

A review of the use of *pain-inducing techniques* in the youth secure estate

Charlie Taylor

Introduction

In October 2018 Edward Argar MP, youth justice minister at the Ministry of Justice (MoJ), invited me to conduct a review into the Department's policy framework¹ which permits the use of certain pain-inducing techniques on children who are in Young Offenders Institutions (YOI), Secure Training Centres (STC) or being transported between court and custody. In part, this was due to a lawsuit bought by the children's rights group Article 39 against the MoJ that sought to challenge the policy on three grounds:

- 1 That pain-inducing techniques are available to contractors that escort children to and from SCH in which pain-inducing techniques are not permitted.**
- 2 That permitting these different rules for restraint for the same children constituted discrimination.**
- 3 That the policy prohibiting the use of pain-inducing techniques to maintain good order and discipline during escorts was unclear.**

This is a highly emotive issue that provokes strong opinions. In June 2016, the UN Committee on the Rights of the Child published the outcome of its scrutiny of the UK's progress in implementing the Convention. It expressed concern about "the use of pain-inducing techniques on children in institutional settings in England, Wales and Scotland" and urged the UK to "ban the use of any technique designed to inflict pain on children".

For UK human rights groups the use of restraint has long been an area of concern, particularly since the tragic and avoidable death in 2004 of Gareth Myatt at Rainsbrook STC as a result of restraint by staff, and the suicide of Adam Rickwood at Hassockfield STC that occurred soon after he had been restrained. The Children's Rights Alliance for England (CRAE), the Howard League for Penal Reform, Article 39, the Children's Commissioners for both England and Wales, and the serious case review into Medway STC have all called for the use of pain-inducing techniques to be outlawed in all settings where under 18s are detained.

In March 2019, CRAE published their annual report on the state of children's rights in England,² which recommended that "restraint against children should only be used when the child poses an imminent threat of injury to themselves or others and it should never be used to deliberately inflict pain."

The report published by the Independent Inquiry into Child Sexual Abuse (IICSA) in February 2019³ that considered historic abuse cases in the youth secure estate concluded that

1 <https://webarchive.nationalarchives.gov.uk/20140714183103/http://www.justice.gov.uk/downloads/youth-justice/custody/mmpr/use-restraint-policy-framework.pdf>

2 <http://www.crae.org.uk/publications-resources/state-of-childrens-rights-2018/>

3 <https://www.iicsa.org.uk/reports/cici>

“the use of these [pain-inducing] techniques, however challenging the behaviour of the child, normalises pain for staff and children...Pain compliance contributes to a culture of fear and has the effect of silencing the child at a time when it is important that the child feels safe to speak out about aspects of their lives, including sexual abuse.”

The Chair and Panel of IICSA recommended that “the Ministry of Justice prohibits the use of pain compliance techniques by withdrawing all policy permitting its use, and setting out that this practice is prohibited by way of regulation”.

The Joint Committee on Human Rights (JCHR) has also looked at this issue and, in its report on solitary detention and restraint in youth detention published in April 2019,⁴ concluded that “the use of pain-inducing techniques (which are designed to cause pain and work by deliberately inflicting pain) on children inflicts physical distress and psychological harm in both the short and longer term” and made the recommendation “that the use of specific pain-inducing techniques in Youth Offenders’ Institutes should be prohibited”.

My aim with this review has been to look at the evidence, including answers to the following questions:

- What pain-inducing techniques are permitted in YOI and STC?
- What are the circumstances in which the use of pain on children is allowed?
- How effective are pain-inducing techniques in preventing serious harm?
- What are the alternatives to allowing the use of pain-inducing techniques?
- What are the governance arrangements for the use of pain, and are they effective?

I have sought to understand this issue through talking to experts and children, and through observing video footage to understand whether there are circumstances in which the use of pain on children can be justified.

4 <https://publications.parliament.uk/pa/jt201719/jtselect/jtrights/994/994.pdf>

The Minimising and Managing Physical Restraint programme

During this review I have defined a pain-inducing technique as “the use of a technique that is deliberately designed to cause pain to a child”.

I have used the following definition of pain: “a subjective perception of a noxious stimulus which causes mild to severe physical discomfort”.

In 2007, in response to the deaths of Gareth Myatt and Adam Rickwood in STC, two senior social workers, Peter Smallridge and Andrew Williamson, were asked by the MoJ and the Department for Education to undertake an independent review of physical restraint.

In response, the National Offender Management Service was asked to develop restraint practice that would better reflect the vulnerabilities and challenges posed by children in custody. The Minimising and Managing Physical Restraint (MMPR) syllabus emerged from that work as a single system of restraint that would be used by YOI and STC.

MMPR is built on the principle that physically restraining children should be kept to a minimum and viewed as the last available option. The MMPR training programme that is completed by all staff members in YOI and STC aims to provide them with the skills to use behaviour management techniques, and de-escalation and diversion strategies to avoid the need to resort to physical restraint.

In August 2011 the Restraint Advisory Board (RAB) presented its assessment of MMPR in a report entitled “Assessment of Minimising and Managing Physical Restraint for the Children in the Secure Estate”. The report made 37 recommendations that were designed to assist responsible authorities in implementing the new MMPR restraint system.

The government published its response to the RAB in July 2012 and MMPR was rolled out under the oversight of the Independent Restraint Advisory Panel. Alongside this, a new independent medical panel was established to oversee the process for restraints where a report of a serious injury or medical warning sign was recorded.

A phased roll out of MMPR took place across STC and YOI in the youth secure estate between September 2012 and the summer of 2017, starting with Rainsbrook STC and concluding with HMYOI Parc.

The introduction of MMPR and much improved monitoring processes have led to a reduction in incidents of serious harm to children during restraint. Since MMPR was introduced there have, thankfully, been no deaths and the number of hospitalisations for serious conditions as a result of restraint have reduced significantly. There has been determination in the

HMPPS ORRU (Operational Response and Resilience Unit) and the Youth Custody Service (YCS) and their predecessor organisations to improve the governance of restraint, make sure that staff are regularly trained and that there is ongoing monitoring of practice.

All new staff members complete an eight-day MMPR training course and receive one day of refresher training every six months. Members of staff who move to the YCS from HMPPS adult establishments where they were trained to use the Control and Restraint system undergo a five-day conversion course to learn the MMPR syllabus and techniques. They will attend the same refresher training every six months.

Staff trained in MMPR are currently allowed to use a pain-inducing technique in the under-18 YOI at Feltham, Cookham Wood, Wetherby and Werrington, and Parc YOI in South Wales (operated by G4S), and the Rainsbrook, Oakhill and Medway STC.

Staff who transport children in modified taxis to STC and SCH are also trained in MMPR and are also permitted to use a pain-inducing technique. Staff who transport children to YOI in cellular vehicles (prison vans) and court cell staff are not trained in MMPR. When restraint is necessary, they use C&R and this training package allows the use of pain, including some techniques that are not permitted in MMPR.

Staff in SCH, from which the YCS commissions 107 places for sentenced children in 7 homes across England and Wales, are not permitted to use pain-inducing techniques.

In Annex A, I have included the introduction to the use of pain-inducing techniques from the MMPR training handbook showing the circumstances in which the use of pain is allowed.

