Independent Restraint Advisory Panel

IMPLEMENTATION OF THE MINIMISING AND MANAGING PHYSICAL RESTRAINT SYSTEM IN SECURE TRAINING CENTRES AND YOUNG OFFENDER INSTITUTIONS

June 2014

FOREWORD

In August 2011, the Restraint Advisory Board (RAB) presented its report titled 'Assessment of Minimising and Managing Physical Restraint (MMPR) for the Children in the Secure Estate', to the Restraint Management Board (RMB) in the Ministry of Justice.

The report made 37 recommendations that were designed to assist the responsible authorities to implement the new system and included "changes to deeply held working practices (which) can take years to overcome" (Williamson and Smallridge)[1].

Subsequently, the Ministry of Justice (MoJ) formed a new group of experts. The new group was named the Independent Restraint Advisory Panel (IRAP). It contained several members who were members of the RAB previously.

IRAP was established with two main purposes. They were to:

- Assess the quality and safety of systems of restraint commissioned for use with children in Secure Children's Homes (SCHs). The report on this aspect of IRAP's role has also been completed (A Review of Restraint Systems Commissioned for use with Children who are Resident in Secure Children's Homes, June 2014).
- Support the implementation of MMPR in Young Offender Institutions (YOIs) and Secure Training Centres (STCs).

As we describe in Section 1, the introduction to this report, a Memorandum of Understanding was agreed relating to the second of IRAP's tasks. This task is the subject of this report and it was carried out by a sub-group of the panel. I am very grateful to Geoff Hughes for leading this work.

Members of IRAP carried out a comprehensive range of activities in order to discharge its tasks. As Section 1 shows in more detail, they: made visits to two STCs and two YOIs; conducted meetings during visits to the STCs and YOIs with managers, staff, national and local trainers, YJB monitors, healthcare staff and young people resident in the STCs and YOIs; provided reports to the YJB and MoJ; attended meetings with national trainers and the YJB's staff to review cases that had been reported as exceptions; reviewed data on the use of MMPR as well as documents provided by the STCs and YOIs; and attended meetings with the Restraint Management Board and officials employed to work in the YJB and MoJ.

[1] Smallridge A, Williamson P. Independent review of restraint in juvenile secure settings. London: Department for Education, 2007. http://webarchive.nationalarchives.gov.uk/20130401151715/https://www.education.gov.uk/publications/eOrderingDownload/Review%20of%20restraint.pdf Last accessed 18 April 2014.

In particular, the members of IRAP undertook visits to STCs and / or YOIs to both observe and take part in some or all of events as a part of the roll-out prior to implementation of MMPR.

Overall, IRAP members noted that the quality of training was very high with a heavy emphasis on a child-centred approach and evident professionalism (Section 4).

IRAP members also undertook visits to STCs and YOIs following implementation of MMPR (Section 5). IRAP fully acknowledges, and in no way underestimates, the considerable challenge for both the MMPR trainers and all staff at all levels who work in the secure establishments in introducing a wholly new system of child-centred restraint. IRAP draws attention to its extant concerns in this report (see Section 9 for summaries) and it makes practical suggestions on how to address them.

IRAP acknowledges the solid progress made in improving the governance of the restraint system used in the STCs and YOIs with the introduction of a much improved data collection, analysis and feedback system that has accompanied the introduction of MMPR. IRAP recognises how accurate feedback loops can reduce risk gaps and create a culture of learning and improve delivery of timely change to minimise the risks that are associated with physical restraint of children (Section 6).

IRAP strongly reaffirms the recommendation of the RAB report that a specially recruited and dedicated team within the National Offender Management Service (NOMS) should undertake training of staff on MMPR. Moreover, having observed tangible progress to date, IRAP strongly recommends that this core specialist team should be retained and maintained. IRAP's opinion is that to do otherwise would jeopardise the progress that has been made to date.

IRAP created a sub-group (otherwise referred to as the IRAP Medical Panel) consisting of a paediatrician, a psychiatrist and a physiotherapist, to meet regularly with representatives of the MoJ, the MMPR National Team of trainers, and the local Youth Justice Board (YJB) monitor at a number of venues since the process started. The purpose of these Serious Injuries and Warning Signs (SIWS) meetings has been to discuss the reports that the members of the sub-group wished to review in more detail following the internal scrutiny process of the serious injuries and warning signs (Section 7).

