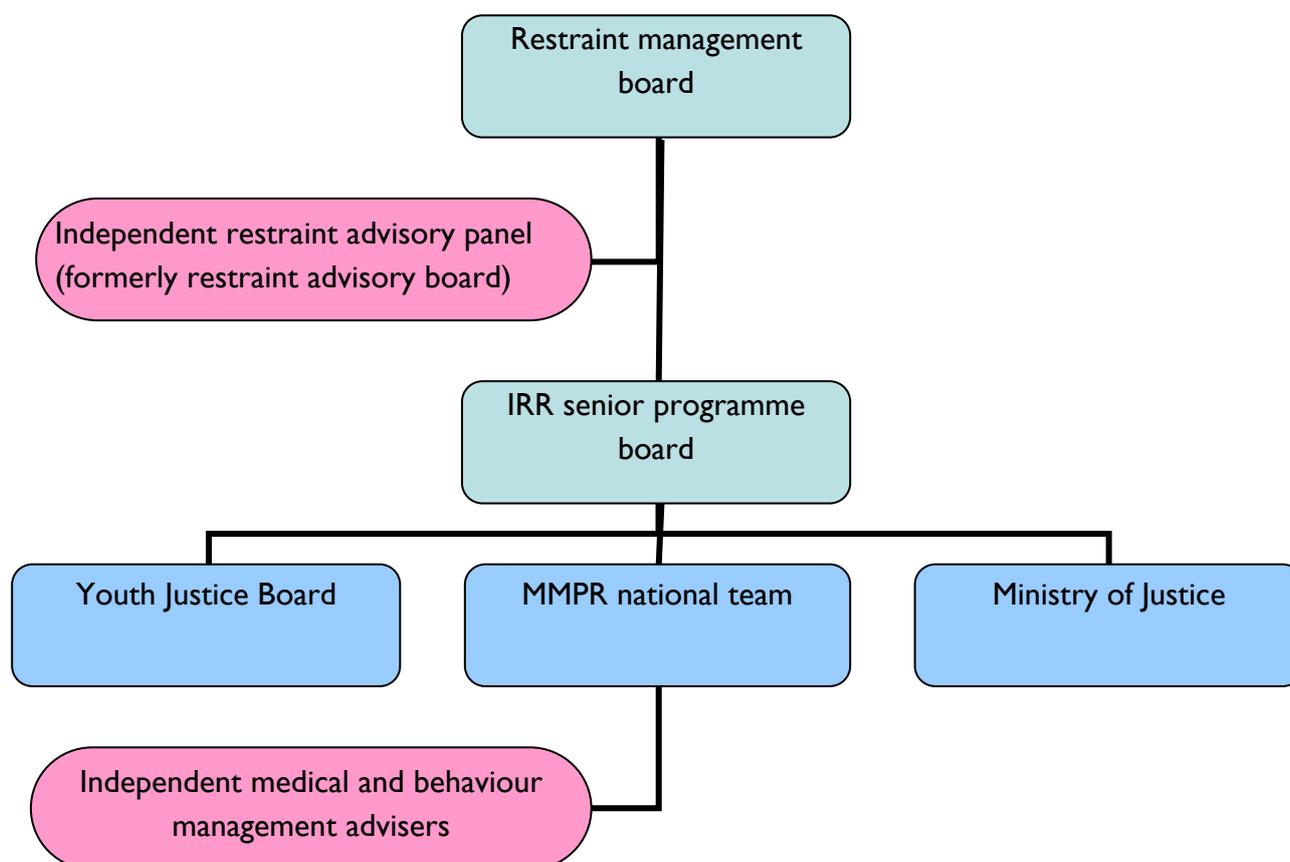
### **Developing MMPR**

**2.38** In 2009, NOMS and its specialist unit, the national tactical response group (NTRG) was appointed to develop the new restraint system and place it within a wider behaviour management framework. The new method of restraint was termed 'minimising and managing physical restraint' (MMPR).

**2.39** Various groups and bodies were established to provide oversight and continual monitoring to ensure that the MMPR system was appropriately developed, reviewed and modified to be effective and safe for both children and staff. The original governance arrangements that describe the roles and responsibilities of each agency and how strategic and implementation arrangements will be planned and agreed are clearly set out in a joint Ministry of Justice (MOJ), NOMS and YJB document, *Minimising and Managing Physical Restraint, Safeguarding Processes, Governance Arrangements, and Roles and Responsibilities*,<sup>25</sup> published in July 2012.

**2.40** Figure I shows the various overarching bodies that shared responsibility for the implementation and delivery of MMPR in establishments.

<sup>25</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/367051/minimising-managing-physical-restraint.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/367051/minimising-managing-physical-restraint.pdf)

**Figure 1: MMPR implementation phase high-level governance structure****Restraint management board**

**2.41** The restraint management board (RMB) was chaired by the MOJ and comprised senior officials from the YJB, MOJ and NOMS. The RMB was established as the senior decision-making body for restraint-related matters in the secure estate for children and young people. The RMB was responsible for overseeing restraint policy and practice and a range of local and central monitoring and evaluation processes during the development phase of MMPR.

**2.42** The RMB directed a number of work streams and research, in particular in relation to emerging concerns that arose from the analysis of the operational evidence base. The board then made recommendations to ministers about MMPR and proposed changes in light of findings from operational evidence and national monitoring. This advice was also informed by the evidence from the restraint advisory board (RAB) and subsequently the independent restraint advisory panel (IRAP).

**Restraint advisory board (RAB)**

**2.43** To provide ongoing oversight and assessment of MMPR as it was under development, the MOJ formed the RAB, which reported to the RMB and comprised a wide range of people with relevant professional, medical and operational expertise. The RAB had the status of an ad hoc advisory board with a specific objective to advise the Secretary of State on whether the new restraint system under development by NOMS should be approved for use in YOIs and STCs. The RAB began its work in June 2010.

- 2.44** At the end of August 2011, the RAB reported to the government on its assessment of MMPR.<sup>26</sup> The report contained 37 recommendations covering a range of issues, including the removal or adaptation of some restraint techniques. Other recommendations concerned managing health warning signs and risks, training and behaviour assessment, and reporting and governance.
- 2.45** The RAB noted that ‘the implementation of our recommendations amounts to a major cultural change programme going well beyond the initial assessment of the restraint proposals.’ This was significant in acknowledging that a wider programme of change was required in YOIs and STCs to address some of the working practices and approaches to behaviour management and restraint that were of concern within secure settings.
- 2.46** Following consideration of the report, ministers approved MMPR for use on children in STCs and YOIs and accepted all 37 of the RAB’s recommendations.
- 2.47** The RAB was formally dissolved in February 2012, evolving into the independent restraint advisory panel (IRAP) in April 2012 with a brief to provide ongoing independent advice to the RMB.

### ***Independent restraint advisory panel (IRAP)***

- 2.48** The IRAP was established in February 2012 as a successor to the RAB. The IRAP’s role was to offer independent advice to the RMB on progress with the implementation of MMPR, with particular regard to key recommendations for changes approved by ministers. The IRAP comprised members with medical and operational expertise. The IRAP’s role involved analysing MMPR data from medical and risk management perspectives, reassessing techniques where risks were identified, undertaking research, and taking account of national and international restraint-related medical evidence.
- 2.49** The IRAP also created a sub-group, the IRAP medical sub-panel, consisting of a paediatrician, a psychiatrist and a physiotherapist. This sub-panel met regularly with representatives of YJB and the MMPR national training team to discuss serious injuries and warning signs (SIWS) incidents identified as concerning following the internal scrutiny process. This included reviewing CCTV footage as well as use of force reports.
- 2.50** The IRAP published two reports before it was disbanded in 2014, one into the implementation of MMPR<sup>27</sup> and one on restraint systems used in secure children’s homes,<sup>28</sup> not covered in this review. The IRAP report into the implementation of MMPR made several recommendations about its future:
- that a dedicated MMPR training team remains in place
  - that an independent medical review panel is established to continue the work of the IRAP medical sub-panel
  - that petechial rashes (resulting from ruptured blood vessels) arising from the use of the head hold continue to be monitored
  - that improvements are made to the MMPR recording processes.

<sup>26</sup> Restraint Advisory Board (2011) *Assessment of Minimising and Managing Physical Restraint (MMPR) for the Children in the Secure Estate*. London

<sup>27</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/368626/irap-mmpr-final-report-2014.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/368626/irap-mmpr-final-report-2014.pdf)

<sup>28</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/376933/irap-restraint-in-youth-custody-report.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/376933/irap-restraint-in-youth-custody-report.pdf)

- 2.51** The review also made recommendations to HMI Prisons that it should continue to monitor MMPR and keep the process under regular review over a longer timescale in order to test the sustainability of the process.

### ***The senior programme board (SPB)***

- 2.52** The independent review of restraint senior programme board (SPB) was chaired by a senior manager from the YJB and attended by representatives from the MOJ, Home Office, Department for Education, NOMS and the MMPR national team. The SPB took responsibility for reviewing and coordinating the work of the MMPR national team (see below) and had oversight of implementation of the project and restraint practice issues, including some individual cases of concern. The SPB ensured that the RMB was kept up to date with emerging local and national themes, which were reported by the MMPR national team, ensuring that the RMB was able to take prompt action to address identified risks and concerns.
- 2.53** The SPB also monitored the delivery of the independent review of restraint recommendations<sup>29</sup> and maintained a watching brief on levels of physical restraint in individual establishments and escort providers across the secure estate. The SPB commissioned additional research and learning reviews to address common issues across sites, and ensured that required action arising from the reviews was considered by the RMB and incorporated into practice where necessary. Learning reviews included the use of the head hold, petichial rashes, entry into children's cells, the behavioural management aspects of incidents, and debriefing children after restraint.

### ***The MMPR national team***

- 2.54** The MMPR national team was established in 2012 and comprised staff from the YJB and NOMS. The team was tasked with developing and maintaining the safety and effectiveness of the MMPR syllabus. During the development of MMPR, the team received regular specialist advice from independent medical and behaviour management advisers who were consulted on all matters relating to restraint techniques, including any proposed changes and the impact these might have on children. Advice was primarily derived from reviewing restraint-related injuries, any warning signs and/or symptoms, and informed the national team's reports to the SPB.
- 2.55** The national team has continuing responsibility to deliver MMPR training to all senior and operational staff, with a particular emphasis on ensuring medical safety. The team supports STCs and YOIs to restrain children properly in line with the MMPR syllabus, and encourages staff to avoid using physical restraint disproportionately or unnecessarily. The team works closely with MMPR coordinators in establishments to deliver coordinator training, and supports them in scrutinising their establishment's use of restraint.

### **National governance**

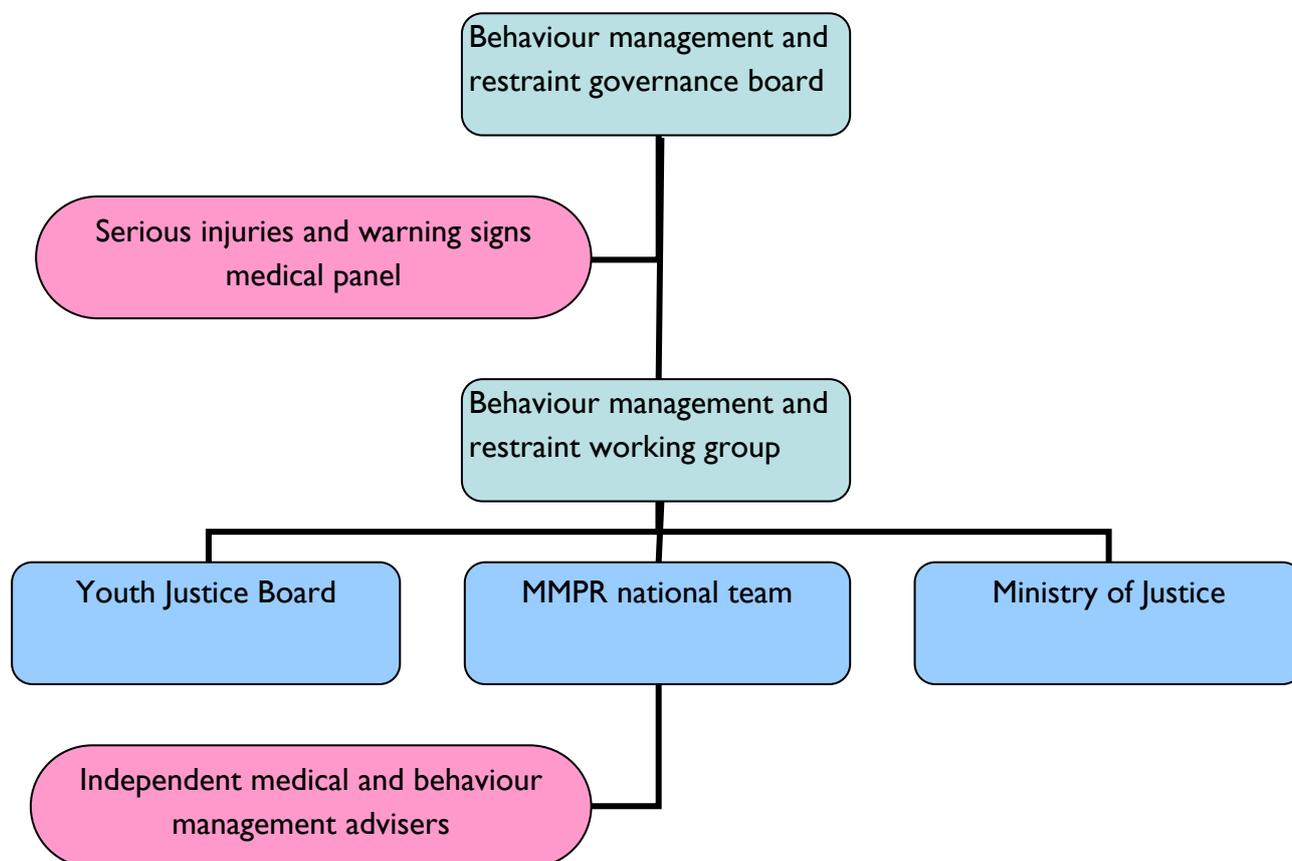
- 2.56** In recognition of the culmination of the policy development phase of MMPR, the national focus has shifted to operational delivery.
- 2.57** As a consequence of this revised focus, the RMB and SPB were formally dissolved in December 2014 and have been replaced with one governing body, the behaviour management and restraint governance board (BMRGB), which will continue to oversee the work of both new and existing bodies.

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<sup>29</sup> Smallridge, P. & Williamson, A. (2008) *Independent Review of Restraint in Juvenile Secure Settings*. London.

2.58 Figure 2 provides an overview of the current governance structure:

**Figure 2: MMPR operational phase high-level governance structure**



#### ***Behaviour management and restraint governance board***

2.59 The BMRGB is chaired by the chief executive officer of the YJB, as the lead organisation with oversight of operational practice. The BMRGB met for the first time in February 2015 and intends to meet quarterly. The meeting will continue to fulfil the previous role of the senior programme board, with an emphasis on operational practice, reflecting the now operational phase of MMPR. Its terms of reference were included in the revised *Roles and Responsibilities* document published in 2015. A representative from HMI Prisons attends the board in an advisory capacity.

2.60 The BMRGB retains input from the MOJ to progress any outstanding or developing policy issues. The BMRGB is informed by the behaviour management and restraint working group.

#### ***Behaviour management and restraint working group***

2.61 The behaviour management and restraint working group (BMRWG) is an inter-agency operational working group chaired by the YJB with members from NOMS and the MOJ.

The group meets fortnightly and supports and informs the work of the BMRGB, attending to specific issues in more detail. The group is critical to ensuring that the delivery of MMPR is properly managed and its terms of reference reflect this:

1. Oversee detailed progress of MMPR training programme.
2. Agree actions required to ensure parties discharge duties as per MMPR roles and responsibilities.
3. Manage monthly incident review sessions.
4. Manage SIWS process and medical panel.
5. Prepare and quality assure data.

***Serious injuries and warning signs (SIWS) medical panel***

**2.62** In line with the transition of MMPR towards a primarily operational delivery stage, the IRAP was disbanded in July 2014 and a new SIWS medical panel was established. The panel consists of medical experts from the IRAP, along with some additional members, and feeds back its findings to both the BMRGB and the BMRWG. The panel will continue to provide independent medical advice to those involved in the national management of MMPR. The newly reappointed panel now meets quarterly to consider and report on all reported SIWS.