The MMPR programme allows three types of pain-inducing technique:

- **Mandibular angle** – this involves putting pressure on a nerve centre on the jaw bone, below the ear. In most people it causes a sharp burst of pain. It is not permitted to be used for more than 5 seconds as there is a risk of long-term nerve damage. In theory the pain goes soon after the application has stopped, but in some cases it can continue for hours or days afterwards. Some children said that it had no effect on them – this could be because of a physiological reason such as prior nerve damage or because the technique was misapplied.
- **Wrist flexion** – is applied by taking hold of the thumb and forefinger and, with the elbow bent, pressing the hand downwards. It causes pain in the back of the hand and wrist. Too much pressure with this hold can cause damage to the wrist joint, ligaments and nerves. In two cases I observed, children said that they had not felt pain – this was probably because the technique was wrongly applied. There is a variation of this hold – the wrist flexion with rotation that involves pressing down on the hand and twisting at the same time.

- **Thumb flexion** – this involves taking hold of the back of the thumb and pressing the last joint down and inwards, causing pain in joint and along the thumb. It is the least commonly used pain-inducing technique.

The MMPR training guide allows the use of pain where there is “an immediate risk of serious physical harm”. It does not give a precise or detailed definition of what this might be. This was a deliberate decision taken when the programme was devised, because it was felt that there was a risk that the application of pain could become a formulaic response to certain situations rather than expecting staff members would use their professional judgement.

Review methodology

As part of the evidence-gathering I visited every YOI and STC, and two SCH and spoke to staff from two more. I have watched CCTV and body-worn camera footage of 66 incidences of restraint, of which pain-inducing techniques were used in 44, and I have reviewed the paperwork for each incident. I have also spoken with 25 children on whom pain was used, hearing about their experiences of the incident and more widely about their lives and their time in custody.

I talked to individual officers who had used a pain-inducing technique, about the circumstances of its use and its effectiveness. I have also listened to the views of YOI governors and the directors of STC and SCH. I have met and observed trainers in both MMPR and other techniques and looked at their systems for reviewing and quality-assuring the use of restraint.

I have visited west London NHS Trust High Secure Services (Broadmoor Hospital) Violence Reduction Training Centre and met expert witnesses and medical professionals who give evidence in cases where incidents of restraint have come to court.

I have also had meetings with human rights organisations, advocacy groups and Parliamentarians. Where possible I have also spoken to and heard from people or organisations that have conducted previous reviews in this area such as: IICSA, Lord Carlile, Lord Ramsbotham, Professor Dame Sue Bailey and John Drew, former chief executive of the Youth Justice Board and commissioner of the Medway STC serious case review.

Though it has not been possible to visit jurisdictions outside England and Wales, I have spoken to representatives from Northern Ireland and Scotland, as well as the Dutch Department of Justice and Safety.

Observations on the use of restraint in the secure estate

During the review, in observing CCTV and body-worn camera footage and in conversations with children, I have concluded that there is widespread overuse of restraint in YOI and STC. I often saw officers either fail to intervene when they could have stopped a situation from developing into a confrontation or too quickly moving to use restraint in circumstances in which it was not necessary.

In a YOI, CCTV shows a group of boys standing together becoming noticeably agitated, with the body language of two becoming aggressive. There is no officer visible. The boys begin to fight, others join in and a number of officers attend. A chaotic scene follows in which officers attempt to regain control. In the melee, F manages to get another boy in a head lock and officers struggle to separate them. F falls to the ground on top of the other boy while maintaining the hold and repeatedly punching him. After a warning an officer applies mandibular angle technique and F releases the other boy. Officers place him in standard MMPR holds and guide him away. Officers followed up with a restorative intervention between F and the other boy.

In other cases, the decisions of officers contributed to restraint and then force being used. In the example below, restraint and use of pain were consequences of making a boy crawl, humiliatingly, on the floor at the feet of his peers.

C, in an STC, had been asked to clear up a mess he had made. This involves him kneeling on the floor while a group of boys and an officer are sitting on a pool table above him watching. One of them appears to make a remark. C gets up and assaults one of the boys, they fight. Staff intervene and pain is used to get him to release the other child.

I also witnessed situations where officers and staff opted to restrain a child when their behaviour was preventing the delivery of the regime. While I understand the pressure to make sure that every boy gets his entitlement, there was often a lack of flexibility or imagination as to how a developing situation could be resolved without recourse to restraint. The incident below took place in November. Had B been left alone and officers stopped paying him attention, cold, boredom and hunger would likely have brought him in.

On a dark evening, B refused to leave the exercise yard at the end of Association. After a short attempt at negotiation, officers decided to restrain him so that he could be brought inside. B locked his fingers together with an “S-grip” to prevent the officers taking control of his arms. After a short struggle, an officer used the mandibular angle technique, B released his hold and was returned to the wing.

When I watched videos of incidents, MMPR coordinators were keen to point out how the restraints were conducted within the rules, particularly the warning that is given to children before a pain-inducing technique is used. It is encouraging that the training and refresher programmes have been effective in emphasising that procedures should be followed. I also saw some evidence that poor restraint practice is picked up and acted on, including providing additional training or in some cases disciplinary investigations. There is, however, much less, if any, reflection on what led to the incident, the way that staff contributed to the situation – whether positively or negatively – nor was there consideration of what the alternatives might have been, how things were resolved, what follow-up took place and what could have been learned.

In some cases, we observed an authoritative senior officer take control of a restraint, give staff members clear instructions and help to bring the incident to a close.

T and J are at an STC and have had a falling out. They pass each other on the way to classes, T grabs hold of J by the neck. Staff intervene quickly and separate the boys. A senior officer comes over and takes the lead. T complains that his wrist is hurting from an inverted wrist hold whereupon the senior officer instructs the officer to change his hold. The boy calms and the restraint quickly ends.

In other cases, there appeared to be no one in control and no plan of action.

L is 16 years old, a slight boy serving a sentence at a YOI. His relationship with staff was not good. He told me that he had been regularly restrained during his time at the establishment and staff said that they found him to be extremely challenging, often refusing to keep to the rules or follow instructions.

L has been asked to clean his room, but he refuses to complete the task. As two officers are leaving one notices that a bottle of cleaning fluid has been left behind. One of them tries to get the bottle, but L, who is closer, picks it up. The officers try to negotiate with him, but he refuses to return the bottle. After more officers arrive, L is restrained and with difficulty, he is moved out of his room.

L continues to struggle violently against the restraint and he is moved into a prone position on the floor, where he is held for several minutes by five officers. An inverted wrist hold is applied in order to put on hand-cuffs, this causes him to shout out in pain.

Once handcuffed, L is brought to his feet, but staff appear unsure what to do next. He now seems to be calmer, but there is very little communication with him. After several more minutes it is confirmed via the radio that L could be moved to a “safe cell” in another part of the YOI. He continues to struggle on the way there and manages to wrap his leg around the leg of the officer who is holding his head. After refusing to release the leg, an officer uses the mandibular angle technique.