All observations made by members of IRAP across the whole of its remit, but, in particular, what the IRAP Medical Panel has been able to glean from all information including written reports, data recording and analysis, and CCTV footage, have led its members to begin to see the concept of accumulative risk factors coming into play for young people who are running into difficulties. Examples include prolonged use of

a technique (specifically the head hold), obesity and other pre-disposing health problems.

The observations made by the SIWs meetings emphasise how challenging it is in day-to-day operational practice to follow the techniques as they are taught, however rigorous and thorough the training package.

Hence, IRAP's firm recommendation which is that, because its role has now finished, an independent external panel should be constituted to continue the role of monitoring 'exception reports' involving SIWS, and that any interim arrangements that are required to retain this monitoring function should be put in place.

IRAP has now come to the end of its planned duration. Therefore, it is bringing its work to a close. It has followed the work streams agreed in the MoU in support of the implementation of MMPR in YOIs and STCs and considered the actions taken following the Government's responses to the 37 recommendations in the RAB's report.

Some of the RAB's recommendations were implemented almost immediately. Others required actions in the medium-term and several require longer-term work. IRAP believes the evidence it has examined through a substantial variety of activities and analysis indicates the following findings and recommendations.

1. There has been a significant change during IRAP's tenure in the approach to managing young people in the secure estate for people who are under 18 years old. This is not just because of changes to systems for physical restraint and its governance, but, also, it has occurred as a consequence of the changed context on which MMPR is founded. MMPR does not reflect solely a policy change or a change of operational procedures. In addition, it has involved a significant culture change, particularly in YOIs in which Control and Restraint had been in place for many years.
2. During visits made by members of IRAP, senior managers and staff have told them that MMPR will take at least three years to become fully embedded in the culture of establishments.
3. There may well be truth in the opinion that the culture change that the RAB recommended will take several years as change is a notoriously slow process in large organisations. Furthermore, MMPR had gone live and been fully implemented in only four establishments as this report was being drafted. This gives an indication of how long the full process might take. It would appear that MMPR is not to be implemented in Feltham until near the end of 2015, which will, inevitably, present further problems to the process of culture change.
4. IRAP is to have no further role in supporting the roll-out programme. However, it understands that Her Majesty's Chief Inspector of Prisons (HMCIP) has been

commissioned to carry out a review focussing on the implementation and impact of MMPR in STCs and YOIs relating to its use with children and young people who are under 18 years old.

5. Such a review will give a further opportunity to examine the work carried out by all parties to devise, implement, manage and monitor MMPR and to confirm, or otherwise, that the governance systems put in place are robust.

6. Given that the HMCIP review may take place at a time when roll-out is still not fully complete, it is IRAP's opinion that HMCIP should keep the process under regular review over a longer time scale in order to test the sustainability of MMPR.

Furthermore, given the panel's ongoing concerns about the head hold, I, as Chair of IRAP, am grateful that the YJB has afforded me the opportunity to be part of the group that is receiving interim findings from the research commissioned (on the recommendation of the RAB) by the YJB into the head hold. I urge the YJB, and IRAP recommends, that it should explore with the researcher who has been commissioned the possibility of (as is done across the field of medicine) undertaking some modeling work on how laboratory research findings can be projected out into extant circumstances in day-to-day operational practice (i.e. circumstances in which the range of cumulative risk factors that are described in Section 7 come into effect).

I wish to thank all of the IRAP members for all their hard work. Most of all, I want to thank all staff across the establishments, MMPR trainers, the YJB, and NOMS for being so cooperative with all of our requests and for the patience and forbearance they have shown at all times towards the panel in undertaking its agreed tasks

Professor Dame Sue Bailey
Chair of the Independent Restraint Advisory Panel

June 2014

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SECTION 1: INTRODUCTION

1. The Ministry of Justice (MoJ) formed the Restraint Advisory Board (RAB) in April 2010 as an ad hoc advisory body. That action following the Government's acceptance of Recommendations 17 and 18 in the report, which was published in December 2008, on the 'Independent Review of Restraint in Juvenile Secure Settings' that had been conducted by Andrew Williamson and Peter Smallridge[2].

2. The terms of reference for the RAB were confined to restraints conducted in Young Offender Institutions (YOIs) and Secure Training Centres (STCs). The MoJ set the terms of reference. In essence, they required the RAB to assess and make recommendations on a new system of restraint and new systems of governance arrangements for the new restraint system while also taking into account operational realities and constraints.

