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Independent Advisory Panel on Deaths in Custody

Report of the Cross-Sector Restraint Workshop held in May 2010

Acknowledgements

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Introduction by Lord Toby Harris, Chair of the Independent Advisory Panel (IAP)

The government has a special duty of care towards an individual in state custody, which is enshrined in Article 2 of the Human Rights Act 1998. When a death in custody or following contact with custodial agents occurs, it can have a significant emotional impact not only upon the family and friends of the individual concerned, but also upon staff. Where these deaths have involved the use of restraint they can be among the most contentious because they have occurred as a direct result of the actions of a state agent. In the past 11 years, we have seen that the deaths of David 'Rocky' Bennett, Roger Sylvester and Gareth Myatt have all attracted high levels of public concern regarding the use of restraint and the subsequent independent inquiries have led to numerous recommendations for government departments and agencies in order to try and prevent similar deaths in the future.

The reports into the deaths of David Bennett[1] and Roger Sylvester[2] also reflected public concerns on the use of restraint involving individuals from Black and Minority Ethnic (BME) groups and patients detained under the Mental Health Act (MHA). These concerns were also echoed by the Joint Parliamentary Committee on Human Rights' report into 'Deaths in Custody' in 2004[3]. To gain a greater understanding of these issues, the IAP is currently conducting a review of Rule 43 Recommendations, narrative verdicts and investigative reports where restraint was identified as either a direct cause or a contributory factor in the death in order to highlight any trends in relation to ethnicity and mental health. It is crucial that in order to try and prevent future deaths, learning is identified from these tragic cases so that lessons can be disseminated across the custodial sectors to help inform safer approaches to the use of restraint.

In March 2010, the IAP working group on the use of physical restraint, led by Professor Richard Shepherd, presented a number of recommendations to the Ministerial Board on Deaths in Custody, which were supported by Board members. One of the recommendations was to hold a workshop, which brought together representatives from across the custodial estate to explore the use of physical restraint. In order to ensure that a sufficient focus was given to the complex medical and legal issues surrounding the use of restraint, a number of medical and legal practitioners were also invited to attend. There were 34 attendees at the workshop and whilst the IAP recognises that the numbers on the day were relatively small, it

[1] Norfolk, Suffolk and Cambridgeshire Strategic Health Authority (2003) *Independent Inquiry into the Death of David Bennett*
[2] Metropolitan Police Service (2004) *Restraint and Mental Health Report*
[3] Joint Committee on Human Rights (2004) *Deaths in Custody: Third Report of Session 2004/05*

represented an important first step in bringing together policy makers, operational staff and practitioners to discuss the salient issue of restraint. The aim of the workshop was to:

1. Identify common themes and approaches to restraint and to share instances of good practice, which had relevance for the other custodial sectors;
2. Identify learning from each of the custody sectors concerning restraint deaths for dissemination across all the custodial sectors and;
3. Discuss the viability of establishing a high level cross sector group on restraint in order to formalise and encourage inter-agency co-operation and to add coherence to the issue of safer restraint in custody by disseminating learning and good practice quickly and more effectively.

This report provides an overview of each custodial sector's policies and guidance around the use of physical restraint. It also provides a summary of the key discussions from the day, which followed three general themes: training and restraint techniques; the collation and analysis of statistics on the use of restraint and sharing the learning from restraint related deaths. The report also contains a series of recommendations, which the IAP hope will contribute to the prevention of restraint related deaths in the future. These recommendations will not operate in a vacuum. It is expected that they will, along with parallel work being led by Professor Shepherd, feed into the development of a series of common principles, which it is hoped the custodial sectors will adhere to as a minimum. These will cover factors such as the content, delivery and accreditation of training, the collection, collation and analysis of statistics on the use of restraint, the identification of vulnerable groups who may be particularly at risk including those with a medical condition, psychiatric disorder or drug/alcohol consumption and recovery procedures following the use of restraint including the involvement of healthcare staff. The aim of these common principles will be to bring about an improvement in operational practices across the custodial sectors in order to reduce the number of restraint related deaths in the future.

I would like to personally thank all of those who contributed to this valuable debate.

Section 1: Statistics on the Number of Restraint Related Deaths within State Custody

The table below provides an overview of the number of deaths that occurred between 1st January 1999 and 31st December 2009 where restraint was identified as a cause of death at the coroner's inquest. The statistics are broken down by custodial sector per calendar year.

The number of deaths of individuals in state custody where restraint was a direct feature of the death between 1st January 1999 - 31st December 2009

Custodial sector	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Prisons	0	0	0	0	0	0	1	0	0	0	0
Age breakdown	-	-	-	-	-	-	-	-	-	-	-
11-20	-	-	-	-	-	-	-	-	-	-	-
21-30	-	-	-	-	-	-	1	-	-	-	-
31-40	-	-	-	-	-	-	-	-	-	-	-
41-50	-	-	-	-	-	-	-	-	-	-	-
51-60	-	-	-	-	-	-	-	-	-	-	-
61-70	-	-	-	-	-	-	-	-	-	-	-
71-80	-	-	-	-	-	-	-	-	-	-	-
Total	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**
Secure Young People's Estate*	0	0	0	0	0	1	0	0	0	0	0
Age breakdown	-	-	-	-	-	-	-	-	-	-	-
11-20	-	-	-	-	-	1	-	-	-	-	-
21-30	-	-	-	-	-	-	-	-	-	-	-
31-40	-	-	-	-	-	-	-	-	-	-	-
41-50	-	-	-	-	-	-	-	-	-	-	-
51-60	-	-	-	-	-	-	-	-	-	-	-
61-70	-	-	-	-	-	-	-	-	-	-	-
71-80	-	-	-	-	-	-	-	-	-	-	-
Total	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**
Immigration Removal Centres	0	0	0	0	0	0	0	0	0	0	0
Age breakdown	-	-	-	-	-	-	-	-	-	-	-
11-20	-	-	-	-	-	-	-	-	-	-	-
21-30	-	-	-	-	-	-	-	-	-	-	-
31-40	-	-	-	-	-	-	-	-	-	-	-
41-50	-	-	-	-	-	-	-	-	-	-	-
51-60	-	-	-	-	-	-	-	-	-	-	-
61-70	-	-	-	-	-	-	-	-	-	-	-
71-80	-	-	-	-	-	-	-	-	-	-	-
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Police	2	1	1	1	4	1	1	3	0	1	0
Age breakdown	-	-	-	N/A	-	-	-	-	-	-	-
11-20	-	-	-	-	-	-	-	-	-	-	-
21-30	1	-	-	-	-	-	-	-	-	-	-
31-40	-	-	1	-	2	1	-	1	-	1	-
41-50	1	-	-	-	-	-	1	1	-	-	-
51-60	-	1	-	-	-	-	-	1	-	-	-
61-70	-	-	-	-	1	-	-	-	-	-	-
71-80	-	-	-	-	1	-	-	-	-	-	-
Total	**2**	**1**	**1**	**1**	**4**	**1**	**1**	**3**	**0**	**1**	**0**
In-Patient Mental Health Setting	0	0	0	1	1	2	0	1	0	0	0
Age breakdown	-	-	-	-	-	-	-	-	-	-	-
11-20	-	-	-	-	-	-	-	-	-	-	-
21-30	-	-	-	-	1	1	-	-	-	-	-
31-40	-	-	-	1	-	1	-	1	-	-	-
41-50	-	-	-	-	-	-	-	-	-	-	-
51-60	-	-	-	-	-	-	-	-	-	-	-
61-70	-	-	-	-	-	-	-	-	-	-	-
71-80	-	-	-	-	-	-	-	-	-	-	-
Total	**0**	**0**	**0**	**1**	**1**	**2**	**0**	**1**	**0**	**0**	**0**
Total restraint related deaths in state custody in England and Wales	**2**	**1**	**1**	**2**	**5**	**4**	**2**	**4**	**0**	**1**	**0**
Total deaths in state custody for England and Wales	**648**	**607**	**562**	**512**	**566**	**582**	**561**	**554**	**550**	**526**	**483****