Seventeen minutes after the start of the incident, L arrives at the new unit and is placed in an empty cell where staff members speak to him about what has happened. Several minutes later he is walked back to his room on the original unit and released. Another officer begins to remove a calendar that is blu-tacked to L's wall. As he tries to stop this from happening, the officers take hold of him and he is restrained again.

I spoke to L after watching camera footage of this incident who said that he had been trying to disentangle his legs from the officer when the mandibular angle was applied. He went on to say that most officers were all right but that *“if there's any reason, they will restrain you.”*

As Dr Ian Maconochie, consultant in paediatric emergency medicine and independent medical advisor to HMPPS put it, “the response to any high-stress situation needs to be choreographed effectively by someone in charge. There should be a moment to take a pause and assess the intervention in the same way that things are handled in A&E.”

Recommendation 1:

That in any restraint situation, particularly where it is taking a long time, a senior officer must take control, make decisions and give instructions.

Managing behaviour

The MMPPR training manual has an extensive and well-developed section on managing behaviour in a way which should avoid physical restraint, but I saw little evidence that the methodology or principles it describes are yet fully embedded in the practice of staff across YOI and STC.

The Executive Director of the YCS and her team have ambitious plans to address this challenge with the aim of making youth custody safer through rollout of the Framework for Integrated Care (SECURE STAIRS) and Building Bridges initiatives, which have both been designed in partnership with partners including the YJB, the Secure Accommodation Network, NHS England and NHS Improvement. Both programmes will seek to support the development of positive relationships between staff, and children and young people in the secure custodial estate.

It is, however, symptomatic of the way in which behaviour is currently managed that there is much more talk in custody about physical restraint than there is about the other skills that keep children and staff members safe. One officer at an STC told me that during the refresher training, the behaviour management section had been skated over and almost the entire focus was on restraint.

Developing a staff group with the skills, knowledge and confidence to manage behaviour effectively is not easy, particularly where they are working in a challenging and high-stress environment. Children told me they were never able to relax in custody. Similarly, staff members described having to maintain constant vigilance – one talked about taking off her “prison mask” on her drive home. In such circumstances in which the emotional arousal levels of both children and staff are so high, it makes it particularly hard for anyone, adult or child, to change the way that they act.

“More experienced staff will deal with situations very differently and can take a bigger picture view with more confidence. With inexperienced staff small incidents can escalate very quickly.”
Officer YO1

The behaviour management training outlined in the MMPR handbook will never become established practice as a result of a single day’s training every six months. It is only through the unrelenting commitment from leaders to integrate the principles of therapeutic behaviour management into the practice of everyone in the establishment, that progress will be made. Without this commitment, behaviour management will remain subordinate to active physical control.

“I have a different relationship with different members of staff ... some staff want to restrain you straight away.”
Girl, 15, STC

Recommendation 2:

It should be mandatory for operational managers in the YCS and STC to complete and be refreshed in the MMPR training package on the same basis as officers.

Throughout the review I was constantly struck by the courage of individual officers and staff who put themselves at great risk in order to protect children or colleagues. Working in these establishments can be enormously fulfilling, but it can also be frightening and corrosively stressful.

After a serious incident or a difficult day, there are limited formal opportunities for staff to reflect on what happened or the effect it has on individual officers. While I have seen leaders invite staff members to come forward if they have been affected, officers usually talked about an expectation that people “just have to cope”. There are opportunities for officers to get help, but these are not embedded in the way that they should be. Without a formal, managed process in place to support staff and leaders under such stress, there is a greater likelihood that they will make poor decisions and overuse restraint. In secure hospitals nursing staff are given professional supervision, but there is no equivalent for those working in youth custody.

Recommendation 3:

That Governors and Directors and the YCS should consider how they can make sure that staff have a formal opportunity to debrief after a difficult day or a serious incident. That debriefing becomes a normal and accepted part of the job of all front-line staff.

In much of what I observed, there seemed to be little embedded understanding of why children behave as they do and what adults can do to help children to change. I saw many excellent officers doing outstanding work and who had a deep understanding of the children in their care and great sensitivity to their needs but this was often in spite of, rather than because of, the prevailing culture.

HMIP and Ofsted inspection reports of the youth secure estate over many years refer to the ineffectiveness of reward systems in custody. Children frequently told us that there was little difference between being at the highest and lowest level of the Incentives and Earned Privileges scheme (IEP) because they were locked in their cells for so long. Officers often do not use the reward system, meaning that children who behave badly are punished, but those who behave well are often ignored.

“We spend too much time in our cells...there’s no incentive to behave.”
Y, aged 17, YOI

Whenever I observed an incident, large numbers of staff became available to help, but when things are quiet there are few adults around. When children were locked behind their doors, I frequently saw staff members chatting in the office rather than take the opportunity to go and see individual children, get to know them, and build the relationships that are essential for working with children who have social, emotional and mental health difficulties.

There is not enough focus on the importance of building good, appropriate, authoritative, parent-like relationships with children. It is perhaps because of the challenging environment that staff appear to avoid spending all the time they can with children. It was surprising to come across senior officers who did not seem to know children’s names. Without the influence of good staff role models and effective training and leadership, officers in such stressful circumstances have often retreated away from interacting with the children in their care.

Recommendation 4:

That there is a sustained, committed effort from the YCS and custody leaders to train staff on the basics of good behaviour management including an effective reward system.

Recommendation 5:

Each establishment needs a strong focus on appropriate relationship building with the children in their care at every level from leaders to individual officers.

Using restraint has often become the default way to manage behaviour. Of six restraints I observed in one STC, just two were precipitated by assaults. Of the others, in two the child was sitting on a bench when officers intervened, in one a child was standing on a table and in the last a girl was messing around in the kitchen.

A number of the boys talked about how violence had become normal behaviour for them in custody.

“On the out, I would just walk away, I wouldn’t get involved, but in here you have to. You can’t let people get away with it, you have to fight back. I don’t like fighting, but in here you can’t be pushed around.”

R, 16, YOI

Or:

“I’m ok here, I don’t get pushed around, people can’t bully me, they don’t charge me rent or take my things, but you have to be always on the watch, you never know what’s going to happen.”

J, 17, YOI

This sense of threat and the need to be hyper-vigilant increases the likelihood of violence. The risk is that this pattern of behaviour takes over the institution meaning that children who are not violent must become violent to keep themselves safe. By allowing, and to some extent fitting in and feeding this culture, custodial staff end up taking up their own place at the top of this hierarchy. They too must use force to maintain their position and their behaviour helps to solidify the violent culture.

When I asked one boy about how he felt about having a pain-inducing technique used on him, his depressing response was:

“I do my thing, they do theirs.”

Boy, 16, YOI

The challenge for leaders is to create a new norm for children for whom being violent has become a habit. This means actively working to reduce violence in the institution to make it a rarity. It means creating a culture in which children feel safe enough to let down their guard, become less vigilant and to re-imagine themselves as a person who can exercise self-control and choose to turn away from threat without risking harm or the loss of face. The aim must be to create an environment in which potentially violent children feel safe enough to trust

each other, and any hierarchies are based on something more positive than physical strength, courage and a willingness to use force.

Ultimately it is possible to create a positive cycle in which the more that individuals – both children and officers – feel safe, the less likely they are to use physical force, thereby increasing everybody's feeling of safety.