3. The decision to replace Control and Restraint (C&R) in YOIs and Physical Care in Control (PCC) in STCs had been taken prior to the MoJ establishing the RAB. The MoJ commissioned the NOMS National Tactical Response Group (NTRG), as its preferred provider, to develop a new system of restraint for use with young people resident in both types of establishments. The new system, Minimising and Managing Physical Restraint (MMPR), was designed to take a more child-centred approach and include training in behaviour management as well as physical restraint techniques. MMPR was thoroughly reviewed and assessed by the RAB, which also consulted with stakeholders and reviewed the research and evidence that was available before it completed its work.

4. In August 2011, the RAB presented its report titled 'Assessment of Minimising and Managing Physical Restraint (MMPR) for Children in the Secure Estate' to the Restraint Management Board (RMB) in the MoJ.

5. That report made 37 recommendations. They were designed to assist the responsible authorities to implement the new system and included "changes to deeply held working practices (which) can take years to overcome" (Williamson and Smallridge, 2007).

6. Publication of the RAB's report concluded the work of that body and it was dissolved. Subsequently, the MoJ formed a new group of experts. The new

[2] Smallridge A, Williamson P. Independent review of restraint in juvenile secure settings. London: Department for Education, 2007. http://webarchive.nationalarchives.gov.uk/20130401151715/https://www.education.gov.uk/publications/eOrderingDownload/Review%20of%20restraint.pdf Last accessed 18 April 2014.

group was named the Independent Restraint Advisory Panel (IRAP) and it contained several members who were members of RAB previously.

7. IRAP was established with two main purposes. They were to:

   a. Assess the quality and safety of systems of restraint commissioned for use with children in Secure Children's Homes (SCHs).

   b. Support the implementation of MMPR by YOIs and STCs.

8. A Memorandum of Understanding (MoU) was agreed between IRAP, the MoJ, the Youth Justice Board (YJB) and NOMS outlining the ways in which IRAP would work with the other parties including how it would monitor progress made on implementing the 37 recommendations made in the RAB's report.

9. The MoU asked IRAP to:

   - Monitor the implementation of the recommendations made by the Restraint Advisory Board (RAB), which Ministers had accepted on recommendation from the Restraint Management Board.
   - Continue its membership of the RMB by IRAP's Chair being a member and taking forward any actions / tasks agreed by the RMB.
   - Receive regular data and associated analysis on use of MMPR and provide advice, analysis and interpretation to the YJB, NOMS and MoJ.
   - Receive notification of any occurrences of 'serious injuries or warning signs' (SIWS) and provide advice.
   - Highlight to the MoJ, YJB and NOMS any good practice from other sectors that use physical restraint, including that gleaned from international evidence.
   - Attend MMPR training days over the roll-out period to observe and comment on delivery of the new system of restraint.

10. Members of IRAP conducted a wide range of activities to enable them to carry out IRAP's tasks. Their findings were instrumental in enabling IRAP to compile this report and to develop the recommendations that it contains.

11. IRAP's members conducted these activities in the time between IRAP's establishment in 2012 and April 2014 during the period in which training of the staff of a number of the STCs and YOIs was conducted and MMPR was implemented in several of them. The activities included IRAP's members:

   - Making visits to Rainsbrook STC, Oakhill STC, Hindley YOI and Wetherby YOI on several occasions in each case.

- Making follow-up visits to each of the establishments listed above after implementation of MMPR.
- Taking part in training on MMPR at establishments with groups of staff. Members of IRAP attended parts of courses or a full course.
- Conducting meetings during visits to the STCs and YOIs with managers, staff, national and local trainers, MMPR Coordinators, YJB monitors, healthcare staff and young people resident in the STCs and YOIs.
- Providing reports to the YJB and MoJ.
- Attending SIWS Meetings with national trainers and YJB staff to review cases that had been reported as exceptions. These meetings included IRAP's members viewing CCTV footage of incidents, and resulted in them providing reports to the YJB and MoJ.
- Receiving and reviewing data on use of MMPR in establishments in the secure estate for young people who are under 18 years old.
- Reviewing documents and data provided by the STCs and YOIs during visits to these establishments.
- Attending meetings with officials employed to work in the YJB and MoJ.
- Attending meetings of the Restraint Management Board with officials of the YJB and MoJ.
- Meeting with representatives of the YJB and MoJ to discuss the observations of officials from the YJB and MoJ on the content of the near-final version of this report in order to check and resolve matters of factual accuracy.