## Section 3. The MMPR system

- 3.1** MMPR as a system of behaviour management and physical restraint operates within a larger system of behaviour management in YOIs and STCs. MMPR specifically focuses on strategies to de-escalate situations that may result in the need to restrain, and how to bring restraints to a quick and safe conclusion. The details of MMPR behaviour management strategies and physical restraint techniques are in the MMPR syllabus, which is a training manual for MMPR. The syllabus is set out in six volumes that detail the various aspects of restraint, the training of staff, and the monitoring and improvement of practice. Further detail of the MMPR syllabus is in Appendix II.

### Behaviour management

- 3.2** One central tenet of MMPR, alongside ensuring that children and staff are kept safe when there is a restraint, is a focus on managing the behaviour of children to minimise the use of physical restraint. The MMPR syllabus contains a module on behaviour recognition and decision making<sup>30</sup> to improve staff and children's relationships and promote positive behaviour in establishments.
- 3.3** De-escalation is a key technique in behaviour management to prevent an incident turning into a physical restraint; this refers to reducing the intensity and pace of interactions to gain control over a situation. MMPR draws on verbal and non-verbal techniques, such as giving clear instruction and not crowding children, to defuse conflict situations.
- 3.4** If behaviour management techniques fail and physical restraint is deemed necessary, the following process and stages must be adhered to. This necessarily begins with assessing whether the criteria for using physical restraint have been met, and ensuring that appropriate safeguards are in place to protect both the child being physically restrained and all staff involved.

### Physical restraint

- 3.5** Physical techniques are to be used only when other methods not involving use of force have been tried and have failed, or are judged unlikely to succeed, and action needs to be taken to prevent injury or serious damage to a child, member of staff, other people or property. Before a member of staff restrains a child they should ask themselves two key ethical questions: 'have I exhausted all reasonable options?' and 'am I acting in the best interests of the young person, another young person, or staff?'. The full criteria for physical restraint are set out below. If a member of staff deems it necessary to use such restraint, the guiding principle is that the minimum amount of force necessary should be applied at all times.

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<sup>30</sup> <http://webarchive.nationalarchives.gov.uk/20140715125548/http://www.justice.gov.uk/downloads/youth-justice/custody/mmpr/mmpr-vol2-behaviour-recognition-decision-making.pdf>

### Criteria for the use of physical restraint<sup>31</sup>

The application of physical techniques are to be used only when:

- other methods not involving use of force have been tried and failed, or are judged unlikely to succeed
- action needs to be taken to prevent injury or serious damage to:
  - the young person
  - staff
  - other people
  - property.

Restraint for reasons of good order and security is permitted in YOIs only. PSI 06/2014 provides that the use of restraint for good order:

*'Must always be the last option and must be planned and authorised in advance by an officer of custodial manager rank or above. The authorising officer must be assured that all other options including persuasion and negotiation have been tried and have proved ineffective for the use of force to be considered justified'.*

### Supervision during a physical restraint

- 3.6** Clear management of a physical restraint situation is vital to ensure that no one is accidentally hurt and that the physical restraint is ended as soon as possible. The incident manager, use of force supervisor and member of health services staff have the three main supervisory roles during a physical restraint.
- 3.7** The role of the **incident manager** is to take overall responsibility for the management of resources and logistics throughout an incident until it is safely concluded. The **use of force supervisor** is responsible for monitoring the physical restraint techniques applied during an incident. The staff who take up these roles during a restraint should play no active part in the restraint. The guidance recognises that in some circumstances, such as unplanned use of force incidents, staffing levels and the need to resolve the incident quickly may preclude the appointment of an incident manager or a use of force supervisor. In these circumstances, the initiating member of staff, or the most senior, will assume the role of the use of force supervisor until a staff member of an appropriate grade assumes control. In planned incidents, the incident manager and use of force supervisor roles should be allocated beforehand.
- 3.8** Where possible, all MMPR physical restraints should also be attended by a member of **health care** staff. Their role during a physical restraint is to ensure that any serious injuries or warning signs (SIWS)<sup>32</sup> are acted on, and to provide clinical advice to all involved in the event of a medical emergency.

### MMPR approved techniques

- 3.9** MMPR includes 11 core techniques taught as part of the training programme. The holds are categorised as low level, medium level, high level and pain inducing. Further detail about the specific holds is in Appendix II. MMPR holds are intended to be applied and removed

<sup>31</sup> <http://webarchive.nationalarchives.gov.uk/20140715125548/http://www.justice.gov.uk/downloads/youth-justice/custody/mmpr/mmpr-vol5-physical-restraint.pdf>

<sup>32</sup> Serious injuries and warning signs include: lost or reduced consciousness, abrupt/unexpected desistance of struggling or sudden calmness, blueness of lips/fingernails/ear lobes (cyanosis), tiny pinpoint red dots seen on the skin (upper chest, neck, face, eyelids), difficulty breathing, vomiting, and complaints of feeling sick or difficulty breathing.

sequentially, although it is not necessary to start at the lowest level, to ensure that the minimum amount of force for the situation is applied at all times.

- 3.10** The majority of holds permissible under PCC and C&R have been incorporated into MMRP, along with some additional specific MMRP techniques. All holds were assessed by the RAB before MMRP was implemented.
- 3.11** Pain-inducing techniques, which account for over a third of all approved MMRP techniques, must be restricted to circumstances where it is necessary to protect a child or others from immediate risk of serious physical harm, and the minimum necessary amount of force must be used at all times.<sup>33</sup>
- 3.12** An equivalent MMRP system for escorts was not in place when the fieldwork for this review was conducted and its implementation has been delayed. At the time of writing, the escorts version of the MMRP syllabus had undergone rigorous medical risk assessment by NOMS independent medical advisers and the SWIS medical panel. Ministers approved the delivery of the syllabus in July 2015, and the training for escort officers is included in the implementation plan for 2015/16. These arrangements will not apply to children being escorted to or from YOIs who are transported with adults.

### Post-restraint support for staff and children

- 3.13** The MMRP guidance<sup>34</sup> requires that both staff and children who are involved in a physical restraint are medically assessed as soon after the incident as is practicable to identify any injuries sustained.
- 3.14** The guidance also states that children should have the opportunity to participate in a structured debrief after an incident of physical restraint. For the child this is a chance to discuss their behaviour in the lead up to the restraint and identify strategies to avoid future restraint. The debrief also gives the child time to talk about any specific concerns they have with the restraint and should identify whether they need any immediate support. Outcomes should include an agreed action plan to encourage positive behaviour by the child, minimising the likelihood of future behaviour deteriorating to the point where there is a need to use physical restraint. Support should also be available for children through key workers/personal officers, social workers or independent advocates, such as Barnardo's.
- 3.15** All staff involved in physical restraint should also have the opportunity to participate in a debrief where they can discuss the incident and review their own involvement. These debriefs can be conducted individually or as a group with all staff involved in the physical restraint.

### Use of force records

- 3.16** After any restraint, a use of force record should be completed, and volume six of the MMRP syllabus (*Use of Force: Report writing*) contains detailed guidance on how to complete this. Use of force records serve two purposes: first, to record restraint data on a technique-by-technique basis, which is submitted to the YJB and NOMS for monitoring; and second, to include narrative and additional details about the incident itself. The narrative, which should be provided by each member of staff involved, should include the reason for restraint, the background to the incident, the staff involved, and the de-escalation methods deployed.

<sup>33</sup> HM Government (2012) Use of restraint policy framework for the under -18 secure estate (page 7) <http://webarchive.nationalarchives.gov.uk/20140715125548/http://www.justice.gov.uk/downloads/youth-justice/custody/mmpr/use-restraint-policy-framework.pdf>

<sup>34</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/367051/minimising-managing-physical-restraint.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/367051/minimising-managing-physical-restraint.pdf)

- 3.17** The MMPR guidance sets no specific timescale for submission of reports, but volume six states that staff should be allowed sufficient time (24–48 hours) after the incident to complete their written evidence to enable them to recall and record the incident with more accuracy and clarity.
- 3.18** Any SIWS observed should be included in the report, and it should be made clear if they are believed to be a direct result of the restraint itself, through the application or misapplication of a particular technique. This information is also submitted to the YJB and NOMS for referral to the SIWS monitoring system.
- 3.19** All written records should be quality assured by a senior member of staff or the MMPR coordinators responsible for overseeing MMPR within the establishment. The quality assurance process serves three main functions: to ensure that all relevant paperwork and data collection forms are completed promptly; to review all incidents for SIWS and other concerns; and to identify any additional learning to improve practice within establishments.

### **MMPR coordinators**

- 3.20** MMPR coordinators, recruited as part of the implementation of MMPR in each establishment, support MMPR implementation and delivery in individual establishments. MMPR coordinators review and quality assure restraint incidents and relevant documentation, and provide support to staff using MMPR. Coordinators are effectively the eyes and ears of the MMPR national team during day-to-day delivery, and so should be providing independent and impartial assessments of MMPR within their establishments.
- 3.21** MMPR coordinators deliver refresher training in their establishment, once they are assessed by the national team as having the skills to do so. In the long term, all refresher training will be undertaken by a member of the national team and a local MMPR coordinator.
- 3.22** The national team regularly observes and assesses the coordinators' ability to train effectively, and their accreditation to train is updated every six months. In 2015, an additional course was introduced to give coordinators training in other aspects of their work, such as quality assurance of incidents and debriefing children after they have been restrained. MMPR coordinators will have an additional training session whenever there are any changes to the syllabus to ensure that they are able to train establishment staff in the most up-to-date techniques.

### **Safeguarding in MMPR**

- 3.23** The absence of national restraint-related governance and accountability structures was highlighted as a contributing factor at the inquest into the death of Gareth Myatt. During the development stage of MMPR a robust interlinking governance structure, incorporating local and national processes, was put in place.
- 3.24** Establishments delivering MMPR have the following responsibilities: managing incidents, monitoring local practice, identifying required changes to practice and applying lessons learned, implementing change and reviewing results, and feeding into central oversight.
- 3.25** The MMPR national team and SIWS medical panel provide external scrutiny of local practice, share effective practice across the secure estate, address MMPR delivery issues, and make changes to the efficacy and safety of techniques in response to analysis.

- 3.26** Two formal systems operate nationally to safeguard MMRP: national team incident review meetings and SIWS monitoring.

### **National team incident reviews**

- 3.27** For the first six months that an establishment delivers MMRP, the national team and representatives from the YJB conduct a monthly review of selected cases. Once the team are satisfied that MMRP is being delivered and governed appropriately locally, the frequency of monitoring is reduced to quarterly, subject to continuing risk assessment.
- 3.28** Both monthly and quarterly reviews consider all related documentation and CCTV footage, where available. Feedback is given to the establishment and recommendations for improvements are made, to which the establishment is required to respond.

### **Monitoring serious injuries and warning signs**

- 3.29** The MMRP SIWS reporting process is a system for all staff involved in a restraint to record the circumstances of an incident where a serious injury or a medical warning sign was observed. These include symptoms such as vomiting or difficulty breathing.
- 3.30** Each reported incident is subject to prompt investigation and detailed scrutiny by the MMRP national team, the independent medical adviser to NOMS, and the SIWS medical panel. The panel's scrutiny includes a review of CCTV footage and any other recordings, and all available reports. All evidence is considered to assess whether the incident was handled correctly and if there are any lessons to be learned.
- 3.31** The SIWS panel's conclusions are detailed in a quarterly report to the BMRGB and include action points for consideration. The SIWS reporting process was significant in the development of the operational evidence base from which changes to the MMRP syllabus and techniques were made.



## Section 4. Implementing MMPR

### The planned roll out of MMPR

- 4.1** Starting in September 2012, a three-year implementation programme was devised to roll out MMPR in the children's secure estate, and train over 2,000 operational staff in four STCs, six YOIs and the YJB escort provider. Due to the intensive resources required, a phased implementation plan was devised by the YJB, NOMS and the national team whereby one or two sites would implement the system at a time. The original intention was for all STCs to be delivering MMPR by summer 2014, and for all YOIs holding under-18s to be delivering it by summer 2015.
- 4.2** Before MMPR goes 'live' in an establishment, MMPR coordinators need to be recruited and all staff undergo training. MMPR coordinators are recruited by individual establishments: four are required at each establishment, not at management level grade. Potential candidates have to submit a formal application and complete an assessment and interview that evaluates their knowledge of the principles of MMPR. In addition to the compulsory MMPR training course, which is described below, all MMPR coordinators attend a further two-week coordinators course. Coordinator training involves continuing observation by the national team and the opportunity to be supervised in delivering sections of the MMPR syllabus. Coordinators have to pass all modules, deliver MMPR in a live environment, and successfully complete three lesson observations before they can be accredited as coordinators.
- 4.3** An MMPR national training team was established to deliver the MMPR training. Team members included Prison Service staff and one person from the private sector (G4S<sup>35</sup>), to involve someone from an STC background.
- 4.4** MMPR training is delivered in two stages – all existing staff undertake a five-day MMPR training course, followed by refresher training before MMPR goes live. The training is based on the six volumes in the MMPR syllabus and, in addition to the MMPR techniques, also covers recognising a child's behaviour, assessing threat, and using de-escalation, and diversion strategies to minimise the use of restraint.
- 4.5** Staff who do not reach the required standard during the training are given individual support from the national team and local MMPR coordinators. Staff are referred for additional support if they are unable to achieve the pass mark in assessment of knowledge or cannot demonstrate all physical techniques to the required standard.
- 4.6** A new child-specific personal safety training syllabus has been developed, informed by the principles, ethos and knowledge that underpin MMPR, with particular regard to behaviour management, the law and medical advice. Where MMPR is not live, this one-day standalone training course is delivered alongside MMPR initial training. Where MMPR is already being delivered, it will be taught alongside the refresher training programme. The syllabus has been shared with G4S to deliver to its staff working in STCs and Parc YOI, and it will be offered to the YJB escort service provider when its staff receive MMPR training.
- 4.7** The staff training programme was planned by the YJB, NOMS and the national team to ensure that the training of large groups of staff did not have a detrimental affect on the regime delivered to children. There were plans to reduce the number of children in an

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<sup>35</sup> G4S currently run all three secure training centres (STCs), Medway, Oakhill and Rainsbrook.

establishment to facilitate continuation of the normal regime while groups of staff took part in the training.

**4.8** However, as this next section sets out, the roll out of MMRP did not follow the plan set out by the YJB, NOMS and the national team. While the first YOIs (Wetherby and Hindley) implemented MMRP to schedule, later YOIs experienced significant delays in undertaking MMRP training and going live with delivery. For example, training at Werrington was due to commence during summer 2014 but was delayed by several months due to staff shortages at the establishment and across the wider NOMS estate. The national team and YJB worked closely with NOMS over the summer of 2014 to explore several options, including pausing the delivery to YOIs until the staffing was less problematic, and delivering to two STCs simultaneously. However, this was not possible as the required temporary reduction in the number of available STC beds (to facilitate training) was not feasible.

**4.9** The table below shows the dates when training commenced and the dates when MMRP went live in these sites, or is due to go live.

**Figure 3: MMRP training status by establishment**

Establishment	Training commenced	MMRP 'live' date	Status
Rainsbrook STC	September 2012	March 2013	Using MMRP
Oakhill STC	March 2013	September 2013	Using MMRP
Wetherby and Keppel YOI	April 2013	October 2013	Using MMRP
Hindley YOI*	October 2013	January 2014	Using MMRP
Medway STC	December 2013	June 2014	Using MMRP
Werrington YOI	October 2014	May 2015	Using MMRP
Cookham Wood YOI	February 2015	June 2015	Using MMRP
Feltham YOI (under 18s)**	July 2015	February 2016	Planning stage
Parc YOI	April 2016	July 2016	Planning stage

\* Hindley YOI delivered MMRP until it was decommissioned as a children's establishment on 1 March 2015. Staff at Hassockfield STC were also trained but the centre closed in January 2015, before MMRP went live.  
 \*\* Once training of staff in the under-18s side of Feltham is complete, training will commence for staff working in the over-18s side. When all staff in both sides are trained, the whole of Feltham will use MMRP rather than C&R.

## Staff views on the roll out of MMRP

**4.10** As described in Section 2, there have been significant changes to the children's secure estate over the last decade. Alongside these changes there have been notable staff shortages during the implementation of MMRP, particularly in YOIs, which have led to reductions in regimes.

Voluntary redundancy following benchmarking and subsequent recruitment issues meant that YOIs were implementing MMPR with either too few staff or new and inexperienced staff. This affected their ability to maintain a normal regime during this period and was further exacerbated by the need to deliver MMPR training.