Notes:

* Young people are accomodated in a number of different establishments, depending on their needs. Secure Children's Homes (SCH) are generally used to accommodate young offenders aged 10 to 14, girls up to the age of 16, and 15 to 16-year-old boys who are assessed with high risk factors. Secure Training Centres (STCs) are purpose-built centres for young offenders up to the age of 17. They are run by private operators under contracts, which set out detailed operational requirements. Young offender institutions (YOIs) are facilities run by both the Prison Service and the private sector and can accommodate 15 to 21-year-olds, although the estate is split between establishments that take ages 15-17 and those that take 18-21 year olds.

** As of 1st April 2009, the Mental Health Act Commission's functions were split between the Care Quality Commission for England, and Health Inspectorate Wales. From 1st April 2009, the figures for 2009 only include the deaths of patients detained under the Mental Health Act reported to the Care Quality Commission.

Data sources:

Prisons: National Offender Management Service
Police: Independent Police Complaints Commission
Immigration Removal Centres: UK Border Agency
Secure Young People's Estate: Youth Justice Board
In-Patient Mental Health Setting: Care Quality Commission

Between the 1st January 1999 and the 31st December 2009, there were 6,151 deaths in state custody, of which 22 were as a direct result of restraint. In order to put these figures into context, it is worth highlighting the number of times restraint was used in custodial settings. Using data from the NOMS, between April 2008 and December 2008, there were 14,745 uses of force[4] within prisons[5]. Within the secure youth estate, data provided by the Youth Justice Board (YJB) show that between April 2008 and March 2009, there were 7,909 uses of restrictive physical interventions (RPIs)[6]. Furthermore, the Healthcare Commission's 'Count Me In' census, which provides a one-day snapshot survey of patients held on the 31st March each year, showed that in 2009 of the 31,000 patients surveyed, over 3,500 mental health in-patients had been subject to physical restraint by staff at least once during the preceding 3 months[7]. Finally, statistics provided by UKBA show that in 2009, restraint was used on a total of 555 occasions on detainees held within Immigration Removal Centres (IRCs)[8].

Whilst these figures do not cover the full 11 year time period, they give a flavour of the sheer volume of restraint incidents used on those individuals detained within state custody. The figures highlight that the number of deaths in proportion to the number of times restraint is used within the custody sectors is low. Furthermore, as a proportion of total deaths in custody, restraint related deaths remain low, with 1 in every 280 deaths occurring as a result of this. However, as outlined above, these deaths are among the most contentious and high profile of all deaths in custody and can have important lessons which can be shared to prevent future restraint deaths. From the data available to the IAP, we can provide the following breakdown from the custody sectors. Of the 22 deaths that have occurred:

- 95% (21) of the deaths were male, with the remaining 5% (1) female.
- 68% (15) of restraint related deaths occurred whilst the individual was detained in police custody [9].
- 59% (13) of those who died were between the ages of 21-40.

[4] The official statistics on use of force (which can cover any use of force from the placing of an arm on a prisoner to drawing a baton), are not broken down into specific instances of control and restraint. They still provide context on the sheer amount of times force is used to control a potentially violent situation.
[5] National Offender Management Service: Race and Equalities Action Group (2009) *Promoting Equality in Prisons and Probation: The National Offender Management Service Single Equality Scheme 2009-2012:* 84.
[6] RPI is a definition used by the YJB which captures the vast majority of restraint incidents. An RPI 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. The RPI definition used by the YJB would not capture some of the very low level uses of force, such as the use of a guiding arm to guide a young person away from an incident.
[7] Healthcare Commission (2009) *Count Me In 2009:* 25
[8] UK Border Agency have 10 Immigration Removal Centres, providing around 3000 bed spaces. These figures are not published statistics; rather, they are based on senior management information statistics and are liable to change.
[9] Police custody can refer to deaths which occur as a result of restraint in the custody cells, or whilst the individual is being arrested by officers in the course of their duty.

- 36% (8) out of the 22 deaths were individuals from Black and Minority Ethnic (BME) groups, with 5 classified as Black, 2 as Asian and 1 as Mixed Ethnicity. 59% (13) were classified as White British.
- The ethnicity of the remaining individual is unknown. The IAP have sought to identify the ethnicity from the Care Quality Commission, however, their records do not indicate an ethnicity.

The figures in the table above, only take into account the deaths which occurred as a direct result of restraint and do not take into account those deaths where restraint was deemed to be a contributory factor. The IAP recognises that there is a large amount of learning that can be extrapolated from these deaths and is currently working on a study of Rule 43 Reports, narrative verdicts and investigative reports into deaths where restraint was identified as either a direct cause or a contributory factor in order to identify trends, particularly in relation to mental health and ethnicity and relevant learning for dissemination across the custodial sectors. The results of this piece of work will feed into the development of the common principles on the use of restraint.

Section 2: Overview of Current Policies on the Use of Restraint

The IAP conducted a consultation with custodial sectors in order to gain an understanding of the current policies which govern their approach to the use of restraint. This section provides an overview of each sector's position on the following: the collation of statistics, policy and training on the use of restraint, accreditation of restraint techniques, healthcare involvement following the use of restraint and the structures for learning and de-briefing following the use of restraint.