SECTION 2: THE MMPR ROLL-OUT PROGRAMME

12. Introduction of the system of MMPR and its accompanying manual brought the requirement to train staff in its use. The plan was to implement the new system in YOIs and STCs using a rolling programme.

13. The roll-out programme for the implementation of MMPR in YOIs and STCs is summarised in the Table 1.

TABLE 1: THE MMPR ROLL-OUT PROGRAMME

Establishment	Training start date	'Go live' date	Status (as at June 2014)
Rainsbrook STC	3 September 2012	4 March 2013	Using MMPR
Oakhill STC	25 March 2013	2 September 2013	Using MMPR
Wetherby YOI	29 April 2013	23 October 2013	Using MMPR
Hindley YOI	7 October 2013	6 January 2014	Using MMPR
Medway STC	2 December 2013	2 June 2014	Using MMPR
Hassockfield STC	16 June 2014	8 December 2014	Training
Werrington YOI	1 September 2014 (to be confirmed [tbc])	2 February 2015 (tbc)	Preparatory work
Cookham Wood YOI	February 2015 (tbc)	June 2015 (tbc)	Planning stage
Parc YOI	January 2015 (tbc)	April 2015 (tbc)	Planning stage
Feltham YOI	June 2015 (tbc)	December 2015 (tbc)	Planning stage

14. The dates for the roll-out programme and the duration of IRAP's tenure mean that IRAP is reporting now on implementation of MMPR prior to it being able to observe implementation of the system at Medway STC, Hassockfield STC, Werrington YOI, Cookham Wood YOI, Parc YOI and Feltham YOI.

15. Reviews were carried out by G4S and the YJB to identify lessons to be learned following implementation of MMPR at Rainsbrook STC and prior to its implementation at Oakhill STC, which was the next establishment on the roll-out list.

16. Senior staff at Rainsbrook STC expressed their opinion that training on, and implementation of MMPR at that establishment should have been regarded

more as a pilot site because of the fundamental nature of the change of approach that now requires integrated systems for positively managing young people's behaviour with the new format of restraint. They told IRAP of their perception that there was an expectation from the YJB that everything would be perfect from day one and that the establishment had received unnecessary criticism when the path was less smooth because staff were still on a learning curve.

17. The opinion of IRAP is that it will be some time before such a new system, which involves substantial culture as well as practical changes, becomes thoroughly embedded and the full benefits are felt. Nevertheless, the opinion of IRAP is that the exercise conducted by G4S and the YJB to learn lessons about implementation was most useful and it clearly helped towards easier implementation at Oakhill STC.

SECTION 3: TRAINING ON MMPR

18. The MMPR National Team from within NOMS has taken the lead role on implementing MMPR and delivering training to the staff to enable them to use the system. Its work has been supported by the YJB taking responsibility for logistic organisation of the courses. Initially, the MMPR National Team's cadre of trainers trained the 'in house' trainers, otherwise known as MMPR Coordinators appointed from the staff of the YOIs and STCs. The national trainers attended or are to attend each of these establishments in the roll-out programme to carry out local training for all operational staff.

19. The intention of the training programme is that all operational staff are trained in each establishment prior to all staff receiving a further day of refresher training before the MMPR system is activated in each establishment.

20. Initial training for all existing staff who had been trained previously in the C&R or PCC systems requires each person to attend a five-day up-skilling course. Prior to the MMPR system 'going live' in each establishment, every member of staff should receive a one-day refresher course.

21. The five-day courses follow a set curriculum that includes ethical issues, behaviour management, legal frameworks and medical elements from the MMPR manual with a strong emphasis on risk assessment, warning symptoms and warning signs.

22. Practical sessions on restraint techniques are also taught, building up from simple guiding holds to more complex restraint techniques and holds. Scenario settings are used and de-escalation is emphasised at all times.

23. All students sit a written test at the end of the course. Instructors give personal feedback on a one-to-one basis in order to develop individual learning plans for staff where necessary. It is for the Director or Governor of each of the establishments to decide on the competence of their staff based on recommendations from the MMPR trainers. Generally, though, any staff member who fails the training may continue to work in the secure establishments, but has to refrain from being involved in using restraint.