## MMPR coordinators

- 4.11** Establishments reported significant delays in getting MMPR coordinators accredited. Some establishments we visited were unable to facilitate the mandatory lesson observations required as part of accreditation, which led to significant delays in accrediting MMPR coordinators. In one STC we visited, only two of the four MMPR coordinators were fully accredited nearly six months after MMPR went live. This placed a sizeable burden on the two accredited MMPR coordinators in delivering training and quality assuring use of force reports. Delays in accrediting MMPR coordinators were compounded by staff shortages in establishments.
- 4.12** Some MMPR coordinators we spoke to did not feel that the coordinator training had fully equipped them for their specific roles and responsibilities. For example, they felt they would have benefited from more training in reviewing use of force incidents and the accompanying documentation, as well as undertaking the data inputting. MMPR coordinators raised perceived deficiencies in training as having a negative impact on their ability to perform their role in quality assuring use of force records. Some said that they did not fully appreciate what the role entailed when they applied for it, and would have appreciated more detailed information at that stage.
- 4.13** Coordinators did not always think that they had the required and appropriate support from senior management to establish themselves in the role. One coordinator we spoke to in a YOI said that a governor had made a comment to him about not having much work to do, suggesting that the governor did not fully understand or appreciate the MMPR coordinator role.

## Staff training

### Initial training

- 4.14** Overall, staff were complimentary about the training they received, in particular, that in the specific MMPR holds. While staff appreciated the renewed focus on behaviour management, some felt that the training did not place enough emphasis on this aspect of MMPR. Others felt that the behaviour management elements of the training were mostly commonsense and something they were already doing in their daily practice. Staff told us that the training could be improved to equip them with skills to de-escalate a situation before using MMPR techniques.
- 4.15** Staff we interviewed consistently told us that the training did not place enough emphasis on writing MMPR reports, which are key in the overall governance of MMPR.
- 4.16** In the establishments we visited, health care staff and local authority staff responsible for safeguarding and child protection work had not attended adequate training in MMPR. Some had attended a short three-hour briefing, but none had been comprehensively trained to understand the MMPR techniques fully. This was a concern, as both health care and local authority staff should play a key role in the delivery, monitoring and governance of MMPR, and a thorough working knowledge of MMPR is crucial to enable them to fulfil this role.

## Refresher training

- 4.17** Staff we spoke to appreciated the refresher training they received before MMPR went live, especially those who had attended the early training sessions a long time before. However, operational staff did not feel that that refresher training focused enough on the behaviour management elements of MMPR, and that it was a recap of the physical techniques involved. Senior managers also felt that staff could have benefited from more of a refresher in behaviour management before MMPR went live.
- 4.18** All staff should also receive refresher training every six months, when their accreditation to practice is renewed if they reach the required standard. Staff who were on the six-monthly refresher training recognised its necessity to allow them to continue to use MMPR, particularly to ensure that they were applying all the holds correctly. YOI staff particularly appreciated the frequency of the MMPR refresher training, as control and restraint (C&R) refresher training only takes place annually, which some viewed as insufficient.

## Embedding MMPR into establishments

- 4.19** Senior managers and operational staff spoke of the challenges of introducing MMPR into their establishments and the need for this to be carefully managed. Senior managers told us that clear communication with staff about the principles of MMPR and how its introduction would affect existing practice was essential. One establishment we visited provided an example of unclear communication, with operational staff reporting that they were told that some pain-inducing techniques could not be used with the children or they would be dismissed. This 'misinformation' took some time to be corrected at the initial site and further extended into other establishments, leading some staff to question the overall ethos of MMPR. To counteract this, the director of one STC held several staff meetings before the training began, to clarify the use of pain and other misconceptions. This ensured that all staff had the same information and that any initial questions could be addressed by a senior team member before the training took place.
- 4.20** Senior managers in YOIs acknowledged that the introduction of MMPR constituted a substantial culture change for staff.

*'It takes a long time for staff who have been using C&R for over 20 years to get it out of their system. The six-monthly refresher training is helpful in getting staff to continually develop their skills. But, honestly, we would have to acknowledge that there is still a long way to go.'*

## Staff views on MMPR compared with previous systems of restraint

- 4.21** MMPR was a new system for all staff, whether they were working in YOIs or STCs. Some staff we spoke to in STCs welcomed the introduction of MMPR as they felt it offered them more effective techniques to restrain larger children, for whom PPC was no longer effective. Conversely, some staff in YOIs felt that the holds being introduced would not offer them the same level of control as in C&R. While broadly welcomed in STCs, the primary concern about MMPR was the perception that it embedded the use of pain, which had not been commonly used in physical control in care (PCC).
- 4.22** Staff in both STCs and YOIs expressed concern that learning MMPR would temporarily 'de-skill' them as they would not feel as confident delivering the new system as they did with PCC and C&R. In addition, YOI staff were concerned that they would require dual training and accreditation for both C&R and MMPR to allow them to work in split sites, such as

Hindley YOI (as it was at the time) and Feltham YOI,<sup>36</sup> which accommodated both children and young adults. At the time of the fieldwork, all existing YOI staff had learned C&R as part of their initial prison officer training, including those going on to work with children; they were then subsequently trained in MMPR. Since 2015, all new recruits working with children will now be trained in MMPR only. This change was welcomed by the MMPR national team as delivering MMPR safely and effectively. However, it reduced the ability for staff to be deployed to adult establishments where they would need to undertake C&R training; this was a concern for some staff in YOIs, as it would inhibit any potential move.

- 4.23** STC staff expressed fewer concerns than those in YOIs about learning the MMPR holds, as there was substantial overlap with PCC holds. Other staff told us they were initially uncertain about which holds to apply and in what order because there was a wider range available in MMPR than in PCC or C&R.
- 4.24** Despite the best attempts of the national team to limit the burden on establishments, senior managers spoke about how the implementation of MMPR had created a strain. The allocation of staff to MMPR training required careful detailing to ensure the continuation of the regime, and that children were appropriately cared for during the transition.
- 4.25** Implementation of MMPR in YOIs is now overseen by the new deputy director of custody (DDC) for the children and young people estate through the children and young people (CYP) operational delivery forum. Chaired by the DDC, this forum is attended by deputy governors from all the YOIs in England and Wales and is the central point for sharing learning from the operation of MMPR. This forum is distinct from the formal MMPR governance structures and plays no role in the monitoring of MMPR delivery. The introduction of this group was welcomed by the MMPR national team as a step forward in establishing national oversight of the children's estate, which was previously managed on a local basis by regional DDCs.

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<sup>36</sup> Hindley YOI has been re-roled to hold young adults and adults. All staff at Feltham, including those who work in the units holding males over the age of 18, will be trained and deliver MMPR rather than C&R, thus addressing these concerns.



## Section 5. MMPR in practice

### The national picture

- 5.1** As part of the continuous monitoring of restraint in the children and young people's estate, all establishments are required to report detailed data on all uses of force to the YJB, irrespective of whether they meet the restrictive physical intervention (RPI) definition.<sup>37</sup> This includes the use of MMPR techniques and any use of force that is not an MMPR technique.
- 5.2** Data collected from April to September 2014 was available as this report was being produced.<sup>38</sup> The data show that the rate of restraint in YOIs and STCs is similar: there were 29.9 incidents of restraint per 100 children in STCs and 29.2 incidents per 100 children in YOIs.
- 5.3** While the rate of restraint may be similar, the level of force used differed between YOIs and STCs. The data below show the highest level holds used in each MMPR incident. In YOIs, staff used the highest level of restraint available (either the inverted wrist hold or the figure of four leg lock) in almost half of all restraint incidents.

**Figure 4: The highest level techniques used in each MMPR incident<sup>39</sup>**

Level of hold	STC	YOI
Low	36 (14%)	133 (34%)
Medium	136 (53%)	84 (21%)
High	84 (33%)	179 (45%)

- 5.4** The reasons for restraint also varied between YOIs and STCs. The majority of restraint in STCs occurred to 'prevent harm to a third party'. In YOIs, almost half of all restraint incidents occurred for the same reason, but more than a quarter were in response to 'passive non-compliance'.

**Figure 5: The reasons for restraint<sup>40</sup>**

Reason for use of force	STC	YOI
Preventing damage to property	41 (8%)	45 (4%)
Preventing an escape/abscond	1 (0.2%)	24 (2%)
Preventing harm to self	49 (9%)	177 (17%)
Preventing harm to third party	439 (81%)	494 (48%)
Incitement (either to injure himself/herself or others, or cause damage to property)	11 (2%)	14 (1%)
Passive non-compliance (YOI only)	-	276 (27%)

- 5.5** Staff in YOIs told us that the regime took precedence and the review team felt that staff often resorted to restraint quickly, without exploring de-escalation techniques, to ensure that a passive child who was perhaps refusing to move did not disrupt the running of the

<sup>37</sup> A restrictive physical intervention 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'. This includes the use of low level techniques, such as guiding hold.

<sup>38</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/449063/mmpr-data-collection-april-sep-2014.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/449063/mmpr-data-collection-april-sep-2014.pdf)

<sup>39</sup> <https://www.gov.uk/government/statistics/mmpr-data-collection-april-to-september-2014>

<sup>40</sup> <https://www.gov.uk/government/statistics/mmpr-data-collection-april-to-september-2014>

establishment. The frequent use of restraint for passive non-compliance in YOIs supports their views.

## Use of MMPR in review sites

**5.6** This section explores how MMPR is being delivered, through evidence obtained from interviews with children and staff, and documentary analysis of use of force records and behaviour management plans.

### Behaviour management

**5.7** Behaviour management is a central tenet of MMPR and a key element in minimising the use of physical restraint. In our interviews, staff in both YOIs and STCs told us they welcomed the focus of MMPR on behaviour management, and that it seemed more proactive than PCC and C&R and encouraged staff to think more about triggers and de-escalation:

*'The behaviour management training is helpful. It makes you take a step back to think about how their [the child's] mind is working.'*

**5.8** Across all establishments, behaviour management plans (BMPs) were used for at least some of the children in the establishment. BMPs identify children who present challenging behaviour and devise targets to improve this actively to reduce the likelihood that restraint will be required. There was significant variation in the way that they were used between establishments.

**5.9** BMPs were targeted differently at each site. One establishment, for example, took a proactive or preventive approach to targeting BMPs: children were identified if they were causing staff concern and the relevant staff met and decided if the child should be placed on a plan. However, a less effective, reactive, approach was taken in another establishment where a child was placed on a plan if they had been restrained three times. It was our judgement that not all children who would have benefited from a plan had one in place, and that behaviour management should follow a proactive approach rather than as a reaction once an incident had occurred.

**5.10** As part of this review, we assessed 24 BMPs using the following criteria:

- plans included an assessment of need specific to the individual child, and from this targets were devised that addressed these needs and identified how to manage the child's behaviour effectively;
- plans were subject to review and revision as appropriate.

**5.11** Despite the positive perceptions of staff about the importance of behaviour management and several anecdotal examples of effective action, this was not reflected in the plans we reviewed in both YOIs and STCs; the majority (16 out of 24) were not of a good standard. Less than half of these plans (10 out of 24) contained a good quality individual assessment of need. Some plans had no reference to an assessment at all, while others included a standardised, almost generic, assessment that could be applied to any child and lacked reference to individual characteristics or how to manage their behaviour effectively.

**5.12** Of the 10 plans with a good quality individual assessment of need, the majority (eight) included clear and relevant targets for the child, such as specific reference to 'what helped' for the child in their day-to-day behaviour. Examples of poor targets included generic

objectives, such as ‘attend education’, ‘engage in the regime’ or a general list of how children should treat staff.

- 5.13** Evidence documenting a child’s progress against their targets was poor in most plans. While there was evidence of staff assisting children to address their objectives, comments about progress were mostly observational, stating what the child’s behaviour was like rather than demonstrating meaningful insight or effective staff engagement with them.
- 5.14** Only a minority of the plans we examined showed any evidence of being reviewed and updated, with some showing no evidence of being reviewed at all. Good reviews referred to the behaviour of the child and included information about changes to behaviour and what was proving effective, which were, in turn, used to inform decisions about whether or not to maintain the plan.

## De-escalation

- 5.15** De-escalation – actions to prevent a situation developing into one that results in a child needing to be restrained – is an important element of behaviour management in MMPR, and indeed in C&R and PCC. The MMPR training includes de-escalation techniques, such as verbal reasoning and removing a child from a situation that is causing them agitation.
- 5.16** During our fieldwork, we examined 48 use of force records involving MMPR. As well as detailing the restraint itself, records should also describe the build up to the incident and the techniques used by staff to de-escalate the situation before resorting to restraint. Most of the records we reviewed (30 out of 48) demonstrated evidence of de-escalation prior to restraint (18 out of 22 in STCs and 12 out of 26 in YOIs). Most commonly, this consisted of staff asking the child to calm down or attempting to reason with them, for example, asking them to return to the unit. Also evident were attempts by staff to de-escalate a situation by getting the child to move away from a particular location or other children.
- 5.17** In our interviews, the majority of children we spoke to reported that staff had made attempts to de-escalate the situation before restraining them, although this did not occur on every occasion.

*‘No, they were all talking at once and I couldn’t hear what they were saying which didn’t help at all. Having said that I have had good experiences of being calmed down and being spoken to nicely even when I have been nasty.’*

*‘They make more of an effort to talk to me and calm me down and that’s avoided me being restrained. Sometimes they give you a chance to calm down, sometimes they give you mouth and I end up shouting back and maybe threaten them.’*

*‘It did take about 10 minutes of shouting and throwing things before the restraint [happened]. I know that I needed to be calmed down and that was OK, so they didn’t just jump in.’*

*‘They did give me a chance and told me it was my last chance and I ignored it. A week later I did the same thing and refused to go back and one of the members of staff involved last time did talk me down this time and walked me back to my cell.’*

- 5.18** Despite some positive reports of successful de-escalation, some children described feeling that they were not given sufficient opportunity to ‘back down’ or comply with staff instructions before being restrained.

*'[I was] playing Xbox in one of the [association] pods. The person I was playing it with was threatening the officer. They asked me to move, I said no. They went straight in to grab me. They didn't try and talk to me. If they'd tried, I would've gone back to my room.'*

*'I didn't have a chance to put my side of the story. They were very quick to restrain me. If they had talked to me I could have explained the situation to them.'*

- 5.19** Children reported that when staff did not try to de-escalate the situation, or did not provide a clear explanation of why instructions were issued, situations could escalate to a point where physical restraint was necessary.

*'I could have just left the whole thing and gone into my room, but I would not have got a phone call. Yes [staff were too quick to restrain], they should have talked about when I could get my phone call, not just pushed me back in the room.'*

*'I think it could have been avoided if staff had talked to me properly to stop me harming myself. Then I wouldn't have needed restraining.'*

*'They told me to calm down, but I was angry that I couldn't get a phone call and that they didn't tell me when I could have one. They tell you to calm down, but don't try and sort the problem out.'*

- 5.20** While staff and children spoke of the benefits of effective de-escalation in preventing restraint, both groups reported that once a child had reached a 'certain point' there was nothing that could be done or said that would de-escalate the situation, and restraint could be the only option. One child we spoke to, who was physically restrained for fighting with another boy, told us:

*'There was no way I was going to back down or stop. If you stop the other person will hurt you ... they gave me a chance to stop, but I had to go on.'*

- 5.21** Another boy we spoke to who was physically restrained to stop him self-harming told us:

*'I was determined to strangle myself. No [staff were not too quick to restrain] they had to. No [staff could not have done anything else] I try and strangle myself or fight and there is nothing I can do about it.'*

- 5.22** One of the challenges staff in YOIs spoke about on de-escalation was that they did not feel that they had the opportunity to get to know the children they worked with, which most attributed to limited association time. Not 'knowing' the children they cared for meant that staff did not know what would help to de-escalate a challenging situation, and this could result in a situation being escalated if the wrong thing was said or action taken. Staff acknowledged that the relevant paperwork and information-sharing documents were available in wing offices and on computer systems, but did not feel that this replaced actual interaction with children. In contrast, staff in STCs generally reported they had sufficient time to get to know the children they looked after due to the higher staff-to-child ratio, which helped efforts to de-escalate situations.