1. National Offender Management Service (NOMS)

Collation of Statistics

Prison establishments are required to submit monthly returns to the Security Policy Unit (SPU) within NOMS on the frequency and type of force used on prisoners[10]. Establishments are also required to have their own local audit systems in place to monitor the use of force in order to identify any trends and potential learning points. ***The IAP would like to highlight that whilst the submission of monthly returns to SPU has always been a mandatory requirement, prior to November 2009, there was no consistent recording and analysis of these returns. New procedures have since been put in place, which require prisons to fill in a standardised electronic form. This is then sent to SPU who automatically collate the statistics. Work is ongoing to improve this mechanism. The IAP welcomes this procedure, which strengthens the approach to the monitoring and analysis of these returns.***

Policy

Policy on the use of force in NOMS is set out in Prison Service Order (PSO) 1600. The policy applies to all parts of the adult prison estate, three HM Prison Service run Immigration Removal Centres (Dover, Haslar and Lindholme) and Young Offender Institutions (YOIs). PSO 1600 aims to provide prison staff with de-escalation strategies to try to defuse a potentially violent situation, however, where these fail, PSO 1600 sets out the types of force and equipment that can be used, depending on the nature of the incident or situation. Control and Restraint (C&R) is the practice of techniques described in a personal safety training manual, which is closely linked to PSO 1600, but is issued separately to local training instructors in the establishment and Governors. Techniques centre on a three-person team, with a fourth officer supervising. The policy states that force may be used only as a last resort

[10] The term 'use of force' denotes any and all types of force that may be used against individuals detained in state custody, including the use of handcuffs and batons and the use of planned and unplanned Control and Restraint (C&R).

and only to the extent necessary to bring the situation under control. The use of force will be justified only if:

- It is reasonable in the circumstances;
- It is necessary;
- No more force than necessary is used and;
- It is proportionate to the seriousness of the circumstances.

Prison Service Order 1600 dictates that in C&R incidents, the officer who takes the lead at the head of the prisoner during the restraint retains that role throughout the procedure to monitor the individual's condition with particular regard to any medical warning signs. ***The IAP believes that this policy provides an effective mechanism to ensure the continued safety of the prisoner. The IAP feels that other custodial sectors could extrapolate valuable learning from this policy, which provides a very clear command structure during the use of restraint.***

Training

During their Prisoner Officer Entry Level Training (POELT) new staff are trained in all areas that the training manual covers. This includes the law and ethics surrounding use of force, C&R basic techniques and the use of a baton and protective strategies. The techniques and training provided to prison staff are provided by the National Tactical Response Group (NTRG) who operate out of two centres. Both NTRG centres are primarily used to train or refresh local C&R instructors and to train or refresh C&R advanced staff.

All new officer grade staff undertake a minimum of 32 hours training in C&R basic and/or use of force. This is carried out by POELT trainers who are accredited C&R instructors. NTRG instructors are authorised to teach accredited courses relevant to the use of force and incident management. Staff who have passed their use of force training will receive a log book. The log book is updated every time the officer receives refresher training. Upon completion of their training staff are assessed as competent or not. If they are not deemed competent they receive further training to bring them up to the required standard.

Accreditation

All restraint techniques and trainers are accredited to NOMS standards by a panel of medical experts.

Healthcare

When on duty in the establishment, a member of healthcare must attend all planned C&R interventions and where reasonably practical must respond to all incidents where staff are deployed to restrain a violent or difficult prisoner. The role of the healthcare professional is to monitor the prisoner and to give clinical advice in the event of a medical emergency occurring. A prisoner who has been subject to restraint must be examined as soon as possible afterwards by a healthcare professional. ***The IAP welcomes the inclusion in PSO 1600 of detailed guidance to prison staff on the medical dangers related to the use of physical restraint including positional asphyxia, excited delirium, psychosis and sickle cell disease.***

Shared Learning and De-Briefing

Policy in PSO 1600 requires all incidents of C&R to be recorded and reported to the Security Policy Unit using a nationally standardised form and that there should be a debrief following the incident. Additionally, the Prisons and Probation Ombudsman (PPO) investigates all deaths that occur in prisons. If the PPO identifies any recommendations, as a result of the death, prison governors have the responsibility of ensuring they are cascaded down through their establishment for implementation. A copy of the PPO report is also sent to the Offender Safety, Rights and Responsibilities Group (OSRRG) within NOMS who have responsibility for ensuring that any recommendations, which have national implications, are disseminated across the prison estate.

2. Police Service

Collation of Statistics

The collation of use of force statistics is currently not a mandatory data return for local police forces. In 2008, 'The Review of Policing', led by Sir Ronnie Flanagan sought to reduce the bureaucratic burden for police officers. Decisions to collate use of force statistics are taken at local level by individual forces, who will monitor trends. ***The IAP believes that the lack of central monitoring and analysis of the use of force makes it difficult for police forces to identify the circumstances leading to the use of force. This in turn means that the effective identification of lessons and trends is difficult to achieve. Furthermore, lack of centrally collated statistics presents difficulties in achieving a rigorous cross sector analysis of use of force statistics. This issue will be discussed further in Section 3.***

Policy

All staff who may be required to use force during their duties must receive training in accordance with the 'Personal Safety Manual of Guidance (2009)' which is jointly written by

the National Policing Improvement Agency (NPIA) and the Association of Chief Police Officers (ACPO). The key approach which underpins policy on the use of force is the Conflict Management Model. This is a circular, step-by-step model which comprises the elements: information/intelligence received, threat assessment, powers and policy, tactical options and finally action(s). This procedure should always be followed before any force is employed. An additional piece of general guidance is the 'Safer Detention and Handling of Persons in Police Custody (2006)', which provides an overview of the use of restraint techniques both in an operational environment and in a custody setting.

Restraint forms a significant part of the 'Personal Safety Manual of Guidance'. The Manual is supported by the 'Handcuff and Limb Restraint Guidance' written by ACPO. These documents form the national policy and individual forces set their policies within this framework. In the operational environment, individual officers must be able to show that any force used was lawful, proportionate and necessary; the responsibility for the appropriate use of force always lies with the officer exercising it. Officers must always ensure that the level of restraint applied is reasonable and that the health of the detainee is monitored at all times, especially where restraint is for a prolonged period of time.

Training

Restraint is a core item of the national syllabus and a central tenet of the personal safety training. All officers below the rank of superintendent receive a minimum of 12 hours' training each year, which is refreshed every six months. All officers receive one day initial restraint training from accredited trainers, which is assessed as either a pass or fail. Training moves through a structured approach based on conflict resolution and continual reassessment of the situation so that they can de-escalate or escalate the use of force as necessary.