With just a few months left to serve on his sentence, H had stayed in a YOI beyond his 18th birthday. This is a relatively common occurrence, but in this case officers told me that there had been concerns that H was starting to use his age and physical size to intimidate younger boys and “throw his weight around”.

At the end of Association, officers spot H hanging around outside the door to his room. They ask him to go inside, but he refuses. Three officers stand in front of him, each giving instructions. After an attempt to negotiate fails, he is restrained by several officers. They move him into the room where he is forced into a prone position on the floor. He wraps his leg around the leg of his bed so it cannot be controlled by officers.

As the restraint continues, staff become concerned about the effect of being held in the prone position on H's breathing so they apply pain through wrist flexion. H releases his leg and officers leave the cell.

Twenty minutes later, staff return in full Personal Protection Equipment (PPE) to move him to a segregation cell. They are responding after he barricaded his cell with his mattress and made threats to harm himself. The mattress was covering the observation panel in his door so staff were unable to monitor his behaviour.

They open the door to find that H has not harmed himself but is sitting on his bed with his legs wound through the metal slats. He is pulled free and carried in a supine position out of his cell and down the stairs.

I spoke to H at length in his room – he was looking forward to getting out, moving in with his girlfriend and working for his father. He remembered this incident and said that he had been frustrated after being downgraded in the establishment's incentive scheme. He said that he had been particularly angry after staff took away the photos that he had on his wall in response to his demotion, and that they had not understood how important they were to him, particularly one of his great-grandmother who had recently died. He said he knew the officers were going to come and take him to the segregation unit and this was why he blockaded his door and said he was going to self-harm (he knew that this would bring about a response). I checked with officers and he had no record of self-harming.

There was the impression with this incident that officers had set out to win and even to teach him a lesson. Although the restraint had gone on for some time, officers at no point attempted to let go. This was despite his leg being constrained by being wrapped around

the bed. They returned to relocate him to the segregation unit, just 20 minutes later when H was in a state of high emotional arousal. Once they had removed his mattress, they could see that he was not harming himself and he could have been left alone. If the relocation was necessary, which it did not appear to be, then this could have been done safely when he was calm, instead of carrying a large boy, at considerable risk to him and to officers, down a flight of stairs to the segregation unit.

In YOI there is little or no opportunity to reflect on a restraint with a child, on what happened, how it could have been avoided, and what staff could have done differently. The aim of any restraint seems to be exclusively to get the child behind his or her door. The follow up to a restraint is formulaic and relied on a series of standard questions rather than a meaningful attempt to repair the relationship.

After R had got into S's bedroom, staff spend half an hour trying to persuade R to come out. They both get under the bed. In the past, the girls had been the cause of considerable disruption. The duty governor decides that it is not safe and that R should be relocated back to her room. Five staff members arrived in full PPE and begin to pull R out from under the bed. S comes out willingly and sits on the bed. The restraint of R went on for seven to eight minutes, R was very distressed. Staff members apply the thumb flexion and wrist flexion with outward rotation to get control and to get R to her feet. She is put back in her room and the door is shut.

When I met with R she told us that she had not felt the pain and it had not made her comply.

I witnessed children in considerable distress being deposited back in their cells and left until whenever they are next unlocked.

In the best SCH this would not happen. When children are returned to their rooms, they are carefully supervised by staff and as soon as possible they sit down and talk through what happened. In Barton Moss and Adel Beck, I was told that violent children are consulted when staff are planning how to respond if there is an incident. This plays a critical part in reducing restraint and violence, and teaching children how to control violent impulses. They are asked:

- “How would you like us to respond if you are becoming verbally or physically aggressive?”
- Do you want us to leave you alone or help you back to your room?
- If we have to restrain you, what is the best way to do it that keeps you, other children and staff members safe?”

It means that when there is an incident, the staff know what to do and the children, having been consulted, have some control over the response. While I recognise that the enhanced levels of staffing in SCH do, to an extent, enable such an approach, I did not see any commitment to such detailed planning anywhere else in the secure estate.

C is part of a group of children playing football on an Astroturf pitch at an SCH. He is tackled and throws a punch at one of the other boys. Staff are quickly on the scene and move the boys apart with minimal “guiding holds”. As he is leaving the pitch C tries to attack the boy again, he punches and attempts to head butt staff. A member of team from C’s house block leads him away from the pitch and spends nearly 20 minutes talking to him in a corridor to calm him down. Other members of staff are present in the background in case C’s behaviour escalates again, but they keep their distance to avoid making him feel cornered.

The Manager of the home told me that the next day a discussion run along restorative justice principles was facilitated between C and the other boy, and that their usual practice was that a full debrief would take place a few days later when all footage related to the incident had been collated. This would involve C, his personal officer, social worker and other staff who were involved. He would also be offered the opportunity to watch the CCTV footage and comment on what had happened.

At Barton Moss there was a large sign in the staff area, “Every interaction matters”, and this message was reflected in the way in which the staff related to the children in their care.

Recommendation 6:

Staff should include children when they are making handling plans; incidents should be reviewed with the child and plans amended where necessary.

The governance of restraint

Although extensive arrangements are in place to make sure that detailed information about any incidents involving children where staff have used force or any MMPR technique (including pain-inducing techniques) is captured, it is unclear how this informs development of a strategic approach to address the current high levels of restraint in custody. There are a number of stages that staff members are expected to follow:

- After any incident, all members of staff who were involved are required to complete a form to notify their local MMPR Coordinator. The form includes prompts to make sure that they record the details of the incident, the child (or children) and staff members who were involved and the techniques which were used.
- After receiving notification about the incident, the MMPR Coordinator will gather footage from CCTV and body-worn cameras, and written statements from members of staff who were present.
- Immediately after conclusion of the incident an assessment should be undertaken by a member of staff from the healthcare team. If they identify that the child is experiencing

delayed symptoms or injury as a result of the restraint they should make a report to the local MMPR Coordinator, and the National MMPR Team should be notified.

- After any restraint the child should be given an opportunity for a debrief discussion about the incident. He or she can ask for an Independent Advocate to be present and the outcome should be shared via local safeguarding arrangements and with the child's Youth Offending Team caseworker.
- Any member of staff has a route for raising concerns via internal safeguarding arrangements or to the local social work team, which may result in a referral being made to the local LADO or child protection measures being initiated.
- Where a serious injury or warning sign (SIWS) was observed during or after the incident, staff are required to complete a second section of the form. Once completed this is also submitted to the local MMPR Coordinator, and the local social work team. The report will then be emailed to the National MMPR Team. Establishments will receive feedback on these SIWS incidents with a rolling programme of monthly review meetings where footage and documentation for the restraint is reviewed by a paediatrician, the National MMPR Team and staff from the establishment (usually the local MMPR Coordinator and member of the safeguarding team). Feedback and any actions on each review is shared with the establishment after the meeting.

Oversight of this system is undertaken locally and at national levels, however it is unclear how these mechanisms link up. Officers spend huge amounts of time completing paperwork, but it is not clear how explicitly this data is used locally or nationally to assess performance and clearly drive forward improvements in practice.