- 5.23** During our fieldwork, we reviewed CCTV footage to assess the build up to incidents of restraint, looking for evidence of de-escalation taking place to offset the need for restraint (as well as reviewing the use of MMRP itself). Viewing CCTV provided a valuable insight, but the CCTV footage itself was limited by the fact that it did not include audio. As such, evidence of de-escalation was principally demonstrated by the proximity of staff to children during the build up to the incident – for example, staff not getting too close to a child – as well as how long staff interacted with a child before resorting to restraint.

- 5.24** In contrast to written records, examples of de-escalation we observed in our review of CCTV were mainly poor and even included instances of staff 'squaring up' to children in the lead up to a restraint. In one example in a YOI, an officer was seen to clench his fist and appeared to be prepared to strike the child on two occasions. In the records he argued it was for his personal safety, but as two officers were holding the child's arms his actions and account were clearly not justified.
- 5.25** There were also several examples of staff restraining children very quickly following what could be considered a minor incident. In one such example a child was restrained immediately after kicking a bin on the unit; staff did not attempt to speak to him or ask him why he was frustrated but instead rushed towards him, resulting in the child being restrained on the floor.
- 5.26** Despite our overall view that the de-escalation we observed in CCTV footage was poor, we did witness some examples of apparent good attempts by staff to de-escalate situations. These included good eye contact and instances where staff kept their distance while engaging with a child, rather than getting close, which could exacerbate a situation. In one incident we reviewed, we saw a member of staff kneeling down to the same level as the child to ensure eye contact during the attempt to de-escalate the situation.
- 5.27** Children we spoke to reported that staff behaved differently when they knew there was CCTV coverage of the area. When comparing experiences of incidents where there was CCTV to incidents where there was not, children told us:

*'At other times, when the cameras are around they give you a chance to stop what you are doing. When they [cameras] are not there they assault you.'*

*'Everything on the camera will look legit, it was when they went into my room that he really hurt me.'*

*'When I was in my pad there's no cameras, they go all out on me.'*

*'When you're not on camera, like when you get restrained in your cell, staff give you sly little digs like trying to elbow me in the side of my head while he was restraining me.'*

- 5.28** In one national team incident review that HMI Prisons attended, a member of staff at a YOI was seen to be deliberately blocking the camera during a restraint, so the CCTV could not pick up the detail of the incident. The national team highlighted this as inappropriate and recommended that the establishment review other incidents the officer was involved in for similar questionable behaviour and to detail the advice and guidance given to him. The establishment responded to confirm that an investigation was taking place.

## Supervision of physical restraint

- 5.29** If de-escalation attempts fail, the use of MMPR should be supervised and managed throughout by a use of force supervisor and an incident manager. These staff are responsible for managing the resources and logistics, and monitoring the restraint techniques used throughout the incident.
- 5.30** In our interviews, staff were positive about the presence of someone in the supervisor role during a physical restraint (they did not always distinguish between the incident manager or the use of force supervisor), and acknowledged how important it was for someone to have overall control of the situation. They described the supervisor role as being most effective when the supervisor attended as part of the first response team, rather than being a member

of staff who had initiated the restraint or been present for the build up to the incident. They viewed a fresh person arriving to manage the situation as beneficial, as other staff could potentially be less able to act calmly.

- 5.31** Some staff we interviewed recounted occasions when they felt that the supervisor had not had overall control or sufficient insight to manage the restraint. A member of staff in an STC provided an example of an occasion where supervisors had asked those conducting the restraint to release holds when they did not feel comfortable or safe to do so. Inappropriate direction could lead not only to an extension of the physical restraint incident but could also cause injury to the child or staff involved. Staff also emphasised the need for incident supervisors to communicate clearly with all those involved in the restraint.
- 5.32** During the fieldwork, we observed incidents on CCTV where physical restraint was poorly managed, and where it was unclear who was in charge of the incident and leading the actions of staff.

### Safeguarding children during a restraint

- 5.33** A number of systems operate to ensure the safety of both children and staff during a restraint.

#### Restraint handling plans

- 5.34** Restraint handling plans (RHPs) can be put in place for children in STCs who have specific health conditions or disabilities that could be exacerbated by certain MMPR holds. RHPs should be accessible to all staff who have the potential to restrain a child. We found that where RHPs were available in STCs, they were displayed in the sterile areas<sup>41</sup> on each child's unit to facilitate this. Keeping them in the sterile area is appropriate to ensure that children do not have access to other children's sensitive medical information.
- 5.35** Health care staff were involved in the development of RHPs, providing information about known disabilities and medical conditions. While this was largely positive, health care staff do not always know the MMPR holds in detail and so will be guided by the MMPR coordinators in assessing how a particular hold will affect a child or which areas of their body can come under stress. The IRAP medical sub-panel and, more recently, the SIWS medical panel, provide advice to establishments on how to restrain children safely, for example, how to deal with asthmatic children during physical restraint.
- 5.36** The majority of plans we reviewed were not of a good quality. We found identical handling plans for children with asthma; these were generic in content and only contained the advice that 'the young person's head should not be placed below their heart or be taken to the floor', which applies to all children when restrained, regardless of any health condition or disability.
- 5.37** Despite the variable quality of RHPs in general, we found examples of comprehensive and well-considered plans that gave an overview of the child's medical condition, detailed which holds should be avoided and listed those only to be applied 'if all other options have failed and there is an immediate risk of harm to self or others, serious damage to property or to prevent escape'.

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<sup>41</sup> The sterile area in an STC is the unit office, where children are not permitted.

### Disregard for RHP

In one example of an RHP we saw evidence that the boy's medical condition had been thoroughly researched and included specific detail of the holds to be avoided during a restraint. The RHP also gave specific guidance for staff if they were involved in a restraint:

*'Staff are to be aware of their body positions in relation to restricting free movement of [child]'s chest. Also to be aware that pressure on [child]'s right side could cause significant harm to his internal organs.'*

While the RHP was detailed and provided vital information on the well-being of the child, when we reviewed restraint incidents we found that all the holds specifically listed to be avoided were used on this child, resulting in some holds applied during the restraint that could cause significant internal injuries.

Use of force documentation made no reference to the RHP and it was not clear that the restraint occurred to prevent 'an immediate risk of harm to self or others, serious damage to property or to prevent escape'. The omission of any reference to the RHP was not identified in the quality assurance of the documentation.

- 5.38** Unfortunately, this was not an isolated incident. During this review we found many examples of children being restrained using techniques contrary to information on RHPs; much of this was linked to a limited awareness by staff of their content or their ability to exercise this knowledge during a restraint. This was supported by the staff views in our interviews.

*'Some staff don't know what are on the MMPR plans – they don't bother to find out. I sometimes test them and they can't give me details.'*

*'Recently I knew something about a young person's wrist that was weak. Others involved in the restraint didn't seem to so I had to shout loudly to warn them of the danger. Staff have to make it their business to know about the MMPR plans, but I don't think we all do. Nobody ever checks to make sure that you do know what's on them.'*

*'MMPR plans are difficult to remember when you are involved in a restraint.'*

*'Restraint intervention plans are able to be seen easily and these give the information about any triggers. But the reality is if you need to escalate or do a restraint then you have to go in.'*

- 5.39** If a staff member is called as first response to a restraint taking place on a unit where they do not normally work, they may be unaware that there is an RHP for the child being restrained.

*'The information you get is not good enough. It's okay when it you are going to restrain someone on your own unit as you have time to get to know all about them. But if you go on to another unit or have to restrain someone you don't know, then you probably don't know enough about them, which is a risk. You can move a lot on shifts, so it is quite possible you don't know the issues with a young person you might have to restrain.'*

### Monitoring for distress during restraint

- 5.40** It is the responsibility of all staff involved in a restraint to monitor children for SIWS and respond to these appropriately. This might involve, for example, adjusting holds that are applied incorrectly or releasing holds if the child exhibits signs of breathing difficulties.

**5.41** Children frequently reported to us that they struggled to breathe during a restraint.

*'Once when I was on the stairs I thought that I was going to lose consciousness because they grabbed my neck and held on to it.'*

*'I was slammed to the floor, they were pulling my neck up and had a knee on my back. I was struggling to breathe.'*

*'There was a part when I was on the floor and I couldn't breathe, I couldn't talk because the staff were constricting my windpipe – I don't know whether they had an arm or a leg on me but I couldn't talk to tell them to stop it.'*

**5.42** During MMPR training staff are told that if a child complains of difficulty breathing staff 'must take them seriously and they must urgently reassess both the young person's airway and the breathing'.<sup>42</sup> The circumstances leading to the death of Gareth Myatt demonstrate clearly the explicit link between reported breathing difficulties and the fatal consequences that can occur if these warnings are not heeded. We were concerned about the assumptions of a minority of staff about children who reported breathing difficulties or distress.

*'Kids sometimes just say stuff so that you let them go, like they can't breathe, but you know that they are having you on.'*

*'If they are complaining then it is to get the staff off them.'*

**5.43** Several children we spoke to did not feel that staff had acted appropriately when they alerted them to breathing difficulties.

*'I couldn't breathe. It felt like someone had their hands around my throat. I was telling staff that I couldn't breathe but they weren't listening. I didn't pass out on this occasion but I have passed out in the past.'*

*'I told the staff I couldn't breathe when I was being walked and he said "I'm not asking you to breathe, not even talk".'*

**5.44** An important safeguard in ensuring the welfare of children is monitored appropriately during restraint is for a member of health care staff to be present from the earliest possible point. In the establishments we visited, health care staff told us that they were not able to attend all MMPR incidents, sometimes because it had ended before they arrived on the scene. Health care staff in one STC told us that they were not currently included in the first response radio alerts, which delayed their attendance. In another STC, health care staff only attended incidents when they were specifically called and believed they had up to 30 minutes to arrive, which was a serious shortcoming.

**5.45** A crucial factor in health care staff intervening in restraint is that operational staff recognise and facilitate this. The majority of health care staff we spoke to felt confident in attending a restraint and intervening where necessary, but one said that on one occasion they had been told by staff to get out of the way of an incident, which had hindered their ability to monitor the child for SIWS.

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<sup>42</sup> <http://webarchive.nationalarchives.gov.uk/20140715125548/http://www.justice.gov.uk/downloads/youth-justice/custody/mmpr/mmpr-vol5-physical-restraint.pdf>

- 5.46** One child we spoke to illustrated the importance of having a member of health care staff present and explained how staff had only responded to his complaints about not being able to breathe when the nurse intervened.

*'I have problems with my breathing: when I'm threatened my chest goes tight and I get shooting pains – I told them before I sat on the floor. My chest was really hurting; I had shooting pains and my chest was getting tighter. I was asking them to release me but they wouldn't.'*

- 5.47** These complaints raise significant concerns about the delivery of MMPR as all staff should be aware of and monitor any SIWS that occur during a restraint.
- 5.48** However, other children told us that staff had been responsive when alerted to breathing difficulties and had taken appropriate steps to ensure their welfare.

## How children experience physical restraint

- 5.49** We asked children more broadly about their experiences of restraint and to describe incidents they had been involved in. Here we present the views of the children alongside those of the staff we interviewed to provide a direct comparison between how staff believe they are conducting a restraint and how children experience it.
- 5.50** Children were asked to describe the differences they perceived, if any, between their experiences of MMPR and the previous method of restraint. Children gave mixed responses about each system. Some children in STCs described MMPR as being less suited to the population than PCC.

*'MMPR is more about the specific hold and getting you into it. I think that because of the young people something like PCC is better for here. MMPR is better for YOIs, because in here we're all supposed to be vulnerable young people and to be honest the [MMPR] holds could hurt you a lot if you carried on struggling.'*

*'The new system is rougher and more adult prison like than the last one.'*

- 5.51** Children in YOIs told us they had experienced less of a difference between C&R and MMPR.

*'Not really seen a difference, it didn't hurt as much.'*

*'I didn't even know there was a new system and I have been restrained at [a YOI] and [an STC]. If anything what I experienced at [the YOI using C&R] was the worst one but there isn't a lot of difference.'*

- 5.52** MMPR coordinators also perceived a difference in how staff approached restraint as a result of the introduction of MMPR.

*'We think they are far less likely to rush into restraint and use high level holds. A lot of the behaviour management tools they have been using already, so they have not created much change.'* (MMPR coordinator, YOI)

*'Initially staff panicked. It was completely new, and the most severe form of restraint we ever used was the figure of four, and no one wanted to go beyond that. Staff now have more confidence and will use inverted wrists and think beyond going through the holds sequentially i.e. they will think about what is the best hold to use at the time. They now know that MMPR isn't much different to PCC.'* (MMPR coordinator, STC)

## Discomfort during a physical restraint

**5.53** This section refers specifically to how children experience pain and discomfort through the use of ‘non-pain-inducing’ holds. While these techniques are not designed to be painful for the child, we found that their experiences of pain were not limited to the application of ‘pain-inducing techniques’.

**5.54** Children we spoke to described how all MMPR techniques had the potential to cause pain.

*‘Yes [the restraint was painful], the fact that my arms were behind my back and my head was down. I was asking staff to loosen their hold on my arm several times but they didn’t, not the tiniest bit.’*

*‘Yes. The inverted wrist was painful. If it hurts and you tell them, they tell you to stop moaning.’*

**5.55** This was also supported by staff who had undergone MMPR training and had holds applied to them.

*‘Yes I know they are painful because we practised on each other during the training so I experienced it. Some are uncomfortable. The figure of four leg [lock] is very uncomfortable and the inverted wrist hold hurts.’*

*‘Restraint does hurt young people, especially if you have to get them in a lock. It hurts them when you have to force the situation to get the lock on. So even the non-pain-inducing techniques cause pain.’*

**5.56** Staff told us that if a child struggles when being restrained or the hold is not applied properly then the restraint may be painful.

*‘Restraint isn’t painful, well it shouldn’t be ... If wrongly applied then it could be painful.’*

**5.57** This is in contrast to some children who reported that the holds hurt whether they struggled or not.

*‘The one [staff member] on my head was squeezing so hard I thought I was going to pass out. I told him to stop squeezing, and he said stop struggling – I wasn’t even struggling.’*

**5.58** MMPR guidance states that if a child complains of pain/discomfort when pain is not intended that staff should check the hold(s) is being applied appropriately and readjust as necessary to avoid injuries. In the six months to September 2014, 11 minor injuries, out of a total of 462 incidents, were sustained during restraint in STCs that required medical treatment, and eight out of 764 incidents in YOIs. However, there were two serious injuries in YOIs that required hospital treatment.

**5.59** Some children who complained of pain during a restraint reported that staff had responded to their discomfort and amended holds accordingly.

*‘My wrist was hurting and I told staff so they said stop struggling. They changed into another arm lock without the wrist.’*

**5.60** Children we spoke to reported that even when they told staff that a non-pain-inducing hold was causing them pain or discomfort, staff did not always attempt to address this. Other children told us that they would not tell staff that a hold was painful as they would use it again.

*'I never tell staff that they are hurting me because I don't want them to know what hurts me ... Then they will just use it again another time to hurt me if they know where to hurt you.'*

- 5.61** One boy in a YOI told us that even though he had a wrist injury that was on his medical file, staff still used a wrist hold during the physical restraint, which caused him significant pain and discomfort. He said that despite telling staff about the pain, no adjustments were made.

*'I told them it was hurting my wrist and I have a previous injury and that's on my medical file.'*

- 5.62** The child raised concerns about his wrist with the nurse after the restraint and the next day, after attending hospital, he was found to have a fractured wrist.

- 5.63** Some children reported that MMPR was less painful while others said it was more painful. Interestingly, these views were held in both STCs and YOIs, and views on the subject differed even within establishments. However children in the same STCs also described MMPR as less painful or 'better' than PCC.

*'PCC was more painful.'*

*'I was here before the new system; think that it is better now. You used to get rugby tackled and there were different neck holds, it was really worse. Think that things have become a lot better this time.'*

- 5.64** It is not possible to conclude definitively why some children found restraint under MMPR more painful than others. One potential explanation was the way that holds were applied: for example, in the refresher training we observed, staff who were fully trained and actively using MMPR in their establishments still struggled with applying the holds successfully. Some staff made basic mistakes during refresher training, such as applying holds too close to the wrist, which has the potential to cause injury.

- 5.65** Staff we spoke to expressed differing views about whether MMPR was more or less painful for children than C&R and PCC; for many this perception was based on their own experiences of having the holds applied during training. Staff working in YOIs generally told us that their experience of MMPR was that it was less painful than C&R.

*'Yes it is painful, though it wouldn't be if they didn't struggle. The pain-inducing techniques are all painful but they don't all work on everyone. The pain is less than in C&R.'*

- 5.66** STC staff, through their own experience of training, largely viewed MMPR as more painful than PCC as the holds were more secure.