24. Once each establishment is using the MMPR system, regular refresher training is, or is to be delivered to staff by the MMPR Coordinators. Oversight of their work in this regard is provided by the MMPR National Team.

25. Consequently, the training programmes now comprise:

- Initial courses of seven days for all newly recruited staff.
- Up skilling courses of five days for existing staff trained in C&R or PCC.
- Refresher day courses for all staff every six months.
- Courses for coordinators of 10 days duration for staff who are identified through a selection process as being suitable to become the MMPR Coordinators who work within the establishments.

26. Approximately 1,000 staff who work in the YOIs and STCs with young people aged under 18 had been trained by the time IRAP drafted this report. As a result, PCC will have been removed from all STCs when training of staff at Medway STC and Hassockfield STC has been completed at the end of 2014.

27. The MMPR National Team has conducted reviews of practical application of MMPR at each secure establishment six months after it has gone live to consider how the implementation was carried out and to identify the impact as far as possible. The reviews include scrutinising the monthly incident reviews. As this report is being drafted, the process of review is underway at Hindley YOI and Wetherby YOI, but has concluded at Oakhill STC and Rainsbrook STC. The process had been extended at Rainsbrook STC as an extra safeguard.

28. The MMPR National Team's trainers are also involved in introducing the Serious Injury and Warning Signs (SIWS) process that is being implemented in both the STCs and YOIs. They have monthly meetings with the Independent Medical Adviser to NOMS to review all incidents in which young people are recorded as showing SIWS.

29. In accordance with one of the work streams specifically mentioned in the MoU, several members of IRAP have attended training sessions at Oakhill STC, Wetherby YOI and Hindley YOI. Additionally, one member, who had been trained in C&R previously, participated in the full five-day up-skilling course. Members have also attended refresher courses and / or follow-up visits at Rainsbrook STC, Oakhill STC, Wetherby YOI, and Hindley YOI.

30. A number of other interested parties visited either Oakhill STC or Wetherby YOI during the early training sessions to observe them. They included representatives of the Howard League, the Prison Reform Trust, the Children's Rights Alliance for England (CRAE), officials and a non Executive Director from the YJB, and representatives of Her Majesty's Chief Inspector of Prisons.

SECTION 4: IRAP VISITS PRIOR TO IMPLEMENTATION OF MMPR

31. Paragraph 11 in Section 1 of this report lists the STCs and YOIs that members of IRAP visited.

32. A number of members of IRAP undertook visits to STCs and / or YOIs to observe or take part in some or all of a training session as a part of the roll-out programme prior to implementation of MMPR in the STCs or YOIs they visited.

33. IRAP members noted that the quality of training was very high with a heavy weighting on a child-centred approach and evident professionalism.

34. They noted that emphasis was given to the theoretical aspects of ethics, behaviour management, medical warning signs and report writing over two days of classroom work using presentations, exercises, visual aids, written and verbal exercises, and group work.

35. Frequently, the trainers were observed to make use of the MMPR workbook that contains a great deal of information. All participants were issued with their own personal copies to use during the course and to keep for future reference.

36. Regularly, the trainers stressed and reinforced observation, communication and interaction with the young people who are involved in incidents in which physical restraint is used, which, in IRAP's opinion, is vital during all forms of intervention.

37. Members of IRAP noted that the trainers dealt immediately with any negativity on the part of participants, which was rare. Occasionally, some of the more experienced staff who were used to other restraint techniques expressed scepticism, but, generally, they acknowledged, by the end of the training, that their doubts had been misplaced. IRAP hopes that the positive impression of MMPR developed by experienced staff will have a positive impact on new staff who seek guidance from their more experienced peers.

38. MMPR trainers systematically built up the range of physical techniques through:

    - Demonstration and then practice in groups.
    - Teaching everybody to the same level taking account of different learning styles and experiences.

- Emphasising that judgement about what to do is the responsibility of whoever is present at the incident.
- Showing that there is a sliding scale of response to need.
- Emphasising that de-escalation should always be the aim.
- Highlighting the importance of debriefs of staff and the young persons after every incident.

39. Trainers also emphasised the:
    - Matrix of harm.
    - Best interests of the young person.
    - Legal and ethical framework of physical restraint.
    - Need for detailed reporting.