The training emphasises good communication and officers are trained in verbal de-escalation techniques, using many of the same techniques as the prison service and mental health services. Where communication does fail, at the other end of the spectrum is the use of force, which is taught to be applied properly and safely with the safety of the detainee and the officer remaining paramount. ***The IAP welcomes the inclusion in the guidance of a section on positional asphyxia, the heightened dangers of using the prone restraint position and other factors that may contribute to death following restraint.***

Accreditation

ACPO has overall responsibility for accrediting police restraint techniques and ensuring they are safe. The Personal Safety Manual of Guidance is refreshed annually to take into account changes in operational practices and to ensure continued safety for the detainee and the officers.

Healthcare

The role of the police as an emergency service poses different operational challenges given that they will often have to deal with unpredictable situations. Police may have very little information about the individual at the time of restraint and arrest and the vast majority of restraint incidents will be unplanned, which makes the presence of a healthcare official difficult. Any person taken into custody who was been restrained should be seen by an appropriately trained and experienced Forensic Physician (FP) as soon as possible. Should a restrained individual require cell relocation whilst in custody, a supervisor and a healthcare professional should be present during the relocation wherever possible.

Shared Learning and De-briefing

After each restraint incident, officers are de-briefed to identify the circumstances leading to the use of restraint and whether different pathways could have been used to de-escalate the situation. The Independent Police Complaints Commission (IPCC) is responsible for investigating deaths in police custody, or following police contact. One of its primary aims is to make recommendations to lead to safer police practices. To facilitate learning further, the IPCC has, with ACPO, the Association of Police Authorities, HM Inspectorate of Constabulary, the Home Office and the National Policing Improvement Agency (NPIA) established a multi-agency committee known as 'Learning the Lessons'. The committee receives regular reports on investigations and decides which of these are of use to police forces to improve policies and practices. These are included in a regular bulletin for dissemination three times a year. Where necessary, the IPCC can issue 'quick time' learning should there be systemic failings in the report. Guidance stipulates that the recommendations must be shared with ACPO and the force in question.

3. UK Border Agency (UKBA)

UKBA has responsibility for securing the UK border and for controlling migration into the UK. For the purposes of this report, there is a distinction to be made between the different parts of UKBA responsible for delivering on this objective:

1. Enforcement teams who are responsible for the arrest of illegal immigrants;
2. Detention Custody Officers (DCOs) who are responsible for detaining the illegal immigrant at an Immigration Removal Centre (IRC) and;
3. Detention Escorting Officers (DEOs) who are responsible for the escorting of illegal immigrants back to their country of origin.

Collation of Statistics

The Detention Services Intelligence Team within UKBA has overall responsibility for collating and analysing the statistics on the use of force within the IRCs. Additionally each IRC is responsible for gathering statistics locally for monitoring and analysis purposes. Any use of force used by enforcement officers is recorded and sent to the National Arrest Training Centre for monitoring and learning.

Policy

ACPO use of force guidance used by police officers is also used by officers in UKBA enforcement teams and DEOs. Policy for the use of force that can be used by DCOs in IRCs is set out in PSO 1600.

Training

UKBA enforcement officers are trained in techniques similar to those taught to police officers using the ACPO Conflict Management Model, which is a circular, step-by-step model covering information/intelligence received, threat assessment, powers and policy, tactical options and finally action(s). This procedure should always be followed before any force is employed.

DCOs have the same training as prison officers; local instructors attend an initial Control and Restraint (C&R) instructors course on a pass or fail basis. They must also attend and pass an annual C&R instructors refresher course and training includes conflict resolution and de-escalation techniques. The local instructor can then train staff at their IRC in basic C&R and 'breakaway' techniques. Advanced C&R (Tornado Response) requires locally selected staff to attend one of the two National Tactical Response Group Training Centres (NTRG) to complete the C&R advanced training, again this is on a pass or fail basis and is subject to annual refresher training.

DCOs employed in IRCs that detain children are also trained in Physical Control in Care (PCC) techniques. Instructors in PCC undergo the same process as for C&R training and must be accredited by NTRG before delivering training to DCOs at their IRC. The training

delivered to DCOs is the same as that delivered to NOMS staff and staff from contracted prisons. PCC provides guidance on when the use of force can be used on children down to the age of 12, or in exceptional circumstances children aged 10. ***However, given that UKBA detain children of all ages[11], there is a clear gap here in terms of how UKBA staff approach the use of force on a child under the age of 10. This will be discussed further in Section 3.***

DEOs receive the same training as DCOs; however, they receive additional training on the use of rigid bar handcuffs, which can be used to escort detainees back to their country of origin. This training is accredited and delivered by the NPIA. ***However, the IAP is aware that the three-person C&R techniques used by prison staff are often not appropriate for use on aircraft given the space restrictions on board and further work is needed to address this gap. This issue will be discussed further in Section 3.***

Accreditation

All training for enforcement staff is accredited to ACPO standards. All enforcement training officers undergo a two week trainer's course, with some trainers going on to be NVQ accredited. All trainers follow the ACPO manuals of guidance used in police training. Training for DCOs and DEOs is subject to the same stringent accreditation policy as prison officers, which are accredited to specifications set by NOMS.

Healthcare

If an individual is restrained by enforcement staff and taken into custody, a member of the healthcare team should examine the individual as soon as possible. Within the detention estate, all planned use of force requires a member of the healthcare staff to be present. Any detainee who has been subjected to a spontaneous use of force must be seen by a member of the healthcare team as soon as possible after the incident.

Shared Learning and De-Briefing

All enforcement visits should include a de-brief if force has been used. If a critical incident has taken place, which has led to serious injury or death, a de-brief is then mandatory, with the findings recorded in decision logs and UKBA visit packs.

[11] In May 2010, UKBA launched a review seeking views on ending the detention of children for immigration purposes. As a result of the findings from this review, in December 2010, Yarl's Wood Immigration Removal Centre no longer detains children for immigration purposes, and UKBA are now working towards an approach to family removals, placing the welfare of children at the centre.

Detention staff must complete a use of force reporting form as soon as practicable. The forms are completed without conferring with staff that have been involved in the use of force. These forms are collated at the IRCs and should be viewed by the C&R instructors. The instructors will give individual advice and guidance as necessary and will cover any generic areas of concern at training sessions.

Deaths in an IRC are also subject to a PPO investigation, which will seek to identify any recommendations and learning as a result of the death. Directors then have the responsibility of ensuring they are cascaded down through their establishment for implementation. The Head of Detention Services at UKBA should make provision for sharing recommendations with national implications and ensuring they are applied estate wide.

4. Youth Justice Board (YJB)

The YJB oversees the youth justice system in England and Wales and is responsible for commissioning places for young people sentenced or remanded to custody in Young Offender Institutions (YOI), Secure Training Centres (STC) and Local Authority Secure Children's Homes (LASCH).