- 5.67** An additional concern for some girls we interviewed was being restrained by a male member of staff.

One girl we spoke in an STC to told us about an incident where staff had removed an item from her room after she had been 'acting up' on the unit; this subsequently led to her being restrained. She felt that staff had acted too quickly and that their response was not proportionate:

*'Members of staff here put hands on too quickly and don't manage our behaviour. Sometimes they provoke the behaviour. They should challenge our behaviour before putting hands on.'*

Of primary concern for this girl, however, was the fact that men had been involved in the restraint:

*'Okay, pull me away from the situation and then talk to me, but instead they had hands on me and were shouting ... I had two men on both my hands. I said to the member of staff I don't think that men should restrain girls ... I don't like men touching me – I think it's unacceptable and irrelevant ... Staff need to realise that when they touch me it makes me worse; some staff understand it but others don't.'*

- 5.68** For children who have been victims of abuse in the past, restraint can be a highly traumatic experience, as illustrated by this girl and others we interviewed.

*'One member of staff grabbed my neck and then others pushed me to the ground and held me there telling me to calm down. While I was on the floor a male member of staff was holding my head almost between his knees. I have been sexually abused in the past so you can imagine how that made me feel. I was terrified.'*

### Level of force used

- 5.69** MMPR emphasises legislation and government policy that 'the minimum amount of force necessary should be applied' during a restraint. Some children viewed the level of force used on them as necessary to prevent them causing further injury to themselves or others.

*'I think they were trying to help me. They had to do what they did otherwise me and others would have got hurt. It was the right amount of force used.'*

*'I don't think that staff tried to hurt me. They had to hold on to me tight, as I was struggling and if they had not I would have broken free. I think that staff would have stopped if I had stopped struggling.'*

- 5.70** However, some children we spoke to, both in YOIs and STCs, thought staff had used too much force when restraining them.

*'No, too much [force used]. That amount of force should be for a grown man.'*

*'They overdo it. They know how to use it but they overdo it and go for the parts that hurt.'*

*'No, they use way too much – the pressure they apply is the worst. When they put you in a wrist lock and someone's going too hard they should know.'*

### Releasing MMPR holds (deceleration)

- 5.71** Staff in both YOIs and STCs told us that they made every attempt to use only the minimum amount of force necessary, and that they released holds as soon as possible to reduce the discomfort felt by the child. However, children we interviewed did not support this view and records in YOIs were not always completed well enough to enable us to make a judgement.

- 5.72** Some children told us that on occasion staff had continued to restrain them when they did not think that this was necessary. This view was more pronounced in YOIs than in STCs.

*'[They were] too excessive. No they carried on [restraining when I stopped struggling]. They always do that even when you stop struggling because they try to get you to the floor. Even when you tell them that you will stop they still keep grabbing at you.'*

*'They can continue it after you have stopped [struggling]. They are not sure what you will do. It is usually okay because I have a good relationship with the DOMs [duty operations managers].'*

**5.73** Some children told us that they had been moved to their rooms in high-level MMPR holds but did not feel that this was always necessary as they had stopped struggling and were calm. In the use of force records we reviewed, we found some instances when holds were reduced, for example, from a head hold to a lower level hold, to allow the child to walk to their room safely. However, in our review of CCTV, we saw examples of children being walked long distances across the establishment in head holds; this included being moved up and down stairs, which is potentially dangerous. This was further supported by the accounts of some children we interviewed.

*'I had my wrist bent back; all the while I was walking up the stairs. It was really painful. I went up three landings with my neck and wrist in flexion.'*

*'My wrists were behind my back and my head was pushed down and I was taken all the way to the seg like that. I wasn't kicking or going mad but I was trying to struggle because I wanted to get some control back.'*

### De-escalation during a restraint

**5.74** To aid the release of MMPR holds (deceleration), staff should be active in trying to de-escalate the child's behaviour *during* the course of a restraint, helping them to calm down and thus ensuring holds are released as soon as possible. Some use of force records documented good examples of de-escalation during the restraint itself, making specific reference to known triggers for the child and the steps taken to offset these during the restraint.

#### Incorporating known triggers into de-escalation during a restraint

In one record in an STC we reviewed a boy had become aggressive after another child had pushed his way into the boy's room. The boy then started making threats to staff and became physically aggressive, at which point he was restrained.

One staff member involved in the restraint referred in his account to the 'MMPR protocol' for the child; the 'protocol' recorded that restraint incidents could be prolonged if the child was not left alone by staff to calm down. As such, the staff member suggested that the child should be moved to his room as quickly as possible to allow him time and space to calm down away from staff. The account recorded that staff were making the child's room safe to do this.

**5.75** There were many examples of staff who had a positive rapport or working relationship with the child being restrained being 'swapped in' to continue specific holds, such as the head hold, or take on a supervisory role to attempt to calm the child down and bring the restraint to an end sooner.

**5.76** Children we spoke to were clear that the quality of verbal interactions played a key part in helping them to calm down and told us that meaningful communication had a positive impact. Some children we spoke to reported that staff were talking to them throughout the restraint, telling them to remain calm and to relax.

*'Staff were OK; they talked to me throughout the incident, so I didn't feel bad about the restraint at all.'*

*'They did try to calm me down. They talked to me nicely.'*

**5.77** A small number of children reported that in some restraints staff identified a member of staff, with whom the child got on well, to talk to them. They were clear that this helped them to calm down.

*'Yes, they talked to me. It was more helpful to calm down when the lady was talking to me, because she was a familiar face.'*

- 5.78** Some children identified that poor quality verbal communication during a restraint was decidedly unhelpful, especially if it was simply repeating basic phrases such as 'calm down'.

*'Just telling me to calm down isn't going to have any effect.'*

## Children restrained on the floor

- 5.79** Under MMPR and on the advice of medical professionals, staff are no longer allowed to restrain children purposefully on the ground to gain control and secure compliance. If children are restrained on the floor, they should be brought to a standing position as soon as possible, and MMPR training incorporates techniques for doing so. Staff we spoke to were aware of these changes and reported efforts to avoid this happening.

*'We used to be able to take them to the floor, but we try not to do that now as the doctors say that it is safer for the young people'*

- 5.80** Some children were also aware of this change, and indicated that staff were less likely to restrain them on the ground than previously.

*'In the old system they used to pin you to the floor but that doesn't happen much now. Unless there is a fight. Anything can happen if there's a fight'.*

*'I think staff have changed their approach to restraining us. If there is a fight they now hang back and some let the fight go on for a bit, so that more staff can arrive. They used to slam you down on to the floor, but now they get as many staff around and try and keep you on your feet.'*

- 5.81** In our review of use of force documentation, however, 23 out of 48 records contained examples of children being restrained on the floor. This was more pronounced in YOIs than STCs (in 19 of 26 records in YOIs compared with four of 22 records in STCs.).

- 5.82** Where children told us that they had been restrained on the ground, the majority attributed this to a conscious decision by staff to take them to the floor.

*'I always end up on the floor. Staff deliberately take you to the floor.'*

*'They pushed me to the floor. You always get taken to the floor during a restraint.'*

*'I didn't end up on the floor to start with because I resisted but staff tried to get me on to the floor and eventually they did.'*

- 5.83** This perception by children contrasts to the accounts given by staff. In our interviews, staff generally described incidents where children were restrained on the ground as a result of the child having thrown themselves to the floor, or the group having fallen down in the struggle.

*'Sometimes lads take themselves to the floor because they don't like being touched by staff and it is much more difficult for staff to get hold of them now when they are on the floor.'*

*'You also don't take boys to the floor, which happens all the time in C&R. Boys still go to the floor, but I think that staff try to avoid it.'*

*'Don't think restraint is generally painful, though it can be if they try and drop to the floor – though staff move quickly to try and stop that.'*

**5.84** It is not clear from use of force records, or from the accounts of children, how long they were restrained on the floor or whether reasonable attempts were made to return them to a standing position as soon as possible. Some of the use of force records, however, detailed many attempts by staff to bring the child being restrained up from the floor, sometimes to no avail.

## Restraint to prevent self-harm

**5.85** MMPR guidance states that according to the law children can be restrained to prevent harm to themselves or others. As in all cases, the decision to restrain should be taken as a last resort when de-escalation attempts have failed. Between April and September 2014, 9% of MMPR incidents in STCs were to prevent a child from harming themselves; in YOIs this figure was 17%.<sup>43</sup>

**5.86** Through our review of CCTV, use of force records (both randomly selected and those we specifically selected to review due to the use of pain-inducing techniques) and interviews with children, we found several examples of children being restrained to prevent them from self-harming, both in STCs and YOIs; some of the cases in YOIs included the deliberate use of pain. In our analysis of use of force documentation, we found two examples of children who had been restrained following attempts to self-harm.

### Restraint to prevent self-harm: case 1

A boy in a YOI had tied a ligature around his neck; staff entered his cell to remove the ligature, and restrained the child in the supine (face up) position. Staff accounts recorded that they took control of the child's arms, legs and head before forcibly removing his clothing and conducting a full relocation.<sup>44</sup> The child was left in his boxer shorts. Staff returned to the cell to find the child had placed a plastic bag over his head and later began to use his boxer shorts as a ligature. It was recorded that staff then used a pain-inducing technique to gain control of the child; staff recorded that this was 'to stop the young person causing any more harm to himself'. A second full relocation took place.

The recording of this incident alluded to some de-escalation, but this was limited in detail and the quality of the interaction was unclear, as was the length of time staff attempted de-escalation before taking the decision to restrain. Recording about the removal of clothing or steps to ensure the welfare of the child after the incident was poor. There was inconsistency between staff accounts about the pain-inducing technique employed, with no mention of this by the incident supervisor, although the member of staff who used the technique recorded that it was at the instruction of the supervisor.

The child saw health care staff afterwards but had no debrief until four days later. The debrief was perfunctory and contained little detail, aside from the boy highlighting that the incident had occurred as he had not received his medication.

<sup>43</sup> <https://www.gov.uk/government/statistics/mmpr-data-collection-april-to-september-2014>

<sup>44</sup> A full relocation involves a child being controlled in a specific position on the floor to allow staff to exit the room as safely and quickly as possible.

### Restraint to prevent self-harm: case 2

A boy in a YOI had concealed a ligature down his trousers. In contrast to case 1, several of the staff accounts carefully recorded the background to the restraint, as well as an account of the 20 minutes spent talking to the child about his concerns.

Once again, the child was restrained on the floor and was forcibly stripped and placed into alternative clothing. In this instance, however, staff recorded that a blanket was used to cover the child while this was carried out. Despite the provision of alternative clothing, the member of health care staff who attended recorded that they were 'unable to see [child] at this time as naked'.

There was no further detail about the steps taken to ensure the welfare of the child after the incident, and his debrief lacked detail, although it was recorded that the child was on assessment, care in custody and teamwork (ACCT) case management due to his risk of suicide or self-harm.

- 5.87** Only half of the staff involved in each of these incidents participated in a debrief following the restraint. None of the staff debriefs demonstrated any insight into how the restraint might have affected the child who, in both instances, was already distressed and self-harming, or what steps could be taken to prevent a similar incident in the future.
- 5.88** While we acknowledge the difficulty in managing children in periods of crisis, restraint, strip searching and pain compliance are extreme responses, and we were not assured that staff had exhausted other options before taking this action. In addition, a forcible strip search or a pain-inducing technique is not possible unless staff have full control of the child, and if they have full control there is no risk to the child at that point.
- 5.89** In one YOI case we reviewed, pain had been used on a child as he was walked back from an ACCT review. He had a shoelace in his hand. Staff did not give him any time to give it up, but acted because they did not want to disrupt the regime, so felt that they needed to end the incident as quickly as possible.
- 5.90** Other options that could have been used include spending time talking to distressed children and giving them as much time as is required to give up any item that they could use to hurt themselves. Such interventions take time, patience and skill, but are more effective in dealing with troubled and troublesome children than the infliction of pain or strip searching.
- 5.91** Some of the children we interviewed discussed occasions when they had been restrained to prevent them from self-harming. One felt that there was little else staff could have done other than restrain him, although he was critical about the level of force used.

*'I was trying to strangle myself with the sheets from my bed. They [staff] jumped on my back and cut the sheet from around my neck and they left me in my room. I still had another piece of the sheet in my hand so they came back in and tried to take it off me. They didn't give me a chance to give it up but grabbed my wrist and twisted up my arm. Someone put their knee in my elbow and put pressure on it, so I thought my arm was going to break. I screamed out in pain. They kept going until they got the sheet from me. I had done this before and they knew that I would strangle myself if I had the chance.'*

- 5.92** However, one girl we interviewed in an STC felt that although she was thinking about hurting herself, the restraint could have been avoided if staff had talked to her 'properly'; she poignantly expressed her feelings that restraint for people trying to hurt themselves was counterintuitive.

*'I think there should be two different systems for someone who is self-harming to someone who is fighting. You don't want to make people who are hurting themselves suffer even more.'*

### Strip searching under restraint

- 5.93** The forcible removal of clothing under restraint is an extreme practice that can cause considerable distress to a child and should not be undertaken to ensure the smooth running of the regime, or until other options, such as those described above, have been exhausted. During our fieldwork we found several examples of children held in YOIs having their clothing removed under restraint; we did not come across any instances of this in STCs.
- 5.94** In our analysis of use of force documentation, we found two instances where children had their clothing forcibly removed while under restraint, both because of concerns about self-harm (see paragraph 5.86, cases 1 and 2). Both records contained very little meaningful detail about how clothing was removed, which made it difficult to assess whether this had been done in accordance with MMPR guidance. In case 2, staff recorded that the child was covered with a blanket while being forcibly changed into alternative clothing (as in the MMPR guidance), but beyond this there was no evidence to demonstrate that MMPR-approved methods had been followed. In both cases it was also unclear whether there had been any action to make the process less distressing for the children, who were both trying to self-harm and already visibly distressed.
- 5.95** In our interviews, some children in YOIs told us about times they had been forcibly strip searched or had their clothing removed while under restraint; once again, some related to concerns about self-harm while others involved the child being in possession of a weapon. In the accounts provided, staff did not appear to follow approved protocol, as in the example below.

#### Children's experience of being strip searched

One boy we spoke to was restrained after threatening staff with a broken plastic knife. Once staff had restrained him and taken the knife, he was moved to a special cell and asked to remove his clothes.

*'When they got me to the special cell they asked me to take my clothes off. I said I would, though I did say it in an aggressive attitude but you would [respond aggressively] as you are not going to respond nicely to a question like that; anyway I would have taken them off. They took me straight to the floor, before I had a chance to do it myself. Someone put a knee in my back, which did hurt a lot. They took my shirt off completely, then my trousers, boxers and shoes. They chucked a jumper on me to cover my bum.'*

- 5.96** As mentioned above if a child is properly restrained and staff have full control of them it should not be necessary to strip search the child to prevent them self-harming.

### Head hold

- 5.97** The MMPR guidance states the head hold should only be used when the child is 'so violent that not controlling the young person's head would place them, or staff at risk'.<sup>45</sup> Using the head hold requires a minimum of three staff, and must only be applied when both arms of the child are secured. Lowering the head decreases the angle between the chest and lower limbs and can cause breathing difficulties, so staff must be aware of the angle of the child's head in

<sup>45</sup> <http://webarchive.nationalarchives.gov.uk/20140715125548/http://www.justice.gov.uk/downloads/youth-justice/custody/mmpr/mmpr-vol5-physical-restraint.pdf>

relation to neck and spine alignment and breathing, use the minimum amount of pressure, and be conscious not to cover the ears, nose or throat.

- 5.98** The use of the head hold is kept under close scrutiny due to concerns by those involved in the governance of MMPR about the potential for it to be misapplied and cause considerable harm to children. In particular, the RAB, and later the IRAP, expressed concerns about potential vascular compromise experienced by children who had had been restrained using the head hold.
- 5.99** In response to a recommendation by the RAB, the YJB recently published a piece of research<sup>46</sup> that compared the physiological and psychological impact of four different head hold techniques, including the MMPR head hold, to identify the lowest risk approach. The report concluded from a laboratory-based study that none of the head holds caused significant changes in physiological measures, although a potential limitation to breathing was observed if head holds were misapplied and causing the restrained person's mouth to be closed. Less discomfort was reported in the more upright restraint positions and when using a head hold where the person was held at arm's length.
- 5.100** The research made three key recommendations to improve the comfort of those restrained:
- Restraint should be carried out in the most upright position possible in the circumstances.
  - A head-hold technique with the young person held at arm's length ('amended head-hold 2') should be subject to further review and development by NOMS. This technique should only be brought into operational use if there is confidence that it is safe (for staff as well as the young person) and effective.
  - The potential for misapplication of restraint, resulting in the mouth being held closed, should be highlighted and warned against in MMPR training materials, and explicitly emphasised during MMPR training.
- 5.101** Throughout this review we observed considerable use of the head hold in CCTV footage. We also spoke to children who reported pain, difficulties breathing, and strained necks from the head hold being applied.