Reports and statistics about use of force and restraint incidents are considered within each establishment by local Review of Restraint and Safeguarding meetings and are passed to HMPPS for collation in the MMPR Toolkit and publication in MoJ national statistics on a quarterly and annual basis.

Local Safeguarding Boards are responsible for undertaking an annual review of restraint at each YOI and STC, which is shared with the Governor or Director. The purpose of these reviews is to look back at the previous years' recommendations and identify strengths and areas for improvement and make recommendations for the coming year. Local Authority Designated Officers (LADO) receive referrals from YOI, STC and SCH in their area if there are any safeguarding concerns, however there is not consistency in the way that these are responded to and dealt with as local authorities have different levels of capacity to intervene effectively.

“Restraint minimisation meetings enable us to highlight knowledge of the child's background, such as previous trauma, and to challenge the prison about the length of restraint...however, staff are usually quite defensive.”

Social worker, STC

An annual report on incidents which have triggered the Serious Injuries and Warning Signs process is written by the National MMRP Team. It is shared with HMPPS directors.

Reports about individual incidents are included in a daily report which is shared with HMPPS directors and MoJ ministers, however the threshold for including an incident in this report is high and most incidents of restraint in youth custody are unlikely to be included unless they are particularly serious. For example, ministers would not be routinely informed if a pain-inducing technique had been used.

The governance of restraint is not sufficiently joined-up between YOI, STC, LADOs, the National MMRP Team and the YCS meaning that the aftermath, reporting and investigation of restraints is not consistent.

The use of pain in the youth secure estate

This review has confirmed the concerns held by many about the capacity and capability of the youth secure estate to be able to manage, care for and educate the children in its care. There is an unacceptable level of violence in YOI and STC meaning that both staff and children are under a high degree of stress. This feeds the cycle in which children, who may already have a tendency towards violence, become more violent leading to greater levels of stress and hyper-vigilance that create the wrong environment for children to change and flourish.

Many of the children have led traumatic lives and have been subjected to abuse – around 39% have been in the care system and a high percentage have themselves been victims of crime. This is compounded by putting them in, what can be, a frightening and dangerous environment in which they can find themselves assaulted by their peers and physically restrained. This is made worse when adults deliberately inflict pain in circumstances in which it cannot be justified.

The inexperience of prison staff and leadership of variable quality means that there is an over-reliance on restraint to maintain a semblance of order. The certainties of restraint and the short-term sense of control takes precedence over the use of more complex, relational, therapeutic and behaviour management techniques and skills that require constant reinforcement, strong leadership and professional judgement.

During the review, I frequently witnessed the use of pain-inducing techniques in situations in which, by any reasonable measure, though unpleasant, there was no risk of “serious harm” to the members of staff or children who were involved, such as children refusing to give up their hands to be handcuffed or pulling an officer’s hair.

Urgent action must be taken to address the situation in YOI and STC to begin to reduce the amount of violence, time spent locked in cells and lack of access to meaningful activity.

A strong case has been made by a number of organisations and people with whom I consulted for removing the right to use pain on children in any circumstances. This would send a clear message that deliberate harm inflicted by adults on children is never acceptable. Banning the use of pain-inducing techniques would prevent its use in all the many cases that I witnessed in which there was no risk of “serious harm”.

However, if the use of pain was banned, officers who found themselves confronted by a situation in which a child or colleague was at immediate risk of serious injury would have to respond by relying on a common law defence that the force was “reasonable and proportionate”.

When it comes to working with children, particularly those who are damaged and potentially violent, it is imperative that staff are well-trained for every part of their job. They should learn to use behaviour management techniques, understand the effects of trauma and abuse and be taught the importance of appropriate adult to child relationships so that they respond in a way that helps children to move on from their offending and become successful adults. Well-trained staff in establishments with leaders that reinforce these techniques and the values that sit behind them are the most powerful tool that the YCS has in reducing violence and the need for physical restraint.

There will however, continue to be situations in which restraint will be required. I saw examples where staff in STC and YOI intervened with a pain-inducing technique to ensure that a child released a weapon or a choke or strangle hold on another person to prevent serious physical harm. Staff must be trained to know when it is right to intervene and to use the techniques appropriately, proportionately and safely. They must understand that, where restraint is required, they should always aim to use the minimal amount of force necessary and they should reduce the level of the hold or let go entirely as quickly as possible. They must know what is most effective with individual children considering age, physical development and other needs. They must also know the physical and mental effects of poorly used restraint.

The work done by the West London NHS Trust Violence Reduction Training Team at Broadmoor High Security Hospital shows that with relentless focus from leadership, improved staff training, rigorous review and refinement of practice the need for physical intervention can be dramatically reduced even in the most difficult circumstances. This leads to a positive cycle in which people feel safer and less anxious, meaning they become less likely to act violently, are better able to access programmes of support and can begin to become rehabilitated.

The hospital trains staff to assess using the Hierarchy of Response Triangle below, where the aim is to be always seeking to intervene at the lowest possible level and to reduce the intensity of holds as soon as the situation allows. The black area at the top of the triangle represents an emergency where staff will need to intervene to save life or prevent serious harm.

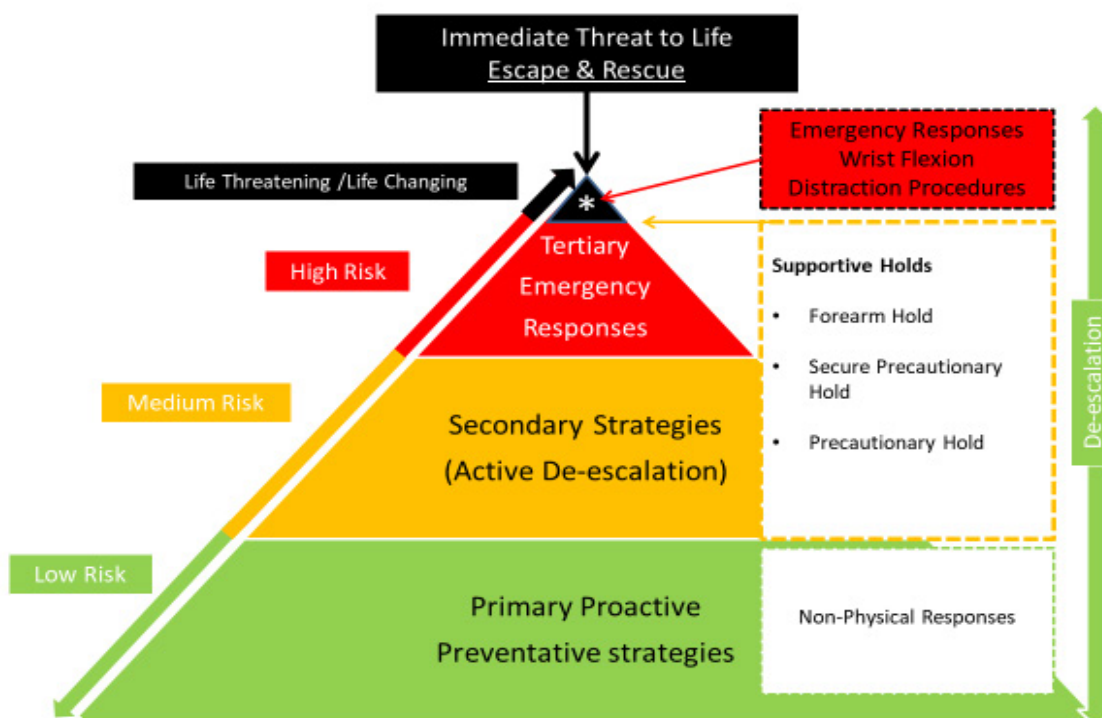
Currently the use of a pain-inducing technique sits at the top end of a hierarchy of responses to children’s behaviour within the MMPR syllabus. There is a linear progression through the