Collation of Statistics

The YJB requires every YOI, STC, LASCH and commissioned STC escort provider to send monthly returns on the use of restrictive physical interventions (RPI), which is defined as any occasion when force is used on a young person[12]. This data includes, but is not limited to, information on the use of restraint by age, gender and ethnicity, the number of injuries to staff and young people and the duration of RPIs.

The Independent Review of Restraint

In 2008, the Government published its response to the 'Independent Review of Restraint in Juvenile Secure Settings' conducted by Peter Smallridge and Andrew Williamson to examine the policies and practices surrounding the use of restraint across YOIs, STCs and LASCHs. This review took place as a result of the deaths of 15 year old Gareth Myatt, who died whilst being restrained and 14 year old Adam Rickwood, who committed suicide shortly after being restrained in STCs in 2004. The authors made 58 recommendations to bring greater clarity and consistency across all three secure settings and to build in safeguards for young people and staff during and following restraint incidents. Key recommendations included:

[12] As mentioned earlier, RPI 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. The RPI definition used by the YJB would not capture some of the very low level uses of force, such as the use of a guiding arm to guide a young person away from an incident.

- Developing a new behaviour management system for use in YOIs and STCs;
- Establishing a Restraint Accreditation Board to accredit all restraint systems in use in the secure estate and;
- Ensuring that every establishment has a restraint minimisation strategy in place.

The Youth Justice Policy Unit within Ministry of Justice (MoJ) is currently co-ordinating the cross-government work on implementing these recommendations, many of which have been achieved. A key part of this work is the Conflict Resolution Training (CRT) currently being developed by NOMS. CRT is designed to provide staff working in the under 18 secure estate with a package of accredited measures aimed at reducing the need for restraint. It places a strong emphasis on resolution and approaches to using de-escalation techniques as a first resort. Where there continues to be a risk of harm, staff will be trained to apply restraint techniques as a last resort when all other stages of the toolkit have been exhausted.

Policy

In the under-18 estate, there are three pieces of legislation which govern the use of force: The Young Offender Institution Rules 2010; The Secure Training Centre Rules 1998; and The Children's Homes Regulations 2001. The YJB has issued general guidance on use of restraint to all three sectors, in the form of its 2006 code of practice Managing the Behaviour of Children and Young People in the Secure Estate.

Young Offender Institutions

Control and restraint (C&R) is the restraint system currently used in all YOIs, developed and owned by NOMS. This is the same system that is used within adult prisons.

Secure Training Centres

STCs are required by law to use restraint methods approved by the Secretary of State. The only method currently approved for STCs is Physical Control in Care (PCC). PCC was originally designed by NOMS specifically for use on younger children (12-14 year olds).

Local Authority Secure Children's Homes

The policy on the use of restraint within LASCH is covered in the training section below.

Training

Young Offender Institutions

All new YOI staff members are trained in C&R via the Prison Officer Entry Level Training (POELT). The training provides officers with an understanding of the law surrounding the use of force and C&R basic techniques. All prison officers are required to undergo annual refresher training in C&R.

The Juvenile Awareness Staff Programme (JASP) has become an integrated part of the POELT programme and is delivered to existing staff in accordance with local training plans. JASP forms part of the National Qualifications Framework in Youth Justice and provides child focused training for staff working with young people. JASP currently includes a module on safeguarding and child protection, mental health, substance misuse, vulnerability assessment, training planning and behaviour management. Following a recommendation in the Review of Restraint, it is hoped that in the future, additional training will be provided to YOI staff on how to manage challenging behaviour and enhanced training will be available on de-escalating conflict effectively without the need to use restraint. ***The IAP supports the integration of JASP into the POELT programme and welcomes the proposed moves to provide additional training to YOI staff on managing challenging behaviour and de-escalating conflict.***

Secure Training Centres

All new STC staff receive a minimum of seven weeks training, which includes modules in safeguarding and child protection, security, child development, mental health, suicide and self-harm, managing challenging behaviour, first aid and health and safety. All staff are trained in the use of PCC prior to being allowed to work with young people. Training in PCC was developed and is delivered initially by National Tactical Response Group (NTRG) instructors to nominated staff selected as PCC Trainers by the STCs. The PCC Trainers then cascade the training to STC staff locally, by means of a 5 day course. All staff must attend a refresher training course once a year in order for them to continue to be authorised to use PCC techniques. The NTRG are responsible for undertaking a quality assurance programme for PCC training within STCs and Reliance STC escort providers.

Local Authority Secure Children's Homes

There is no central mandating of either the policy or restraint training in LASCHs – as each LASCH, through their local authority's lines of accountability, may take their own decisions on which restraint training to use. None of the methods are subject to Ministerial approval. The Independent Review of Restraint noted that the range of restraint training providers was diverse, but generally felt to be appropriate to the ethos of LASCHs and the needs of children

there and are well integrated within behaviour management strategies[13]. ***However, the IAP believes that the requirement for LASCHs to use an accredited set of restraint techniques needs to be strengthened as the lack of central mandating could cause problems for the effective monitoring of the suitability and safety of the restraint techniques used in LASCHs. These issues will be discussed further in Section 3.***

Accreditation

One of the key recommendations in the Independent Review of Restraint was that the MoJ should establish an accreditation board to review and accredit all restraint systems used across the youth justice system. The Restraint Accreditation Board (RAB) has now been established and will be responsible for accrediting all restraint systems used in the secure estate for young people. They will begin by exploring avenues for accrediting the new CRT system, which has been developed for use in YOIs and STCs.

Healthcare

Current practice in a YOI is to ensure that a young person is seen by a health professional as soon as is practicable and at the very least within 24 hours of a restraint. In practice this is often within 30 minutes of an incident occurring, but it is not possible to guarantee this under the current contractual arrangements with Primary Care Trusts. In STCs it is a contractual requirement for all young people to be seen by a healthcare professional within thirty minutes of a restraint incident. In LASCHs, this requirement is included within the new National Minimum Standards, but the visit must take place 'as soon as possible' rather than specifically within 30 minutes.

Shared Learning and De-briefing

Any death which occurs in a YOI or an STC will be subject to a Prisons and Probation Ombudsman (PPO) investigation. If the PPO identifies any recommendations as a result of the death, governors have the responsibility of ensuring the recommendations are passed down through their establishment for implementation. A copy of the PPO report for YOI deaths is also sent to the Offender Safety, Rights and Responsibilities Group within NOMS who have responsibility for ensuring that any recommendations which have national implications are disseminated across the prison estate.