*'The head hold seems to stop you from breathing and it made me talk in a squeaky voice.'*

*'I remember them using a head hold. I felt as if I was choking.'*

*'It was a head support and was painful. The first time that I was restrained my head and neck was in bits. They didn't loosen up when I was in pain.'*

*'I have had the neck hold and it was painful. I got really light headed.'*

- 5.102** We have also found examples of the head hold being misapplied, such as:
- one use of force record stated that the head hold had been applied first, before both arms were in hold
  - in one STC we found an example of a child being moved a considerable distance in the head hold, which has been highlighted by the medical experts as dangerous

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<sup>46</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/449860/Head-hold\\_restraint\\_techniques\\_report.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/449860/Head-hold_restraint_techniques_report.pdf)

- a child we spoke to described how he was lifted up while in a head hold, which led to difficulty in his breathing
- CCTV footage we observed showed children having their heads pushed down while in the head hold.

**5.103** Of significant concern was the number of children in our interviews who, when talking about methods used to gain control of their head, described being put in a ‘choke hold’. Several children, particularly in YOIs, told us how staff had put an arm around their neck, which clearly did not relate to the approved MMPR guidance about applying a head hold.

*‘When they do the head support they have their arm round your neck, lifting you up.’*

*‘I was stood up. One got me in a headlock, the other picked my legs up and they put me on the floor face down. My arms were bent back and [they] had a wrist lock on one arm; they still had me in a choke hold.’*

*‘Two staff then grabbed me and held both my hands and then started walking me to my room. Then another member of staff grabbed me in a head lock and they got me to my room and put me in a choke hold in my room and pushed me in my room.’*

**5.104** Concerns about the application of the head hold have also been raised by the MMPR SIWS medical panel, which noted the misapplication of the head hold technique as a key factor in incidents that result in SIWS. The original head hold as described in the MMPR syllabus has been subsequently amended to reduce the risk of misapplication.

### **Pain-inducing techniques**

**5.105** Three pain-inducing techniques are included in MMPR.<sup>47</sup> The guidance states that all should be used as a last resort and only when ‘it is necessary to protect a child or others from immediate risk of serious physical harm.’ The most recent MMPR data show that in the six months to September 2014 there were 23 incidents where pain-inducing techniques were used in YOIs, compared with none in STCs.<sup>48</sup>

**5.106** In addition to reviewing a randomly selected sample of use of force records, we reviewed all records where pain-inducing techniques had been used in the three months before our fieldwork.

**5.107** Consistent with the national data, in STCs where MMPR had gone live we did not find any examples of pain-inducing techniques used. We did, however, find one concerning case where a child with a broken wrist was threatened with a pain-inducing technique for non-compliance. Poor recording and unclear CCTV footage meant that we were unable to verify if a pain-inducing technique was actually used on the boy.

**5.108** In YOIs, however, we found that pain-inducing techniques were in regular use. Of significant concern was that these techniques were not always used in accordance with the prescribed criteria in the MMPR guidance: we found pain used for non-compliance and failure to obey staff instructions immediately. In one use of force record, the reason for use of pain was recorded as ‘refusal to move back to cell. Needed to move [child] to continue with the regime’.

<sup>47</sup> The three pain inducing techniques are: the mandibular angle technique, thumb flexion and wrist flexion.

<sup>48</sup> <https://www.gov.uk/government/statistics/mmpr-data-collection-april-to-september-2014>

**5.109** We also found examples where pain had been applied to bring the restraint to an end quickly, even where the restraint was not prolonged. In one YOI we visited, a senior manager used the potential length of restraint as a justification for applying pain-inducing techniques. The manager stated that prolonged restraint could be a serious risk to the child and so pain could be used early on in the incident to conclude a restraint quickly.

*'Pain-inducing techniques are used when necessary. We need them because our biggest concern about restraint is episodes of prolonged restraint. Therefore we need to use pain to defuse particularly difficult situations.'*

**5.110** If this logic is followed, pain could be applied during any restraint, regardless of its nature, and not specifically to end a physically challenging or prolonged restraint. This is an extremely concerning misinterpretation of the guidance, which potentially leaves children open to ready infliction of pain, without the prescribed criteria being met.

**5.111** In accordance with MMPR guidelines, children should be issued with three verbal warnings before pain is used to give them an opportunity to comply with instructions. The records we reviewed did not always indicate that such warnings were issued, and children we interviewed also stated that were not warned that a pain-inducing technique was about to be used.

*'Some give you a warning but only a few [staff].'*

*'They don't tell you that it is going to hurt, they just do it.'*

**5.112** MMPR procedures require that all use of force records should clearly indicate where pain was used, the justification for doing so, and how long the technique was applied for. In the use of force records we examined – both those we reviewed for their inclusion of pain and those we randomly selected – pain-inducing techniques were not always recorded correctly. Therefore, we were unable to judge the extent of pain compliance from the records we looked at, with the wider implication that the use of pain cannot be accurately monitored by either the establishment or the MMPR national team.

**5.113** In one YOI we visited, we were given six MMPR records that the establishment MMPR coordinators believed to be all the incidents where pain-inducing techniques had been used in the previous three months. When reviewing the randomly selected sample of use of force documentation, however, we found four further incidents where pain had been used. The use of pain had not been recorded correctly: while individual staff accounts mentioned the use of pain this was not reflected in the front sheet completed by the supervisor. This meant that the establishment was not aware of these uses of pain against children and did not have the opportunity to scrutinise them through its internal monitoring.

**5.114** It is only since April 2015 that the MMPR national team has planned to review routinely all restraint incidents involving pain-inducing techniques. This change was the result of two thematic reviews of incidents involving the use of a pain-inducing technique, which were conducted, by the YJB, NOMS and the MMPR national team at under-18 YOIs in February and March 2015. However, due to current resource constraints, this is not always possible.

**5.115** This recent change is an important layer of scrutiny to ensure that pain is used in accordance with the prescribed criteria; if establishments fail to record accurately the number of pain-inducing techniques, the national team will be unable to exercise this commitment. Poor recording of pain also has wider implications for the MMPR data published by the YJB, which relies on the accuracy of data supplied by local establishments to provide both a local and national picture of the use of MMPR.

- 5.116** During our interviews with staff and children, we discussed children's experiences of pain during restraint and staff attitudes towards applying pain. One child felt that the application of pain-inducing techniques was necessary to bring the incident to a close:

*'I wouldn't have stopped struggling, so they had to hurt me to make me stop. So I suppose that it wasn't excessive.'*

- 5.117** However, some children felt that staff sometimes used pain excessively and inappropriately.

*'Staff came and grabbed me and took me to the floor, their restraint was good but not the pressure on my wrist. [They were] holding on my head and arm. I shouldn't be fearing getting hurt by officers.'*

*'They twisted my wrists and do some mad shit with your thumb, they cripple you. I told them to let go and it hurt but they kept it the same.'*

*'They overdo it. They know how to use it but they overdo it and go for the parts that hurt. They all don't know what they're doing.'*

- 5.118** Staff in STCs were more likely to express a reluctance to use pain-inducing techniques than those in YOIs. This could be attributed to pain not having been as embedded in PCC as it is in C&R in YOIs, although the distraction techniques included in PCC were pain inducing.

*'The pain techniques we don't want to use, and have never had to. It's like the handcuffs. I've managed to go without having to use handcuffs. We have enough skills not to have to use pain compliance techniques. I suppose that you would if there was a life threatening possibility.'*

*'I have never used pain inducing techniques and haven't known them to be used. I would only use them if I thought there was a danger to life.'*

- 5.119** However, not all STC staff were against the use of pain-inducing techniques. In one visit a staff member told us that he welcomed the introduction of such techniques and that the possibility of inflicting pain would be a deterrent for children.

- 5.120** The majority of staff in YOIs did not have the same reservations about using pain as it had always been an accepted part of C&R. However, some were still concerned about purposefully inflicting pain on children.

*'It should be the very last option to use pain and I would feel slightly uncomfortable using it as I wouldn't like it done to me.'*

*'I am not comfortable to use pain-inducing techniques and I never have. But I haven't found the need to either.'*

- 5.121** We have consistently made recommendations that pain-inducing techniques should not be used on children in any circumstances and note that in many settings, including STCs, staff are able to manage very challenging behaviour without resorting to inflicting pain.

## Post-restraint

### Support for children

**5.122** Following a restraint incident there are a number of factors that can place children at risk, including potential injuries that might have occurred during the restraint and heightened agitation or distress. The self-inflicted death of Adam Rickwood occurred when he became upset following a restraint. Staff are made aware of the heightened risk to the child immediately after restraint and should take necessary steps to ensure their welfare.

**5.123** Many of the children we spoke to reported that they had been given the opportunity to speak to a member of staff or someone from Barnardo's following a restraint. However, during our fieldwork we found examples of staff failing to provide adequate support to children who were known to self-harm. In one example in a YOI, a child had attempted to hang himself with a ligature following a restraint. He had not been offered appropriate support, despite staff awareness that he had a tendency to self-harm following restraint. Had the child not been discovered when another boy looked through the observation panel, this could have led to another tragic incident.

**5.124** Without appropriate support, children are put in an extremely vulnerable situation post-restraint. The importance of having immediate support was expressed by some children in our interviews.

*'Whoever has rest [time] will come to your window and check you're alright. If you're kicking off they'll leave you to it. It doesn't give you enough support. They should come out with you for five minutes to see if you're alright. I've had problems with feeling low; you go from being dead angry to dead upset.'*

*'The worst thing after being restrained is feeling lonely and missing your mum. I also feel really guilty about my offence a lot of the time and then demoralised for having been restrained. It all adds up.'*

*'Staff usually come the next day but one member of staff always talks to me straight afterwards if he is on duty because we get on well. He lets me talk first and lets me get it out of my system. I prefer to talk straight afterwards if possible.'*

**5.125** Health care staff expressed concerns that post-restraint support for children was not available at all times, which could place children at risk:

*'They get support from Barnardo's workers, their key workers and wing staff. So far as support from health care staff is concerned there is mental health support which is adequate up to a point. I say this because accessibility is limited at night when young people are locked up and in my experience that is when they need support the most. We do need mental health support for young people at night.'*

### Debriefs

**5.126** In addition to providing immediate support, MMPR requires that children receive structured support following a restraint, which should be provided by a member of staff not involved in the restraint itself. This takes the form of a documented debrief with the child shortly after the restraint, and should identify any immediate support needs, as well as exploring why the incident occurred, the child's views about the restraint and any actions that could reduce the likelihood of future restraint. The debrief also provides an opportunity to identify any possible child protection referrals.

- 5.127** In STCs, debriefs take the form of restorative justice interventions (RJIs). These are on a set pro forma that a member of staff completes with the child. A similar pro forma is used in YOIs.
- 5.128** In the use of force records we reviewed in both YOIs and STCs, debrief documents were not consistently available. In some instances, there was no indication that a debrief had taken place; in others, the paperwork was simply absent. In the records we reviewed, 13 of 22 records in STCs included evidence of a debrief with the child, and 18 out of 26 in YOIs included the necessary documentation.
- 5.129** The comprehensiveness of child debrief documents varied in both YOIs and STCs. Some were comprehensive in their coverage and showed engagement with the child and meaningful discussion of the restraint. Other records were perfunctory, simply including an account of the incident and recording that the child had no issues with the restraint.
- 5.130** In our interviews, some children were positive about the process and reported that the staff conducting the debrief gave them the opportunity to go through the triggers to the event and raise any concerns.

*'Yeah – it [the debrief] made me feel better because most of the time they can hear your side of the story – they just see you scrapping so it gives you a chance to say something and put across your side.'*

- 5.131** However, some children did not find the debrief useful and described it as superficial. They reported that the member of staff simply asked them if they were okay and then left, failing to engage them in a discussion.

*'The DOM and the staff [who] restrained me came to my room. They didn't say why they had [restrained me], just told me that it was pointless and I shouldn't have done it. I'd prefer to have been told. They didn't ask any questions.'*

*'I got sent to my room straight after, then I had about a 15-second chat to check that I was OK, but there was nothing else that happened after this, no follow-up discussion.'*

*'You know that someone's there for you but when it's officers from the jail you know it's just fake and they don't really care.'*

*'When I read it [my account] back he'd just summarised what I'd said and missed out the main points.'*

### **Ineffective debrief**

One boy we spoke to in a YOI described how the member of staff who conducted his debrief had tried to get him to admit that he hit a female member of staff – which he denied – and would not accept his version of events.

*'No [the debrief didn't make me feel better]. In the incident they said I hit a female member of staff. The person who came to see me said "say you did it and I'll go away". I wouldn't because I didn't. He stayed for over half an hour because I wouldn't give in. He said "you are taking the piss out of my time". I asked if I could see the CCTV because I knew that I didn't do it but he said that I couldn't. He eventually wrote "refused to admit".'*

- 5.132** The majority of records we reviewed were of poor quality and failed to identify steps to prevent restraint recurring and lacked action points to give children targets to address their

behaviour. The number of debrief documents that referred to any existing BMP was negligible.

- 5.133** Generally, action points, where provided, were generic and lacked any meaningful understanding of the behaviour that had led to the restraint or how it could be addressed. For example, one child in an STC was given the following action points: ‘follow staff requests, apologise to the staff member and accept his sanction’. This was further supported by children we spoke to who did not always feel that they had been encouraged by staff to change their behaviour.
- 5.134** In YOIs, staff and children told us about delays in debriefs. One child told us that they did not speak to anyone about the incident until two weeks after it occurred. The longest delay we identified through our own review of use of force records was five days in one YOI, but not all use of force documentation we reviewed contained debrief documents. This could be an omission in the records or could indicate that a debrief had not taken place at all, in which case delays could be substantially longer than two weeks. Delays in conducting debriefs are inappropriate as they are an important opportunity for the child to raise formally any concerns about the restraint, and are an essential component in ensuring a child’s well-being following restraint. Specifically, children should be reminded of and given the opportunity to complain and, importantly, in some instances, this may result in a child protection referral.
- 5.135** While the majority of children we spoke to knew how to make a complaint, many reported that they would not do so due to concerns that it could affect their relationships with staff.

*‘I like the staff, so I don’t make complaints so that we can work together.’*

*‘No [I wouldn’t make a complaint] you’d lose your bond with the staff if you made a complaint.’*

- 5.136** Other children expressed disillusionment about how complaints would be investigated.

*‘They always believe the staff over the kid and I don’t think that’s fair – if you assault you get extra days or another charge. I thought when I put a complaint in something would happen.’*

*‘Nothing will happen if you make a complaint; it will probably just go to the person who twisted you up.’*

*‘I’ve complained at least once about being restrained. They just said they were following procedure and that was it.’*

### **Staff debriefs**

- 5.137** All staff involved in physical restraint should also have the opportunity to participate in a debrief where they can discuss the incident and review their own involvement. These can be conducted individually or as a group with all staff involved in the physical restraint. In many instances, the debriefs will be conducted by one of the establishment’s MMPR coordinators, but this is not always possible if they were also involved in the restraint.
- 5.138** Positive examples of staff debriefs demonstrated active discussion about the incident itself, what went well or what could be improved, how it might have affected the child, and how restraint could be prevented for the child in the future. But only 22 of the 48 documents we reviewed showed evidence of a meaningful staff debrief. The difference between STCs and YOIs was stark: of the 26 records we reviewed in YOIs, only one showed evidence of a meaningful debrief, compared with 21 out of 22 in STCs.
- 5.139** Staff in YOIs reported that the need to keep the regime going took precedence over engaging in a debrief.

*'No time to relax afterwards and have a cup of tea. Have to go straight back to work. You will be treated if you have an injury. The MMPR coordinators come and ask if you want to talk about it, but the majority of staff say that they don't.'*

*'If you are injured you could get some space to get it seen to, but if it has been emotionally draining, you have to get back on the wing to keep the regime going – nothing disturbs the regime. It can be very difficult to work with young people after a restraint as you are not at your best to deal with issues that crop up.'*

- 5.140** Due to the limited staffing in YOIs, most staff described having to return to operational duties immediately after a restraint to maintain the regime. The flexibility for staff to debrief was limited and, as a consequence, the staff attitude in the YOIs we visited was that there was very little value in attending a debrief.