behaviour management techniques, guiding holds, restrictive restraint and finally to the use of pain. I believe that this places the use of pain-inducing techniques on a spectrum that makes it an acceptable and normal response rather than what it should be, the absolute exception. The introduction of MMPR has led to a welcome reduction in the use of pain-inducing techniques to less than 4% of all restraint techniques used in YOI and STC. It is, however, my view that it is their inclusion in the MMPR syllabus at all that has contributed to the overuse of these techniques that I so frequently witnessed during this review. It cannot be right to include the use of pain-inducing techniques in a syllabus that is designed to minimise and manage physical restraint. Its inclusion blurs what should be a sharp line between restraint and the use of direct physical force in an emergency.

There should be nothing normal or routine about the use of force. When it is used it breaks down trust, damages further already-damaged children and changes the relationship between staff members and the children in their care.

Recommendation 7:

The MMPR training programme should be amended to remove the use of pain-inducing techniques from its syllabus.



High-risk situations

The removal of pain-inducing techniques from the MMPR syllabus and improved behaviour management and relationships will lead to a safer youth custodial estate, but given the nature of some of the children in custody, even in the most humane, well-run setting there will be occasions when direct, immediate physical force is required.

Where children with a tendency towards violence are held, assaults with a deadly weapon, fights in which one party is much stronger than the other, strangulation, biting and eye-gouging are possible. It is naïve to think that in some cases these situations can be resolved without recourse to the use of physical force and this, in reality, means the application of pain. If a strong, post-pubescent child with an adult physique has another child in a strangulating headlock, it is impossible, without recourse to a painful intervention, to resolve it quickly enough to prevent life-changing injury or death.

J, a sixteen-year-old, is playing basketball on the indoor court at an STC with three other boys and two staff members. Unexpectedly, there is an altercation with another boy, M, who is well-built and over six foot tall. The two boys start throwing punches at one another; staff members intervene as fast as they can, but M has managed to get J into a headlock and is squeezing on his windpipe. Two members of staff try to pull on M's arm to release J, but they are unable to get him to let go. A member of staff uses the mandibular angle technique on M and the pain causes him to release J. Staff are able to gain control.

When I asked M how he felt about staff using a pain-inducing technique, he said,

“Fair play to them, his face was turning blue and I wasn't going to let go of him.”

In this situation, and in a small number of other incidents I watched, had staff not used a pain-inducing technique, a child could have been killed or suffered very serious injury.

If front-line staff do not have techniques for use when there is a genuine risk of serious harm, to themselves or to children, then they will have to decide how to act in a fraction of a second. If they are not trained to intervene, it would mean that at the most dangerous moments, when lives are at risk and where potentially their job is on the line, they would need to improvise their response.

I believe that in situations, such as with M above, the risk of untrained staff members either doing nothing, acting ineffectually or using unreasonable or disproportionate force would place children at greater risk.

We rightly expect staff to be as well-trained as possible and it would be unfair on them and the children in their care if they were given training to cope in every situation except those in which lives are at risk. This position was also recognised by the JCHR, which included the following

line in their recommendation on pain-inducing techniques in their recent report: “We also recognise the right of prison officers to act in self-defence.”⁵

The likelihood of these circumstances in YOI or STC is high enough to justify training staff members in self-defence, break away techniques and the use of a pain-inducing technique for use in emergency to prevent serious harm or death as in the black zone in the pyramid at Broadmoor.

Recommendation 8:

The YCS, Governors or Directors should ensure that staff are trained in personal protection and breakaway techniques for use when there is a risk of serious harm to themselves or others. This should include the response to exceptional circumstances where there may be no other recourse but to use a technique that can cause pain.

This training should not be part of the MMPR syllabus and there should be a focus on establishing a “presumption of rebuttal” which means that staff members will be expected to provide a strong justification for why they have used pain and the Governor or Director will be accountable at the Independent Restraint Scrutiny Board (see Recommendation 11).

In order that the routine use of pain-inducing techniques on children is ended, there must be clear grounds for when staff can intervene. It must never be normal or routine, and only used in exceptional circumstances.

Recommendation 9:

That staff in YOI and STC may use a pain-inducing technique to prevent serious physical harm to child or adult. This might be for the:

- immediate release of a weapon
- immediate release of a choke / strangle hold
- immediate rescue of another where non-pain compliance techniques are inadequate
- to stop an act self-harm that is likely to cause serious injury

If it is not an emergency, then the use of pain is probably not justified.

It would be highly unlikely that the use of pain would be justified in the following situations that I observed during the review:

- failing to give up hands for handcuffs to be fitted or refusing to submit to a restraint

⁵ <https://publications.parliament.uk/pa/jt201719/jtselect/jtright/994/994.pdf>

- not complying when being moved
- non-dangerous though unpleasant hurting of a staff member – such as pulling hair or wrapping legs round body or legs
- when there is a weapon, but the risk of its use is minimal or neutralised
- when children are fighting, but not putting themselves at risk of serious harm

The use of pain-inducing techniques to end a long restraint

The longer a restraint goes on for, the more likely a child is to become seriously injured or to die. This is particularly risky where a child has an underlying health complaint such as asthma, but even in apparently healthy people long restraints have led to serious injury or death. Officers and trainers are rightly concerned where restraint goes on for long periods of time.

In a long restraint, the first option must be to consider simply letting go of the child. In the CCTV I watched in SCH, I was often impressed by the way in which staff tried to keep restraint to a minimum and were prepared to let go and end the restraint, even where the child was not entirely compliant. In the YOI and STC, restraints often only end when the child is deposited back in his or her cell, partly due to the culture that seems to suggest that officers need to be seen to have won when a child is being violent or non-compliant. Where restraint was protracted and where there was a warning sign, such as a child complaining about his or her breathing, officers would check and change their holds, sometimes attempting to help the child to stand up in what was deemed to be a safer position.

The use of pain on children to end a long restraint almost always appeared to be unsuccessful and officers ended up having to use other methods to get the restraint to stop. Children I spoke to during the review also suggested that the use of pain had not been effective because the restraint was already causing pain and because their levels of adrenaline were so high that they did not notice. One boy did not realise that the mandibular angle had been used on him, another had the mandibular angle used twice with no effect, while a girl said that wrist flexion had not hurt both times it was used.

It is also unlikely that the use of pain on children with Autistic Spectrum Disorder (of whom there is a sizeable minority in custody) will be effective as a way of ending a protracted restraint.

Recommendation 10:

That pain is not permitted to be used to end long restraints – staff must always try letting go or changing the hold if a restraint is going on too long. However, the same emergency criteria could apply in exceptional circumstances as in Recommendation 8.