Exception reporting was developed to identify any difficulties and risks with holds in the PCC restraint system used by STCs. The exception reporting system aims to strengthen central

[13] Smallridge P, Williamson A. 2008. *Independent Review of Restraint in Juvenile Secure Settings.* Ministry of Justice and Department for Children, Schools and Families: 8.

oversight and management of PCC in STCs and to gather evidence to improve the safety and efficacy of the restraint method. STCs are required to submit an exception report when one or more warning signs or a serious injury are found to have occurred as a result of or during a restrictive physical intervention. A reporting Panel meets to discuss and scrutinise the content of the reports, to learn lessons and amend the PCC system, training or staff practices as necessary. The YJB have devised a new exception reporting procedure to extend the system to include both YOIs and LASCHs. Once a restraint system has been accredited for use by the RAB, they will be required to follow the new Exception Reporting system, with all reports scrutinised by the RAB.

Since April 2009, all serious and significant incidents that occur in establishments must be immediately reported to the YJB. All trends and learning arising from significant incidents are analysed centrally by the YJB on a monthly basis and the YJB are currently developing a follow-up system to record and share lessons learnt from significant incidents across the secure estate. Deaths in LASCHs are also subject to Serious Case Reviews, which are undertaken when a child dies or is seriously injured and abuse and neglect are known to be suspected factors in the death. SCRs are carried out under the auspices of Local Safeguarding Children Boards so that lessons from the death can be learnt locally to improve the safety and welfare of children.

5. Mental Health Services

Collation of Statistics

The National Patient Safety Agency (NPSA) currently monitors cases where restraint resulted in a serious injury in a secure mental health setting and through the National Reporting and Learning System (NRLS) disseminates learning to individual trusts. However, as a result of the Department of Health's review into its arms length bodies, the NPSA is set to be abolished. The review recommended that the NRLS should transfer to the NHS Commissioning Board as a Patient Safety sub-committee of the Board[14]. ***The IAP recognises the NPSA's important role in ensuring that relevant learning is shared and would like to emphasise the importance of this function continuing during this transition period.***

Furthermore, the Healthcare Commission (HCC) 'Count Me In' census is a one-day snapshot of detained patients carried out on 31 March each year. Amongst other things, the census

[14] Department of Health (2010) *Liberating the NHS: Report of the Arm's Length Bodies Review:* 27.

provides information on the number of times in-patients had been subject to physical restraint by staff. The Mental Health Act code of practice stipulates that mental health staff must document the instances of physical restraint and the decision and reasons why restraint was used.

Policy

There is national written guidance on the management of aggression: a national training programme in non-physical prevention and management of violence produced by the National Institute for Clinical Excellence and guidance in the updated code of practice to the Mental Health Act 1983. However, many of the important questions about training in physical restraint and control are left to local judgment including how long the training should last, the content and what qualifications are needed by those who deliver it. All hospitals should have clear written policies including provision for post-incident reviews.

Training

Currently, individual providers meet the training needs of their staff in different ways through a mixed economy of private sector and internal NHS training. Staff are trained to prevent and manage violence and aggression. This includes recognising signs and signals and interpreting body language. Non-physical interventions such as verbal de-escalation are also used. It is necessary to build and maintain a therapeutic relationship with the patient, even during periods of challenging behaviour and the use of restraint can sometimes undermine this relationship.

Accreditation

With over 60 trusts and over 25 different training providers, there is an ongoing issue regarding which type of restraint training is currently being delivered, which makes the quality assurance of techniques difficult. The Department of Health is currently seeking approval for the accreditation of training in the management of violence in mental health settings.

The inquiry into the death of David 'Rocky' Bennett, a patient detained under the Mental Health Act (MHA) who died in 1998 after being restrained, highlighted the need for accredited training packages and techniques for use across mental health trusts. Further inquests held in 2008 highlighted that the lack of restraint training and staff knowledge was a contributory factor into the deaths of Kurt Howard who died in 2002 and Azrar Ayub and Geoffrey Hodgkin who both died in 2004[15]. NHS Security Management Service was identified as the preferred

[15] The Mental Health Act Commission (2009) *Coercion and Consent – Monitoring the Mental Health Act 2007-2009:* 211.

accreditation body, but expressed concern that the scheme would not be viable if voluntary, which was the original intention. The Department of Health are currently exploring legislative routes, but are also liaising with the Care Quality Commission (CQC) to identify whether sourcing training from an accredited provider should be a requirement for registration. ***Since 2003 there have been four restraint related deaths in secure mental health settings. The IAP recognises that this is a complex stream of work, but stresses the importance of this work being completed as soon as possible given that the recommendation for a national system of training and guidance for restraint and control was made in 2003 as a direct result of the Bennett Inquiry.***

Healthcare

In mental health settings when physical restraint is being used, a doctor should be available to attend and staff should be alert to any risk of respiratory or cardiac distress. Restraint in mental health settings is used as a last resort only when de-escalation and other strategies have failed to calm the patient. Mechanical restraint is not a first-line response or a standard means of managing disturbed or violent behaviour in acute mental health settings. Psychiatric hospitals are the only places, which use medication as part of restraint but it should be exceptional and never used to manage patients as a substitute for adequate staffing.

Shared Learning and De-briefing

Hospitals should have in place a system of post-incident support and review which allows the organisation to learn from the restraint incident. The needs of the patient, the staff, any other patients in the vicinity, any family and friends present and other witnesses should be met. The patient should be given the chance to write their account of the incident, which is filed in their notes.

Section 3: Key Issues from Workshop Discussions and Recommendations

To facilitate a discussion on common approaches to restraint, the IAP developed a series of discussion topics for attendees, which covered the following:

- The content of restraint training
- The delivery of restraint training
- Accreditation of restraint techniques
- Structures and mechanisms to learn from restraint deaths
- Gaps in policies and guidance on the use of physical restraint
- Medical issues surrounding restraint
- Identification of vulnerable groups who may be particularly at risk to restraint
- The viability of creating a high level cross sector restraint group.

The workshop was divided into three discussion groups, each facilitated by a member of the IAP. Each group had a mixture of custodial staff, policy leads and medical and legal experts to ensure all perspectives were covered. Below is an overview of the discussions from the day, along with a series of recommendations and instances of good practice. The workshop was subject to Chatham House rules so the discussions do not necessarily reflect official departmental positions, but they are reflective of real concerns and issues raised by those present.

Content, Delivery and Accreditation of Training

Policies and guidance for custodial staff stipulate that anyone who may be expected to use restraint must use it as a last resort, in attempting to control a violent individual and when used, staff must be able to show that the use of restraint adheres to the principles of necessity, reasonableness and proportionality. This was consistent with discussions at the workshop.