*'You have already done the paperwork and the process takes a lot of time which you haven't got. I don't see the value in it.'*

- 5.141** While most felt the debrief process was not of value, staff were clear that structured support for those who were distressed following a restraint was lacking, and that the debrief process did not provide more intensive support when necessary.

*'Senior managers might just make a quick check after a serious restraint incident but there is no structured support for staff. The formal debrief for staff is just a quick round up and it is not effective.'*

*'Everyone is asked if they are alright but there is no further support on offer as a matter of routine – you would have to drive that yourself. We used to get one-to-one support/supervision from the mental health team, which was helpful, but that is no longer available.'*

### Health care assessment

- 5.142** Children should be assessed by health care staff as soon as possible after an incident to identify potential injuries and monitor any SIWS arising from the restraint. The majority of records we reviewed showed evidence that children were seen by health care staff after a restraint, and this was supported by children we interviewed. However, their accounts of the quality of these interactions varied.

*'I had a nurse but only because I requested one. I was annoyed because she wouldn't let me go to hospital. When the doctor came in the morning I was sent straight to the hospital; I had a fractured wrist.'*

*'A nurse examined a bump on my head. I said I had a dizzy pain and she said that if it got worse then let staff know. She didn't come back and ask me herself if I was ok.'*

- 5.143** In YOIs, children commonly told us that health care staff did not always complete an examination or complete the body map. Instead they would 'check on' the child through the hatch in their door, and only conducted a physical examination if the child complained of an injury. The health care staff we interviewed supported this observation.

*'We will examine the young person depending on their mood. We are guided by officers about this and we may just speak to them through their door. If they are pacing around their room we will assess them through their door. Well at least we know they are still breathing.'*

- 5.144** While we recognise that some children may not be calm enough to be seen by health care staff, we were not convinced that this was the case in all instances where children were 'examined' through the door. This was a serious potential risk as it meant that injuries could

go undetected and welfare needs might not be identified. In some records where children initially declined to be examined by health care staff, this information was generally recorded, but it was not always evident whether health care staff returned to see them later to ensure their welfare.

## Section 6. Governance and oversight of MMRP

- 6.1** Governance structures ensure that all incidents involving restraint are reviewed, referred to relevant authorities where necessary, and that learning is applied to future practice.

### Use of force documentation

- 6.2** We reviewed use of force documentation to assess both the quality and the internal review process. Across YOIs and STCs, records contained a mixture of typed and handwritten documents; handwritten records were not always legible. G4S-run STCs used their own templates, although these generally reflected the content of the national template.
- 6.3** We developed the following criteria against which we assessed restraint records:
- timely: staff accounts were completed, preferably within 48 hours, but the review team allowed for up to four days after the incident
  - comprehensive and consistent: all the staff accounts provided a full account of the incident and the events leading up to the restraint; no major details were omitted from any records.

### Timeliness

- 6.4** In the records we reviewed, all staff accounts from STCs (n=22) were completed on the day of the incident. This is in direct contrast to YOIs where only five of the 26 records we reviewed contained staff accounts completed within a four-day period.
- 6.5** In STCs, there is a local operating requirement that all use of force reports are completed on the day of the incident, before the member of staff goes off duty, a requirement that we found was met. The process established, and followed in STCs, is that accounts and accompanying records are quality assured by the MMRP coordinator the next day, which also involves reviewing the CCTV footage, where available. Records are then reviewed by the director within three days and further scrutinised at the weekly use of force meeting.
- 6.6** In YOIs, use of force documentation was not completed as promptly. The same strict requirement to complete paperwork before leaving the site was not applied, and this contributed to considerable delays in staff completing it. In our review of documentation, we found four records where staff accounts were submitted over two months after the incident. One member of staff we spoke to had not completed the paperwork for a restraint that had occurred five months before. In our interviews, staff attributed these delays to lack of time outside their daily role.
- 6.7** A few staff in YOIs said they were frustrated with the amount of paperwork they had to complete for each incident, recording it in multiple places (wing logs, incident books, the C-Nomis IT system, safeguarding monitoring, security incident reports and adjudications). They said this contributed to the delays in the completion of paperwork that we identified, and which were acknowledged by establishment staff.

*'Much more detail is required for recording in MMPR than C&R. A lot of it is duplicated, so you find yourself recording the same thing in a lot of different places. It takes a long time and is a pain. I think some people avoid restraining so they don't have to fill in the documentation.'*

*'The paperwork is very long and they want to know everything about the restraint, though I don't think all they want to know is relevant. You are not given any time to write the records – you have to do it within 24 hours – but mine are often later than that. They do chase you up, if you are late. If you have done a few restraints, you might have to write them up in a different order and it is sometimes hard for you to remember the detail. I always write them up on my own. Everything gets recorded, even low level restraints.'*

*'There is a lot more paperwork and the majority of times I can get it done within the timescales (48 hours). It can be a real struggle if you have a number of restraints in a day. The paperwork is complicated.'*

- 6.8** MMPR coordinators in YOIs told us they were routinely alerted to all restraint incidents and reviewed CCTV footage within 24 hours, even in the absence of staff accounts. However, if the restraint had taken place in an area without CCTV coverage, incidents could not be fully investigated, and concerns identified, until paperwork was submitted.
- 6.9** The delays in completion of the use of force record in YOIs led to backlogs of incidents to quality assure. Similarly, weekly use of force meetings only reviewed incidents after all staff accounts were submitted and records were completed, which could delay the scrutiny of incidents by several months: in one YOI we visited the use of force meeting in September was reviewing incidents from February. This scrutiny was further hindered by the data retention policies in some establishments, which meant that all CCTV footage was routinely destroyed after one month unless there were child protection concerns identified when the incident was initially reviewed. CCTV footage could, therefore, have been destroyed before an incident was fully reviewed. In light of these delays, the national team has instructed YOIs to review all incidents as soon as possible and not wait for all statements to be submitted before conducting the review.
- 6.10** The lack of timely scrutiny minimises the opportunity for staff with a duty of care to the child to identify incidents of concern. In the absence of this, incidents where a full and thorough investigation may be necessary have the potential to go undetected and may only be triggered by a child making a complaint. However, as discussed in earlier sections, many children we interviewed told us they would not make a complaint following a restraint and the incident might not be investigated appropriately.
- 6.11** In late 2014, the YJB and NOMS instructed all under-18 YOIs and STCs using MMPR to retain all footage (including material from CCTV, handheld and body-worn cameras) where the use of a pain-inducing technique is reported, and as well as for incidents where a SIWS is reported.

## Comprehensive and consistent

- 6.12** Less than half of the records we reviewed were judged as being comprehensive (23 out of 48), although the proportion was higher in STCs (11 out of 16) than in YOIs (12 out of 22). Documentation often lacked the appropriate level of detail, such as the holds applied and by who. We also found records in which holds were applied in the wrong order – for example, a head hold being applied before both arms were secured – which could cause serious harm to a child. It was unclear whether these were accurate descriptions of the incidents or were recording errors.

- 6.13** As in other high stress incidents, individual staff involved in the same incident may recall it differently. We found several examples where reporting of the incident was not consistent by all the staff involved. Some records revealed discrepancies about the position of the child, such as whether they were supine (face up) or prone (face down), and differences in accounts about the order in which the holds were applied. A failure to conduct a prompt review makes it more difficult to resolve these discrepancies.
- 6.14** We found information on the use of holds, and in particular the use of pain, was often inaccurately recorded on the front cover sheet, which forms the data return to the YJB. Inaccurate returns mean that there is no accurate picture of the use of restraint in the children's estate. This has wider implications for the governance of MMPR, as this data is used in part to evidence developments in policy and practice.

## Quality assurance and review of use of force records

- 6.15** Of the records reviewed, 21 out of 22 in STCs had been quality assured internally, compared with only three out of 26 in YOIs. Across both YOIs and STCs, some quality assurance we reviewed was perfunctory, simply recording that paperwork had been completed; others provided a commentary on the incident, noting where alternative approaches or behaviour management techniques could have been used.
- 6.16** The quality assurance process itself did not always make reference to the inconsistencies in the accounts of staff (see paragraph 6.13).

### Inconsistent reporting not referenced in quality assurance

One record we reviewed in an STC detailed an incident where a boy was restrained for 17 minutes. From the record as a whole it was clear that the boy was restrained in the prone position and in a head hold during the incident. His breathing became heavy and health care staff were requested to attend. The boy was struggling and, after attempts to bring him back to his feet failed, he was restrained like this for a further three minutes.

At this stage in the records, the accounts detailing the remainder of the incident became inconsistent. Some records showed that the boy became 'calm' after attempts to bring him to his feet were unsuccessful. However, other records noted that he became 'unresponsive', started making gagging noises and spitting on the floor. One member of staff recorded that at this point holds were released and health care staff advised that the child be left to calm down; the child lay on the ground like this for three minutes.

The quality assurance process at both coordinator and director level made no reference to the inconsistencies in the accounts of staff or attempt to resolve them, particularly in relation to the boy gagging and becoming unresponsive, which are both SIWS.

- 6.17** Staff in STCs told us the quality assurance process was more robust with MMPR than with PCC, due to scrutiny by the MMPR coordinators. However, a few staff in both YOIs and STCs resented this additional scrutiny. An MMPR coordinator in a YOI told us this could result in staff not acting to restrain a child when required:

*'They find the scrutiny difficult and can be reluctant to get involved in restraints because they might be criticised for what they have done.'*

- 6.18** The internal quality assurance process includes a review of staff accounts and CCTV footage and makes recommendations about improvements to practice.

## Review of CCTV footage

- 6.19** CCTV footage was reviewed in 19 of the 48 records we examined (10 of 22 in STCs and nine of 26 in YOIs). Incidents where CCTV was not reviewed mostly occurred off camera in locations such as kitchens, classrooms, stairways or cells. The absence of CCTV inhibits MMPR coordinators from applying the same level of scrutiny as in incidents where CCTV footage is available.
- 6.20** Children's cells are not covered by CCTV and some children we spoke to made allegations that they had been inappropriately restrained and physically hurt by staff in their cells (see paragraph 5.27). It is not possible for establishments or other relevant bodies to investigate fully these allegations or quality assure the related restraint incident without CCTV.
- 6.21** Concerns about the coverage of CCTV in establishments led the YJB to pilot the use of body-worn cameras. Pilots are currently under way at the under-18 side of Feltham YOI, Wetherby and Cookham Wood YOIs and also at Rainsbrook STC. The cameras are intended to record all incidents and analyse them thoroughly. Body-worn cameras can record audio, which should further assist the review of incidents as verbal de-escalation can be evidenced. The MMPR national team has reported to us that initial feedback from Feltham YOI has been positive, but it is important that such cameras are not allowed to inhibit proper interactions between staff and children.

## Recommendations arising from quality assurance

- 6.22** The internal quality assurance process often generates recommendations on restraint practice. Of the 48 records we reviewed, 16 included recommendations from the reviewing MMPR coordinators, the majority (n=15) in STCs. Recommendations included addressing specific aspects of the restraint and focusing on the actions of individual staff. For example, one recommendation from an STC specified that praise should be given to the first member of staff for their practice, and that the remaining two should be spoken to about better use of proxemics (physical distance) to enable other staff to maintain control of the incident.
- 6.23** More general recommendations related to how MMPR is delivered more widely within an establishment. For example:
- the importance of not entering a child's room at the end of a restraint because of potential safeguarding allegations
  - improvements that could be made to the reports themselves
  - reiterating to all staff the importance of ensuring they protect themselves
  - the need to always secure the arms before using a head hold.
- 6.24** Use of force records did not routinely record whether a recommendation had been followed up or incorporated into staff learning and development.
- 6.25** MMPR coordinators in some establishments told us they provided individual staff with additional support and training where issues were identified during quality assurance. For example, efforts were made in one STC to include report writing in refresher training after this was repeatedly identified as a problem. In a further example, an STC had established a structured reflection process – following a restraint, the senior MMPR coordinator held a session with each staff member involved to discuss their actions during the incident. The sessions were recorded in a reflective practice folder, and in our review we saw the appropriate 'praising' of good practice.

- 6.26** MMPR coordinators should feel confident about providing independent and impartial assessments of MMPR in their establishment. However, some we spoke to did not feel they were fully prepared for the role of reviewing records. Since the conclusion of the fieldwork, the MMPR national team has devised a quality assurance checklist that details the key points and specific considerations to be incorporated when reviewing documents. We have not been able to review this yet, so cannot draw any conclusions about its effectiveness.
- 6.27** MMPR coordinators should also be confident in critiquing and providing feedback to their peers about their MMPR practice. However, this was a challenge identified by coordinators, with some concerned that peers might not fully understand their role and would view them as 'snitchers'. In one establishment, where coordinators were required to give feedback to more senior staff about their use of restraint, they took the approach of joining with other coordinators to address staff together, as they did not feel confident to do so on their own. Not receiving and taking on board feedback limits the ability of operational staff to improve their practice.
- 6.28** In an incident review meeting we observed that MMPR coordinators seemed more confident in providing feedback to colleagues about the technical elements of restraint, rather than the use of behaviour management techniques. MMPR coordinators felt they had not been trained to challenge staff about their behaviour, which is a key part of their role. In some instances, however, we observed MMPR coordinators being defensive when challenged about their colleagues' actions, in some instances excusing it rather than taking on board the views of the MMPR national team.
- 6.29** MMPR coordinators in both YOIs and STCs also spoke to us about having insufficient time to fulfil their duties as they were often asked to cover staff shortages or perform additional duties, such as hospital escorts and 'lining the route'.<sup>49</sup>

## Reviewing use of force in establishments

- 6.30** Local use of force meetings took place in all establishments we visited. Their purpose was to review restraint incidents on a regular, usually weekly, basis, including monitoring the overall use of restraint in the establishment and reviewing CCTV and written accounts. We were not able to attend these meetings routinely, but from the four meetings we observed and our interviews with staff we were able to make some judgements about them.
- 6.31** Substantial backlogs in the completion and quality assurance of records in YOIs meant that some incidents were not reviewed until several months later, by which time CCTV could have been deleted and serious injuries could have gone unnoticed (see paragraphs 6.5 to 6.9).
- 6.32** Health care staff did not routinely attend restraint review meetings and so were unable to raise health-related concerns. The role of health care staff in safeguarding and overseeing restraint was further inhibited by their limited knowledge of the MMPR system.

## Local authority safeguarding children boards (LSCB) and child protection referrals

- 6.33** The IRRJSS recommended that the local safeguarding children board (LSCB) 'should be properly linked in with any secure setting in its area and should be able to scrutinise restraint techniques and the policies and protocols which surround the use of restraint, and the

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<sup>49</sup> Supervising the movement of children around an establishment.

incidents and injuries'. The review also recommended that 'in order to be able to fully scrutinise restraint incidents, including CCTV footage, staff from LSCBs and local child protection committees who have responsibility for investigating child protection referrals should be trained in the relevant restraint methods used by their area's secure units'.

- 6.34** The four LSCB staff we spoke to, who were the local LSCB links with the secure establishment, principally saw their role in restraint as dealing with specific child protection or safeguarding referrals made by the establishment following incidents, rather than reviewing restraint incidents and injuries within establishments as a whole. This is of concern as it removes any regular, external monitoring of restraint other than that provided through the quarterly national team incident reviews, which are described below. Although HMI Prisons reviews restraint in establishments as part of its regular inspection programme, this is an annual programme of inspection.
- 6.35** In their remit to investigate child protection referrals arising from restraint, local authority staff were inhibited by their lack of understanding of MMPR. None of those we spoke to had been fully MMPR trained, or attended the specific MMPR course developed, as IRRJSS recommended, and all lacked knowledge about the appropriate use of the system. A small number of local authority representatives told us that they took their guidance about what was acceptable from the MMPR coordinators themselves, rather than engaging and challenging the physical restraint they saw. This could be a result of not having undertaken the relevant MMPR training.