Improving the governance of the use of restraint

HMPPS Operational Response and Resilience Unit (ORRU) in conjunction with The National MMRP Team organises a monthly SIWS review meeting in which a senior emergency paediatrician, members of the National MMRP Team, local MMRP co-ordinators from the establishment being reviewed and a Manager from the Safeguarding department look at videos of incidents in which a child has displayed a serious injury or warning symptom or sign.

The MMRP syllabus uses the following headings to define SIWS incidents: *“Breathing Difficulties, Complaints of Difficulty Breathing, Serious Physical Injury, Vomiting/ Sickness, Petechial Rash (Tiny pin point red dots, on the neck, chest eyelids), Blueness to lips/ fingers, Cyanosis, Abruptly/ unexpectedly stopped struggling, Complaints of feeling sick, Loss or reduced consciousness and Other.”*

At the SIWS review meetings there is robust, independent challenge of practice and this work has been important in reducing the number of serious injuries that have been suffered by children. Attendees also look at the antecedents of a restraint and consider what staff might have done. Learning is also taken from this meeting by the National MMRP Team to consider ways of improving and amending training/ interventions in order that children are kept safe – for example, guidance on head holds has been recently changed to make sure that the child’s breathing is not affected.

The Head of MMRP produces an annual report on SIWS incidents that is shared with HMPPS directors within YCS and ORRU. Although there is quality-assurance work completed by the National MMRP Team and information about restraints is considered during Ofsted, HMIP or CQC inspections, there is no independent scrutiny of incidents where pain-inducing techniques are used. It is my firm belief that a lack of accountable governance over the use of pain-inducing techniques has led to pain frequently being used unnecessarily. Regular independent scrutiny and robust governance will mean that appropriate action is taken to improve behaviour and to reduce violence and restraint.

Recommendation 11:

An Independent Restraint and Behaviour Panel (IRBP) should be established.

This panel should meet monthly and consider practice at one YOI or STC. It should review incidents in which serious injuries or warning signs have been identified, or where a pain-inducing technique has been deployed.

It is essential that this panel contains people who are both independent and who have expertise in this field. (As a minimum) it should include the following: a member of the MMRP national

team, a paediatrician, the Governor (or Director) and the MMPR lead of the establishment being considered, a representative of the YJB, the Local Authority LADO, a serving or former head teacher with expertise in behaviour, an expert in restraint and a representative of HMIP.

The IRBP should not look simply at the mechanics of restraint but should have free range to make observations about behaviour management, staff behaviour and leadership.

This panel should produce a report after each meeting that includes data on restraint, SIWS and any use of pain-inducing techniques. The report should reference the concerns of its members on the use of restraint, behaviour management and leadership. It should be sent directly to ministers, senior staff in the YCS and the prison service, Ofsted and HMIP. An annual summary of the work of this panel should be produced and made public.

Meetings should ideally take place at local authority offices away from the custodial establishment. It should visit each YOI and STC once a year with the opportunity for follow up visits where there are concerns. The independent scrutiny provided by this panel will hold governors and directors, the YCS and the government to account for improving behaviour and practice, reduce restraint and make sure that any use of pain is genuinely justified.

The inverted wrist hold

The inverted wrist hold is often used in YOI and STC to restrain children. It involves holding the first finger and the thumb with the elbow bent and then pressing downwards to apply pressure to the top of the wrist. If the pressure is increased it becomes the inverted wrist flexion – a pain-inducing technique, that causes sharp pain on the back of the hand and wrist. One witness to the review described the inverted wrist hold as being like a throttle that can be pressed to increase the amount of pain.

The inverted wrist hold was used nearly 3,700 times in 2017/18, which represented approximately 25% of all occasions where MMPR techniques were deployed. While this is not a designated pain-inducing technique, many people I have spoken to during the review, including many children, have cited the inverted wrist hold as a common cause of pain. A recent paper by Barnett et al (2018)⁶ (Richard Barnett, one of the authors, is a member of the Medical Panel), shows that the average difference between gaining a hold using the inverted wrist and inducing pain involves increasing the angle of flexion by just 8%. It is virtually impossible to use this restraint without at times causing pain, particularly when the child has pre-existing injury, is struggling and when officers are emotionally aroused. There is also the possibility that this technique enables pain to be inflicted with malicious intent without detection. In the videos I watched, children often complained that their wrist was hurting when this hold was applied and some of the children we interviewed said the inverted wrist hold had caused them injuries and pain.

6 http://eprints.keele.ac.uk/5470/1/20181101_barnett_CCBY.pdf

“There’s lots of restraint here, usually because we refuse to bang up on time. Sometimes my wrist goes numb because they hold it so long.”

R, aged 16, YOI

Though I have seen officers adjust their hold when the child has complained of pain, this does not always stop the child from continuing to be hurt. I have also heard officers say that the child will only feel pain if he or she struggles, as if responsibility for the pain rests with the child. This is not an acceptable excuse as if the child was not struggling then there would be no need for the restraint in the first place. The inverted wrist hold has become a pain-inducing technique in all but name, but without the levels of governance and scrutiny that are applied to officially sanctioned techniques. There is considerable variation in the amount that this hold is used in different establishments and the YCS or the central MMPR team does not appear to have considered why this might be so. A hold that should only be used to gain control with strong, post-pubescent children appears to have become a default way of restraining children across YOI and STC.

Recommendation 12:

The inverted wrist should only be used to gain control of strong and / or fully-grown children when there is no alternative and there is a risk of serious harm. Staff must move to a lower level hold as soon as possible.

The YCS and ORRU will need to consult experts on a safe and effective alternative that poses less risk to children.

Where the inverted wrist hold has been used there should be the same scrutiny required as other pain-inducing techniques. The IRBP should consider the use of the inverted wrist hold in its scrutiny of individual establishments.

Healthcare and nurses

In CCTV footage of restraint, a member of healthcare staff can often be seen hovering in the background and not actively assessing or assisting the child. When the restraint has ended, the nurse attempts to see the child and check if he or she is ok. Often though, the child is in such a state he or she refuses to be seen. The nurse will then attempt to come back later to check for injuries.

A has climbed onto a table and is claiming that she had hidden a piece of sharpened plastic in her bra and is threatening to hurt staff. The deputy governor decides that a full relocation and search is required. Officers hold a briefing before the incident, put on PPE gear and then go to take the girl back to her cell. She resists forcibly and she ends up being taken to the ground where handcuffs are applied. On more than 10 occasions she says she could not breathe,

but staff members continue to hold her and the nurse who was present did not intervene. Even when A has handcuffs applied and cannot present any meaningful risk to officers, the restraint continues. A was put in her cell and after the handcuffs were removed, wrist flexion was used twice to get her to comply. Officers fail to conduct the search so, as far as they know, A still had the weapon meaning the restraint has failed in its objective. The debrief afterwards is also filmed and a senior officer appears to recap to the other officers what has happened.

During the review, I never saw the nurse play a proactive role in a restraint. It seems, partly perhaps because of their place in the prison hierarchy, that the nurses do not have the confidence to intervene and direct officers to change holds or let go of the child if there is a danger of injury or worse.