40. Pain induction techniques were explicitly taught as part of the curriculum in the MMPR handbook and in the context of the sliding scale of restraint techniques related to need. The IRAP members noted that the trainers emphasised strongly that use of pain must be at the extreme end of the spectrum of intervention. However, specific circumstances that indicate the requirement for those techniques were not taught during at least one course that IRAP's members visited. IRAP's opinion is that the MMPR National Team should review this aspect of the training provided for staff.

SECTION 5: IRAP VISITS FOLLOWING IMPLEMENTATION OF MMPR

41. Paragraph 11 in Section 1 of this report lists the STCs and YOIs that members of IRAP visited. This Section reports on follow-up visits made by IRAP to Rainsbrook STC, Wetherby YOI, Oakhill STC and Hindley YOI.

The Follow-up Visit to Rainsbrook STC

42. A member of IRAP made a follow-up visit to Rainsbrook STC almost a year after implementation of MMPR. The agenda included meeting with senior managers, young people, operational staff, healthcare staff and MMPR Coordinators. This visit coincided with a visit made by the sub-group of members of IRAP (the IRAP Medical Panel) that focussed on SIWS.

43. It was clear to the member of IRAP who conducted this follow-up visit that there had been initial problems with implementing MMPR for a number of reasons and that some of them were continuing. That member's opinion was that some of the problems might continue for some time, albeit on a reducing scale. The paragraphs that follow provide examples of these problems.

44. Senior managers at Rainsbrook STC told the IRAP member that there was a high turnover of staff. As a consequence, many staff were young and inexperienced and, as a result, lacked confidence. Second, the senior managers reported their perceptions that there had been an increase in the use of restraint and injuries to young people's heads.

45. The managers expressed the view that the increase in number of restraints might have happened because the training had a strong emphasis on the legal implications of restraining young people, which, in some cases, had led to confusion as to when staff could or should intervene. The possible explanation given by the managers of this establishment to the IRAP member who was visiting was that this uncertainty had resulted in delays that had contributed to situations escalating leading, thereby, to higher levels of intervention and a greater risk of injury to the young people and / or staff who were involved.

46. Senior managers at Rainsbrook STC told IRAP that, in their opinion, lessons from the experiences of staff at Rainsbrook had been learned and changes of approach made when implementation at Oakhill STC took place.

47. During the visit, the group of young people told the member of IRAP that, in general, staff tried to calm situations down before resorting to restraint.

48. None of these young people had been restrained by staff using MMPR techniques, but they had seen them being used.

49. All of the young people who spoke to the visitor from IRAP were aware of the complaints procedure, the role of the on-site YJB monitor and the Barnardo's independent advocate. Also, IRAP's member found that there was a restorative justice model in place that was used as a part of the debriefing process after incidents involving intervention.

50. Operational staff said that the MMPR training had provided them with sufficient information, particularly as it included behaviour management as well as restraint techniques.

51. Operational staff expressed their concern to the member of IRAP that CCTV footage used during debriefs could work against them in the sense that it did not include audio coverage. Therefore, situations that involved threats or aggressive comments made by young people that might provide additional justification for intervention could not be heard. Similarly, the verbal efforts of staff to de-escalate situations were not recorded.

52. The healthcare staff told the IRAP member that they were always notified of planned interventions and that paperwork and the quality of reporting had improved.

53. Only the manager of the healthcare staff had received MMPR training. The IRAP member suggested that all nurses should be offered training in order that they would become familiar with the holds, warning signs and the potential for emergency situations.

54. The MMPR Coordinators group includes staff from Rainsbrook and Oakhill STCs. All MMPR Coordinators said that the new system of supervision by national tutors was better than the previous arrangement as they saw local tutors in action rather than solely in national training settings.

55. MMPR Coordinators are closely involved in the quality assurance procedures at a local level. However, they told IRAP's member that the role of coordinator had been added to the existing workload of those staff who are employed to work in the STCs whereas coordinators in YOIs were appointed in a full time capacity.

The Follow-up Visit to Wetherby YOI

56. A member of IRAP visited Wetherby YOI nearly six months after implementation of MMPR there. The format of the visit was similar to that undertaken at Rainsbrook STC. The agenda included meetings with senior managers, including the Governor, young people, operational staff, MMPR Coordinators and the YJB monitor who was also visiting on the day.