## Referrals to SIWS and medical review

- 6.36** In our fieldwork we identified one concerning incident that should have been referred to the national team in line with SIWS reporting procedures, but was not. The establishment had failed to refer the incident as the director believed that the injury had been caused by the child themselves and not by the restraint, and so external review was unnecessary. In line with HMI Prisons' child protection protocols, details of all such incidents were passed to the national team and medical advisers to be investigated.
- 6.37** The failure by establishments to refer SIWS for investigation reveals weaknesses in the reporting system overall: the national team can only investigate incidents that are referred to it. If the establishment fails to refer a concern, for whatever reason, no review can take place. Despite the higher incidence of restraint in YOIs, very few SIWS were reported to the national team from YOIs compared with STCs.

## National governance and review

### National team incident reviews

- 6.38** The MMPR national team has the option to review any individual incident and a random selection as a part of its incident reviews. Incidents are identified through the NOMS young people's group and local MMPR coordinators (and on-site YJB monitors in STCs) based on the following criteria:
- incidents where a medical warning sign or serious injury has occurred and been reported
  - incidents subject to a complaint, allegation or child protection referral
  - incidents where there was a particular concern about any aspect of what occurred

- incidents deemed by the coordinators to be examples of best practice, where staff responded to and managed an incident in a way that could be held up to others as an example to follow.
- 6.39** The number of incidents reviewed by the national team was not specified, but our analysis of the resulting action plans showed that up to 10 incidents were reviewed at each meeting.
- 6.40** Incident reviews take place monthly for the first six months of MMPR delivery and then quarterly after the YJB, NOMS and the MMPR national team is satisfied that MMPR is being delivered and governed appropriately at a local level. If the YJB, NOMS and the MMPR national team are not satisfied with local delivery and governance, the monthly incident review continues until a time when they are satisfied. The incident reviews carried out by the MMPR national team that we observed were well managed and very thorough. They examined relevant documentation alongside CCTV footage, when available, and had full and frank discussions involving the local MMPR coordinators and senior managers in the establishment, including the governor/director.
- 6.41** Although we found this process was thorough, incidents involving the use of pain were not routinely selected for review. Since April 2015, the national team has intended to include all incidents involving pain routinely in its quarterly or monthly reviews; this is not possible at present due to resource constraints, which is unacceptable.
- 6.42** The main weakness was that incidents involving SIWS were not always covered in these reviews, since the process relied on establishments reporting SIWS correctly. After concluding from incident review meetings and HMI Prisons' fieldwork that SIWS incidents were not always reported to it, the national team tightened procedures to ensure that all SIWS are captured.
- 6.43** Concerns about individual and establishment practice were robustly tackled by the MMPR national team. For example, it identified that incidents that used a pain-inducing technique did not always include a sufficient account of the justification for its use, in accordance with the stated criteria. The MMPR national team took action to address this important aspect of recording through its regular contact with the MMPR sites.
- 6.44** Following the incident reviews, comprehensive feedback was sent to establishments setting out, in considerable detail, the review team's findings. Good practice was given credit and recommendations were clearly set out to remedy any shortcomings identified and improve practice generally. Where more serious concerns were identified, the national team took appropriate action, such as requesting an internal investigation and/or that a referral be made to the local authority. Helpful advice was given, often based on established medical advice and, on occasion, additional practical support from NOMS young people's team was offered.
- 6.45** The quality of establishment responses to feedback and recommendations by the national team varied widely from comprehensive to minimal; for example, some establishments set out what they intended to do to meet the recommendation while others simply said 'agree' with no detail about how they were to be implemented or any further action. The MMPR national team made good efforts to seek clarification on responses to recommendations, but this was not always effective. Improved escalation processes, including clearer lines of accountability by the DDC, have now been put in place to secure satisfactory responses from establishments to recommendations.
- 6.46** The YJB, NOMS and MMPR national team routinely identify key learning points and themes from incident review meetings and other monitoring. In December 2014, a *Quick Time Learning Bulletin* was issued to all YOIs and STCs. The bulletin is informed by advice from the independent medical advisers who provide regular advice on the medical safety, risks and effectiveness of MMPR techniques. Practice issues highlighted included lessons to be learned

from SWIS, the risks associated with staff going into children's cells, the criteria for using pain-inducing techniques, reviews of local quality assurance measures, and the importance of good quality debriefs for children.

# Section 7. Appendices

## Appendix I: Detailed methodology

This review looked at the implementation and delivery of MMRP in the children's secure estate. It is based on data collected from multiple sources.

### MMRP governance meetings

Throughout all stages of this review, members of the review team have regularly attended, in an observational capacity, various national and local governance meetings. These included meetings<sup>50</sup> of:

- the restraint management board (RMB)
- the senior programme board (SPB)
- the restraint advisory board (RAB)
- the MMRP implementation board (conducted at a local level by the YJB, NOMS and the MMRP national team)
- local incident reviews by the national team (including an analysis of incident review meeting minutes).

In addition to the formal governance meetings, HMI Prisons also attended many ad hoc meetings with the MMRP national team to keep abreast of developments in policy and practice associated with the roll out of MMRP.

### MMRP training

During the planning stages of this review, two representatives of the review team attended a five-day MMRP training course as observers. This provided context to the review and informed the development of the methodology, provided an overview of the techniques available, and allowed the review team to put the application of MMRP into the context of the course content and the teaching on behaviour management. Further attendance at local refresher training sessions was undertaken, in an observational capacity only, on three occasions at two fieldwork sites.

### Fieldwork

Fieldwork was conducted between February and November 2014 and took place at pre-implementation sites (where MMRP had yet to be implemented) and post-implementation sites (where MMRP had 'gone live'). Pre-implementation fieldwork visits were conducted at one young offender institution (YOI) and one secure training centre (STC); post-implementation visits were undertaken at two YOIs and two STCs.

The establishments remain anonymous throughout the text, except where good practice is highlighted.

Across all establishments fieldwork consisted of the following.

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<sup>50</sup> A full description of the roles and responsibilities of each of these boards is provided in section 2 of this report.

	Pre-implementation sites		Post-implementation sites				Total
	STC	YOI	STCa	STCb	YOIa	YOIb	
Interviews with children	12	10	12	12	12	20	<b>78</b>
Senior manager discussion groups	1	1	1	1	1	1	<b>6</b>
MMPR coordinators discussion groups	1	0	1	1	1	1	<b>5</b>
Operational staff interviews	6	4	6	6	3	6	<b>31</b>
Health care staff interviews	1	1	1	1	2	1	<b>7</b>
Local authority interviews	1	0	1	1	1	1	<b>5</b>
Use of force documentation	12	0	12	10	8	18	<b>60</b>
Behaviour management plans	10	0	8	5	5	6	<b>34</b>

### ***Interviews with children:***

Semi-structured interviews were conducted with children who had been restrained. Children were selected from a list provided by the establishments of all those who had been involved in a restraint. Children were asked about their experiences and perceptions of restraint, as well as the support they received afterwards.

### ***Staff interviews and groups***

At each establishment, interviews and group discussions were conducted with staff to explore the strategic implementation, governance and internal monitoring of MMPR, as well as the experience of applying restraint techniques. Interviews and discussion groups included:

- individual interviews with operational staff who were selected at random from those available during the fieldwork; efforts were made to ensure a gender balance of those interviewed. Operational staff were asked about their experiences of applying restraint techniques for both MMPR and its predecessors (C&R and PCC), factors affecting restraint, and staff perceptions of the impact of restraint on children
- staff groups with senior managers to explore the strategic implementation, governance and internal monitoring of MMPR
- staff groups with MMPR coordinators (responsible for MMPR training and monitoring at local level) about their role and the internal monitoring of incidents of restraint
- interviews with members of health care staff about their experiences of overseeing incidents of restraint

- interviews with representatives from the local authority with safeguarding responsibilities for the children in the establishment and who reported to the local safeguarding children board (LSCB).

The interviews were conducted either face to face or by telephone, depending on availability during the fieldwork.

### **Documentary analysis**

A sample of use of force documentation was randomly selected at each establishment to allow the review team to assess the quality of the records, the internal review process and the accuracy of the returns made to the YJB. In total, 60 use of force documents were analysed.

Behaviour management plans were analysed at each establishment to assess how children's behaviour was being formally managed and addressed by establishment staff, with a view to minimising the frequency of restraints. In each establishment, all behaviour management plans available were analysed, including some that had been closed shortly before fieldwork commenced. A total of 34 behaviour management plans were reviewed.

CCTV of restraint incidents was viewed at each establishment visited to obtain a complete account of incidents. CCTV was selected based on our review of use of force records and interviews with children and staff.

### **Triangulated methodology**

During our review we used a mixed-method approach to data gathering and analysis, applying both qualitative and quantitative methodologies. Evidence from different sources was triangulated to strengthen the validity of our assessments.

While it was beyond the capacity of the review team to triangulate all information provided by children, it should be recognised that children unknown to each other, in separate establishments, were consistent in their reporting of both their experiences and their concerns. As such, children's accounts should be given appropriate weight and consideration.

### **Child protection**

In accordance with HMI Prisons child protection protocols, where incidents raised child protection/safeguarding concerns, those cases were referred to the establishment for investigation or the MMR national team, as appropriate.



## Appendix II: Further detail about MMPR

### The MMPR syllabus<sup>51</sup>

**Volume 1:** *Introduction to MMPR and instructors guidance* – gives an introduction to MMPR and guidance to trainers delivering the syllabus to staff.

**Volume 2:** *Behaviour recognition and decision making* – sets out the expectation to manage challenging behaviour and describes how positive relationships can be formed between staff and children.

**Volume 3:** *Medical advice* – covers the possible medical implications and risks to children while being restrained.

**Volume 4:** *Managing use of force incidents* – describes the roles and responsibilities of staff involved in a physical restraint.

**Volume 5:** *Physical restraint* – covers the MMPR techniques.

**Volume 6:** *Use of force: report writing* – covers the various reports required following a restraint, including the debriefing of children and staff.

### MMPR holds

#### Low level

##### **Guiding hold**

A low level, non-pain inducing technique that can be applied either by one member of staff or two. Not to be confused with everyday physical interaction, this is only applied in response to a specific trigger from a young person.

##### **Single embrace**

A low level, non-pain inducing technique that is applied by one member of staff. This hold can be ineffective if the young person is of much larger build than the member of staff, so other techniques might need to be used.

#### Medium level

##### **Isolating the arm**

This hold can be applied from either the front or rear of the young person. It needs to be applied by two staff and can be used in conjunction with the head hold, depending on the young person's demeanour. It is a non-pain inducing hold.

##### **Figure four arm hold**

This hold is non-pain inducing and must be applied by two staff, one controlling each of the young person's arms. This can be applied in conjunction with the head hold, depending on the young person's demeanour.

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<sup>51</sup> <http://webarchive.nationalarchives.gov.uk/20140715125548/http://www.justice.gov.uk/youth-justice/custody/behaviour-management/minimising-and-managing-physical-restraint>

### **Head hold**

The application of this technique will assist team members in gaining control of a young person whose behaviour has accelerated and could compromise the safety of themselves or others. It must be applied if there is a risk of the young person going to the floor to protect their head from injury.

### **Arm hold**

This technique starts in the same position as isolating the arm and must be applied by two staff. It is a non-pain inducing technique and is applied when staff require a greater degree of control. Since 1 June 2015, this technique has been removed from the MMPR manual as it had been used in less than 1% of incidents, and it appeared that its use in some incidents could increase the risk of the young person going to the floor. Due to the refresher schedules this change will be delivered to all staff in the next six months, and the technique will be completely removed by 1 December 2015.

### **Leg control**

If it is necessary to control the legs of a young person due to level of resistance then an extra member of staff may be used to assist and apply leg control. This can be applied in both the prone and supine position. When de-escalation of the young person's behaviour has been achieved, the legs will be released.

### **Ratchet handcuffs**

Ratchet handcuffs may be applied if it is necessary to remove a young person from one part of the establishment to another (e.g. relocation to a room/ cell or the care and separation unit).

### **High level**

#### ***Inverted wrist hold***

This technique is applied by two staff and provides them with a greater degree of maintaining control. This is non-pain inducing and can be applied in conjunction with the head hold, depending on the young person's demeanour.

#### ***Figure of four leg lock***

This is a technique used for relocation of a young person, but will only be considered and used when all other alternatives are judged to be unsafe for all concerned due to the level of threat posed by the young person.

### **Pain-inducing**

#### ***Thumb flexion***

This is a pain-inducing technique that must only be applied if there is a risk of serious physical harm to the young person or others. It is applied by one member of staff and pain is induced by gradual pressure through the young person's thumb. Where the risk allows, the pain guidelines must be followed.

#### ***Mandibular angle***

This is a pain-inducing technique that must only be applied if there is a risk of serious physical harm to the young person or others. It is applied by one member of staff. The location of the pressure point is behind the base of the ear lobe, between the mastoid and the mandible. For this technique to be effective, the head must be stabilised before application. Where the risk allows, the pain guidelines must be followed.

#### ***Wrist flexion***

This is a pain-inducing technique that must only be applied if there is a risk of serious physical harm to the young person or others. It is applied by one member of staff. Pain is induced by gradual pressure through the back of the young person's hand. Where the risk allows, the pain guidelines must be followed.

Definitions provided by the MMPR national team. Further detail on each technique can be found in volume five of the MMPR syllabus, *Physical restraint*.<sup>52</sup>

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<sup>52</sup> <http://webarchive.nationalarchives.gov.uk/20140715125548/http://www.justice.gov.uk/downloads/youth-justice/custody/mmpr/mmpr-vol5-physical-restraint.pdf>



## Appendix III: Glossary

<b>ACCT</b>	Assessment, care in custody and teamwork case management for those in custody identified as being at risk of suicide or self-harm.
<b>BMP</b>	Behaviour management plan
<b>BMRGB</b>	Behaviour management and restraint governance board
<b>BMRWG</b>	Behaviour management and restraint working group
<b>C&amp;R</b>	Control and restraint, introduced 1983
<b>CCTV</b>	Closed circuit television
<b>C-Nomis</b>	National offender management information system, an offender management IT system used across prison and probation services.
<b>CYP</b>	Children and young people (under 18)
<b>DDC</b>	Deputy director of custody
<b>DOM</b>	Duty operations manager
<b>Double-basket hold</b>	A former PCC technique where a child's arms are held across their chest.
<b>DTO</b>	A detention and training order is a custodial sentence for 12-17 year olds that combines detention with training. A DTO lasts for between four months and two years and is given to children who commit a serious offence or a number of offences.
<b>HMI Prisons</b>	HM Inspectorate of Prisons
<b>IRAP</b>	Independent restraint advisory panel (since April 2012), provides independent advice to RMB
<b>IRRJSS</b>	Independent Review of Restraint in Juvenile Secure Settings
<b>LSCB</b>	Local safeguarding children's board
<b>MMPR</b>	Minimising and managing physical restraint
<b>MMPR coordinator</b>	Minimising and managing physical restraint coordinator
<b>MOJ</b>	Ministry of Justice
<b>NOMS</b>	National Offender Management Service
<b>Nose distraction technique</b>	A former PCC technique where pressure is applied under the nose.
<b>NTRG</b>	National tactical response group (specialist unit within NOMS), the preferred provider to develop new restraint system, and developer of PCC and C&R.
<b>Pain compliance</b>	The use of painful stimulus to control or direct a person.
<b>PCC</b>	Physical control in care (12-14 year olds), used in STCs until replaced by MMPR.
<b>PRICE</b>	Protecting rights in the care environment, a method of restraint devised by the Prison Service and in use in some SCHs.
<b>PSI</b>	Prison Service instruction
<b>RAB</b>	Restraint advisory board (originally restraint accreditation board)

<b>RHP</b>	Restraint handling plan
<b>RJI</b>	Restorative justice intervention
<b>RMB</b>	Restraint management board – senior officials from YJB, NOMS and MoJ with responsibility for oversight of restraint policy and practice. This board has been replaced by the YJB-chaired, behaviour management and restraint governance board (BMRGB).
<b>RPI</b>	Restrictive physical intervention. 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'.
<b>Seated double embrace</b>	A former PCC technique that involves two staff forcing a person into a sitting position and leaning them forward, while a third takes care of the head.
<b>SCH</b>	Secure children's home.
<b>SIWS</b>	Serious injuries and warning signs
<b>SIWSMP</b>	Serious injuries and warning signs medical panel
<b>SPB</b>	Senior programme board
<b>STC</b>	Secure training centre
<b>Sterile area</b>	The sterile area in an STC is the unit office, where children are not permitted.
<b>Straight arm lock</b>	A C&R technique.
<b>Use of force</b>	Any occasion where force is used on a child.
<b>YJB</b>	Youth Justice Board
<b>YOI</b>	Young offender institution