The workshop highlighted that government departments and agencies had recognised the importance of the formal accreditation of techniques in order to provide assurances to staff that the restraint techniques being used were the safest possible. Of course, even the safest technique can lead to serious injury or in the worst case death, but attendees felt that accredited systems of restraint could lead to higher levels of staff confidence and competence by providing a clear and shared understanding of the practical application and ethical and legal context involved in the use of restraint. Most departments and agencies had accreditation systems in place; however, as mentioned earlier, the Department of Health, as

a result of the independent inquiry into the case of David 'Rocky' Bennett who died in 1998, is still exploring legislative routes to develop accredited training packages and techniques for use across mental health trusts, despite the initial recommendations being made in 2003. ***The IAP would like to re-iterate the importance of an accredited training package being developed to address ongoing concerns on the use of restraint in a mental health setting. Since 2003, there have been four deaths, where restraint was identified as a cause of death of patients detained under the Mental Health Act.***

Whilst attendees felt that the accreditation of restraint training was to be applauded, it was felt that for accreditation to be successful there needed to be a robust monitoring system in place to ensure that what was being taught in the classroom was understood by staff and was being used safely and correctly in an operational setting. Representatives from NOMS and UKBA highlighted that staff from their respective training centres perform spot checks on establishments to ensure that restraint training is understood by staff.

Moreover, staff from NOMS can be awarded qualifications whilst being trained at one of the National Tactical Response Group (NTRG) centres. Once qualified, prison staff can then train staff in their own establishments. ***The IAP would like to highlight this as an example of good practice as it provides a good mechanism for NTRG trainers to receive feedback from prison establishment staff during their annual four day accreditation refreshment course. Through this feedback, the NTRG trainers can build an understanding of what techniques work and which techniques require modification.***

Structures for Learning

The workshop highlighted that there were some strong mechanisms in place to ensure learning took place following an incident of restraint. The workshop highlighted that there was a culture of de-briefing evident across the entire custodial estate, which the IAP welcomes as a key mechanism for disseminating learning quickly. Furthermore, within prison establishments, any instances of use of force (including instances where C&R was used) is documented via an electronic form and data is analysed both locally in the prison and centrally in the Security Policy Unit within NOMS to ensure that concerns over safety and other issues are identified and addressed. The UK Border Agency (UKBA) also audits any use of force, which is documented and sent to the Detention Services Intelligence Team where it is analysed and any relevant learning is shared. The YJB requires that all serious incidents that occur in YOIs, STCs and LASCHs are sent immediately to YJB for analysis and identification of any trends. ***The IAP believes that the central collation of statistics is an***

example of good practice, which allows custodial sectors to draw upon data to identify the successful and unsuccessful pathways leading to restraint.

Within a secure mental health setting, the National Patient Safety Agency (NPSA) monitors cases where restraint resulted in a serious injury. The NSPA receive confidential reports of patient safety incidents from healthcare staff across England and Wales and through the National Reporting and Learning System (NRLS) disseminate learning to individual trusts. However, as referenced earlier, the NPSA is set to be disbanded, with the NRLS functions being devolved to the NHS Commissioning Board.

The IAP is aware of the recommendations made by Sir Ronnie Flanagan in 2008 in his report, 'The Review of Policing', which sought to reduce the bureaucratic burden for police officers and is also aware of the current Home Office consultation paper 'Policing in the 21st century – reconnecting police and the people', which is aiming to amongst other things abolish central targets. As stated earlier in Section 2, there is currently no mandatory requirement for the national collation and recording of the use of force in the police, the decision to collate statistics is taken by individual forces at a local level. The IAP is mindful of the Government's drive to reduce police bureaucracy. However the collation and analysis of statistics provides a crucial mechanism, which allows custodial sectors to monitor and quickly identify trends so that an understanding of the situations which led to the use of restraint is gained. This in turn can allow custodial sectors to establish whether the techniques currently in use are fit for purpose. Furthermore, the lack of centrally collated statistics makes a cross sector analysis difficult to achieve. ***The IAP recommends that local police forces submit annual use of force statistics (including instances where the use of restraint was used) to a suitable central body for monitoring and analysis in order to aid the development of future strategies and tactics to reduce the need to use restraint.***

RECOMMENDATION 1: The IAP recommends that local police forces submit use of force and restraint statistics on an annual basis to a suitable central body for monitoring and analysis purposes

Due to time constraints on the day, the IAP chose to primarily focus on deaths where restraint was identified as a direct cause of death. The IAP is undertaking parallel work on a review of Rule 43 Report, narrative verdicts and investigative reports where the use of restraint was identified as either a direct cause of death, or found to be a contributory factor. However, attendees acknowledged that there was a large amount of learning that could be extrapolated

from cases where the use of restraint had resulted in the near death of an individual. Whilst there would be value in this, there is a difficulty identifying these cases given that there is currently no formal collation of near death restraint incidents. The IAP believes there may be greater value for custodial sectors in developing protocols to ensure that there are investigative procedures in place for the near death or serious injury cases following the use of restraint to capture learning quickly and to disseminate relevant learning more effectively. ***The IAP believes it would be helpful if further work was undertaken to attain cross sector agreement on the threshold of what constitutes near death and serious injury.***

RECOMMENDATION 2: The IAP recommends that custodial sectors develop protocols to ensure that investigations are triggered in cases where the use of restraint has resulted in the near death or serious injury of an individual

Furthermore, attendees felt that there would be value in an investigation into the particular restraint techniques, which resulted in the death of the individual. Attendees felt that this may help form an empirical base of evidence, which would allow the safety of restraint techniques to be compared. ***As part of the review of the recommendations from Rule 43 Reports, narrative verdicts and investigative reports, the IAP will seek to identify which restraint techniques led to the death of the individual and to identify whether there are any ongoing concerns about these techniques***.

Identification of Gaps Relating to Policies and Guidance

There was concern that restraint techniques developed by NOMS for use within a prison were often inappropriate for immigration detainee's being escorted back to their country of origin by escort contracting staff, working on behalf, of UKBA on board aircraft. NOMS restraint techniques rely on a three-person team, whereas the confines of an aircraft mean that these techniques have to be used by two escort staff sitting either side of the detainee. ***The IAP are aware that UKBA are now working with NOMS, who are undertaking a review of restraint techniques used by UKBA escort staff on board deportation flights. Should the review highlight a need for the current techniques used by escort staff to be adapted, NOMS will work in conjunction with the escort contractor to develop these. The IAP welcomes this; given NOMS' extensive experience in the development of safe restraint techniques for use within the prison estate.***

Whilst this was not identified during the workshop, scoping work undertaken for this report highlighted that there is no central mandating of restraint methods or training in Local

Authority Secure Children's Homes (LASCHs), as each LASCH procures their preferred restraint training package through their local authority's lines of accountability. The IAP acknowledges that YJB contracts include a generic service specification that is common to all LASCH and includes details on the use of restraint. However, whilst the Independent Review of Restraint believed that training providers who deliver training were appropriate to the ethos of the LASCH, the IAP believes that more needs to be done. With such a wide range of training providers and policies being used by LASCHs, monitoring becomes difficult and the creation of an empirical evidence base on the suitability of restraint techniques is difficult to achieve. ***The IAP recommends that the Restraint Accreditation Board (RAB), in due course, ensure that the systems of restraint within local authority secure children's homes are accredited.***

RECOMMENDATION 3: The IAP recommends, in due course, that the RAB should ensure that the systems of restraint used in LASCHs are accredited

Medical Issues and Concerns

There are a number of different medical theories addressing why some people die following restraint and significant debate still surrounds the subject. With regards to research evidence, two commonly cited concepts are postural or positional asphyxia and excited delirium also known as acute exhaustive mania. The presence of differing medical theories concerning deaths associated with restraint has generated significant debate in the medical community about the physiological causes of restraint related deaths. At the workshop, medical practitioners could not agree on the symptoms relating to positional asphyxia and excited delirium, which they believed made the delivery of a focused training package to custodial sectors difficult.