Recommendation 13:

The role of the nurse must be explicit during restraint. There must be an expectation that, if there are any concerns about the way a restraint is being conducted, the nurse should be expected to intervene. Healthcare is an important part of the safeguarding process and workers should be in the forefront, observing any restraint and intervening where necessary. The importance of healthcare staff and their role must be explicit in MMPR training.

The use of pain by escort services

The original court case that led to this review was generated by a concern that staff taking children to SCH were trained in MMPR and therefore able to use a pain-inducing technique, despite this not being permitted in the children's home. This review has not found a single incident in the recent past in which a pain-inducing technique has been used on a child, though restraint is used on some occasions.

Children in the modified taxis used to escort children to STC and SCH are in the back of an externally locked compartment with two, or occasionally three, escort officers. The child is not handcuffed or physically constrained and, though this is a humane way of transporting children, it is possible that if the child becomes violent or aggressive the escort officers may have to use restraint in a risky, enclosed environment without the option of being able to get help quickly. This is a different situation from anywhere else in the secure estate where staff can trigger their alarms and get a prompt response from colleagues. The good practice that I witnessed by escort officers is in part, I suspect, driven by the fact that escorts operate without direct support and therefore need to use de-escalation and calming techniques before they consider the risks entailed in restraining a child in an enclosed space.

Recommendation 14:

Escorts to STC and SCH should be trained in an MMPR syllabus that no longer allows for the use of pain. Like staff in YOI and STC they may receive additional training in self-defence and an emergency response that can include the use of pain in the same exceptional circumstances that apply to YOI and STC staff. Staff who drive the cellular vehicles between YOI and court should be trained in MMPR. Escort staff should not be allowed to use restraint to maintain “good order and discipline”.

Use of body-worn cameras

MMPR coordinators reported that there had been an improvement in the wearing and turning on of body-worn cameras, but that this was not consistent enough. There are some circumstances in which things escalate too quickly for officers to turn on their body-worn cameras, but in most incidents there is at least some build up during which cameras can be turned on. I witnessed too many restraints in which there was no body-worn camera footage.

Recommendation 15:

All operational staff in STC and YOI should be equipped with body-worn cameras. Staff should be obliged to turn them on when an incident is developing.

Conclusion

Overall there is a substantial gap between the high-end needs of many of the children in YOI and STC and the ability of staff and leaders in the secure estate to meet them. It is this deficit that is the cause of so many of the challenges, especially the way in which children are handled and supported. This has led to completely unacceptable levels of violence in STC and YOI and the frequent use of inappropriate restraint on children that cannot be justified in any framework.

It is not possible to quantify the effect that subjection to these levels of violence and physical restraint will have on children, particularly those who have previously suffered from victimhood and trauma. However, there is no doubt that the children's experience in YOI and STC is likely to have serious, long-term consequences for many of them, and for the people around them.

I have concluded that, given the nature of the risk, it is right that staff in YOI and STC continue to have the option of using a pain-inducing technique, but not as part of the MMPR framework. Cases like the one in which M is strangling J convinced me that without this option, children and officers would be at greater risk. Common law allows for the use of force if it can be shown to be reasonable and proportionate. Training staff to understand when it is reasonable and what actions are proportionate will help them to keep children and staff safe.

It is only through a substantial change in culture that we can have a youth custody system that keeps children safe and gives them the support that they need in order that in the future there are fewer victims of crime and safer communities. The recommendations in this review will help to begin this transformation by reducing violence, restraint and the use of pain.

Acknowledgements

I would like to thank everybody who has given evidence to this to this review, including children, officers, governors and leaders in the youth secure estate, Dr Ian Maconochie, David Perry, Alan Davison, Richard Barnett, Hazel Williamson, Dr Tony Bleetman, Bernard Allen, Eric Baskind, Lord Ramsbotham, Lord Carlile, Lord McNally, Pippa Goodfellow and members of the Standing Committee for Youth Justice, Peter Dawson and John Drew, the Youth Justice Board, Dame Sue Bailey, Emma Lewell Buck MP and my team at the Ministry of Justice - Salma Afzal and in particular Robert Lawman.

ANNEX A

Extract from: MMPR Volume 5 v1.0, page 44–45:

2: Application of pain – considerations, guidelines and recording

The application of a pain-inducing technique should never be used where a non-painful alternative can safely achieve the same objective. However, the use of a pain-inducing technique may be justifiable if that is the only viable and practical way of dealing with a violent incident which poses an **immediate risk of serious physical harm** to the young person, other young persons or staff.

The application of a pain-inducing technique may initially be successful in preventing serious physical harm from occurring. However, it must be recognised that the risk of harm to the young person or others may fluctuate throughout a restraint incident and it may therefore be necessary to re-apply a pain-inducing technique. If this is the case, the number of occasions where pain is intentionally induced must be monitored by the Use of Force Supervisor and kept to an absolute minimum.

Pain-inducing techniques may not always be successful in preventing serious physical harm from occurring. If this is the case, the member of staff must assess whether the technique is being applied correctly and re-apply **only** if necessary. If it is evident that the chosen technique is not successful staff must **cease the application immediately** and consider an alternative course of action.

Staff must be able to justify their reasons for using a pain-inducing technique as part of their decision-making process and be able to set these out in the subsequent ‘use of force’ report.

They must have considered the following prior to the application of pain.

Considerations –

Was there –

- An **immediate risk of serious physical harm** to the young person
- An **immediate risk of serious physical harm** to others or staff members

Two questions a member of staff should always ask himself or herself before using any physical intervention on a young person are:

- **Have I exhausted all reasonable options?**

- **Am I acting in the best interests of either the young person or others?**

Dr Daniel K. Sokol

Honorary Senior Lecturer in Medical Ethics, Imperial College London Editor, Postgraduate Medical Journal

Guidelines –

Whenever possible staff should follow the guidelines listed below prior to applying any form of pain induction.

Refer to responsibilities 1c.

- Prior to application use verbal reasoning – appropriate deceleration dialogue.
- Give the young person a clear simple verbal instruction of what is required – ensure they understand.
- If they continue to refuse, give a clear statement that they are leaving you with few options i.e. one of those is that they may feel pain in specified area.
- Give a further clear, simple verbal instruction of what is required.
- Apply technique and continue to give verbal instructions in a controlled tone (the application of pain with instruction is more likely to result in the young person following the instruction) – the pitch and tone is crucial – assertive not aggressive.

Whenever possible staff should follow the guidelines listed above prior to re-applying any form of pain induction.

NB: It is accepted that in certain situations these guidelines will not be possible due to the immediate risk to staff, the young person or others. In these situations, staff will give clear instructions whenever possible during the application of pain-inducing techniques.

Recording –

Each application must be recorded within the ‘use of force’ or caps? reporting system.

As with any use of force, the application of pain-inducing techniques / procedure within a restraint incident must be –

- Reasonable in the circumstances
- Necessary

- No more than necessary

Additional instructor activity:

- Ensure all learners are made aware of the law, considerations, guidelines and recording.
- Question learners at every opportunity on the law, considerations, guidelines and recording.

It would be impractical for the manual to give detailed accounts of when and where the techniques within this unit should be applied as there are numerous scenarios that could lead to their application. This should be discussed with the students and views sought.