Additionally, attendees at the workshop felt that given the relative rareness of excited delirium as a cause of death in restraint cases, it was perhaps more prudent to gain a greater understanding of the dangers around positional asphyxia and that an initial IAP focus on this condition would be beneficial. The IAP is commissioning a review into the medical theories and research on restraint related deaths in order to gain a greater understanding of the physiological causes of these deaths. Given the evident disparity of medical opinion the IAP feel it is important to identify common themes and key learning points to form a substantial and definitive evidence base, which custodial sectors can draw upon when formulating safer approaches to restraint. The findings from this review will feed into the common principles on restraint, which it is hoped will enable custodial sectors to identify whether the restraint

training packages currently used adequately mitigate the medical risks related to restraint, in particular the dangers of positional asphyxia.

Issues Relating to Vulnerable Groups

The introduction of the Assessment, Care in Custody Teamwork Plan (ACCT) into prisons, which provided a care planning system to help identify and care for vulnerable prisons at risk of self-harm/suicide was an example of good practice highlighted by attendees at the workshop. However, more needs to be done. Given the high number of prisoners suffering from mental illness, it was felt that there would be a benefit from further input from mental health experts in training prison staff on the management of challenging behaviour. Often, the deployment of physical restraint is not necessarily the best avenue for action in dealing with challenging behaviour and a need to focus on de-escalation techniques over the use of restraint is needed.

Attendees at the workshop highlighted a gap relating to the lack of national guidance for UKBA detention staff on how to safely restrain children under the age of 10. As discussed earlier in the report, Physical Care in Control (PCC) provides guidance on when the use of force can be used on children down to the age of 12, or in exceptional circumstances children aged 10. The IAP recognises that the Coalition Government has committed to end child detention for immigration purposes. In December 2010, it unveiled a new approach to family removals, following a review and consultation exercise. An independent family returns panel will be established to ensure that the welfare of children is considered and properly factored into return plans where enforcement action is necessary. However, as an absolute last resort, there may still be occasions where the use of restraint may be necessary to secure the removal of a family from the UK. There is, therefore, a clear gap here in terms of how UKBA staff approach the use of restraint on a child under the age of 10. ***The IAP recommends the production of national guidance for UKBA detention staff, which will detail the correct procedures for safely restraining children under the age of 10, when all other approaches have failed.***

RECOMMENDATION 4: The IAP recommends the creation of national guidance for UKBA detention staff on how to safely restrain children under the age of 10

Some workshop attendees highlighted concerns that there appeared to be a disproportionate number of restraint incidents involving Black and Minority Ethnic (BME) prisoners. The IAP is aware of the recent triennial review by the Equality and Human Rights Commission, which

highlighted that on average, five times more Black people than White people in England and Wales are imprisoned[16]. According to the NOMS 'Race Review' (2008), Black prisoners are consistently more likely than White British prisoners to be on basic regime, to be in the segregation unit for reasons of Good Order or Discipline and to have force used against them[17]. The review also found that the use of force on BME prisoners between April 2008 and September 2008 was well above the expected ranges[18]. However, whilst detention rates have remained higher than average among BME groups detained under the MHA[19], out of 31,786 patients surveyed as part of the 2009 'Count Me In' census, the only ethnic difference on the use of restraint observed was the 28% lower than average rate among Black Caribbean groups. Ethnic differences in rates of restraint have not shown a consistent pattern over the last five 'Count Me In' censuses[20]. The IAP will analyse comparable data to identify whether restraint is used disproportionately on individuals from BME groups across all sectors and to identify any particular trends.

Establishment of High Level Cross Sector Restraint Group

The IAP is mindful that there is a need for a more joined up approach to the issue of restraint with greater co-ordination between government departments and across services. Whilst the IAP is aware there are groups in existence such as the Self Defence, Arrest and Restraint Group led by the ACPO, which forges ties between HMPS, UKBA and the Police, there is as yet no group with full custodial representation. There was a general consensus amongst attendees and other stakeholders that the creation of this group would help achieve a more coherent approach to the issue of safer restraint and would formalise and encourage inter-agency co-operation. It was felt, that in order to encourage this approach, the group should have the following aims:

- Forge close ties with the Restraint Accreditation Board (RAB) and other associated accreditation bodies;
- Oversee the collation of national restraint statistics to identify trends and recommend improvements to operational practices where needed;
- Develop mechanisms to ensure that the sharing of common lessons are disseminated quickly, effectively and efficiently and;
- Commission relevant research into restraint.

[16] Equality and Human Rights Commission (2010) *How Fair is Britain: The first Triennial Review:* 162.
[17] National Offender Management Service (2008) *Race Review: Implementing Race Equality in Prisons – Five years on:* 15.
[18] Ibid, p39.
[19] Healthcare Commission (2009) *Count Me In 2009:* 3.
[20] Ibid, p25.

The IAP welcomes these aims and believes that a high level restraint group, with full custodial representation would provide a valuable forum to share learning and discuss best practice. However, the IAP is also conscious of avoiding the duplication of effort and resources. The recent creation of the RAB within the Ministry of Justice could provide a valuable forum in bringing together representatives from across the custodial estate to discuss the aims listed above. ***In the first instance, the IAP recommends that further discussions take place to determine the feasibility of RAB holding an extended meeting once a year to bring together representatives from all of the custodial sectors to identify and share best practice and learning. If this is not feasible, further consideration should be given to the creation of a high level cross sector restraint group given there is as yet, no such group with full custodial representation.***

RECOMMENDATION 5: The IAP recommends that further discussions are undertaken with RAB to establish the feasibility of them holding an extended meeting once a year to include representatives from all of the custodial sectors in order to share best practice and learning. If this is not feasible, consideration should be given to the creation of a new high level restraint group with full custodial representation