57. The senior managers explained the governance arrangements which were comprehensive and involved external agencies such as Barnardo's and Local Authority representatives. The member of IRAP was told that child protection and safeguarding meetings, minimising harm meetings and monthly steering group meetings were all being held regularly. Additionally, the YJB monitor visits every six weeks or so.

58. The managers said that implementation had not been without its problems. In their opinions, some staff were "frightened" to use MMPR techniques because they were new and offer more levels of intervention and, as a result, they were still unsure about what level to use. Some staff also thought that they had to go through the whole spectrum of levels before reaching the most appropriate holds. Nevertheless, in their opinions and despite it still being new, staff were increasing in confidence as they became more familiar with MMPR.

59. The managers expressed their view that the MMPR training was more child focussed by including behaviour management and de-escalation. They noted that there had been more emphasis on supervision of restraint during the refresher training because the MMPR approach is different to that of C&R supervision.

60. The group of young people were very negative about the use of restraint in general although their own exposure to it was limited. Some had experienced restraint in other establishments, including Secure Children's Homes. Their general view was that if staff "grabbed you" it just made them angrier and they became more violent. They were all aware of the avenues of complaint but they had little confidence in them, saying, "nothing happens". Overall, this meeting was rather dispiriting for the IRAP member.

61. Some of the operational staff group said that, after years of using C&R, they were not confident in following the training on MMPR. They said that MMPR was less effective and regretted that some C&R techniques had "been taken from them", including the option of taking young people to a prone position during restraint. A member of IRAP has noted from reading an incident report form that staff made a young person, who had been removed from his cell

where there was a small fire, lie on the floor while they dealt with the fire. The MMPR Coordinators had highlighted this and queried the need with the staff involved before advising that this course of action had not been necessary.

62. The operational staff group said that some parts of the MMPR course could have been added to the C&R syllabus to improve it rather than introducing the new restraint system. Apparently, some young people were telling staff that they are not allowed to use this or that technique anymore.

63. Some members of the operational staff group said that the lower levels of MMPR would actually aggravate situations e.g. guiding holds.

64. All in the operational staff group said that they were supported by the MMPR Coordinators and were given helpful feedback after they had been involved in incidents.

65. The MMPR Coordinators said that they were now in the process of delivering the second round of six-monthly refresher training for staff.

66. They said that the workload attached to the role of MMPR Coordinator, particularly that relating to attending to documentation, was more than they had anticipated, but that it was enjoyable work. Coordinators said that they reviewed all incidents, gave feedback to staff, ensured that young people were involved in debriefs and made recommendations and analysis to line managers and senior staff.

67. The MMPR Coordinators told IRAP's visiting member that the training model whereby the national trainers visited to assess coordinators on site was seen as a better model than the C&R training model.

68. The MMPR Coordinators expressed the view that they had sufficient support from senior staff at Wetherby and that the Governor and other senior staff had led by example because they had been fully trained in MMPR.

69. The healthcare staff group told the member of IRAP that incidents in which force was used did not seem to have increased since the implementation of MMPR and that there were less serious injuries. The ones they had seen were mainly grazes and bruising.

70. There is 24 hour nursing cover at Wetherby. Nurses attend all incidents in response to a radio call and they attend all pre-planned incidents. When attending incidents, they carry a grab bag containing emergency equipment such as defibrillators and oxygen and emergency drugs.

71. The nurses give medical advice during incidents, but their opinion was that they are giving less advice during MMPR than they did during C&R because there is less need.

72. No members of the healthcare staff group had been trained in MMPR, but they accepted the suggestion made by the member of IRAP that the experience would give them a greater understanding of the techniques involved together with their potential to cause injuries.

The Follow-up Visit to Oakhill STC

73. The visit to Oakhill STC was not a full follow-up visit. Due to the short notice, Oakhill STC was unable to provide the opportunity for discussion with some groups / representatives.

74. The IRAP member met with:

- The Director
- The Head of Operations
- The Head of Care
- The Safeguarding Manager
- The Head of Healthcare (a Registered Children's Nurse)
- The YJB monitor
- Two MMPR Coordinators

75. The member of IRAP was provided with minutes from the recent weekly and monthly management meetings that focus on MMPR and the use of restraint as well as some data in relation to restraints and exception reports.

76. Oakhill STC appeared to the member of IRAP to have in place robust quality assurance (QA) systems. Managers and MMPR Coordinators review all incidents in which restraint is used. There are weekly meetings to review CCTV footage of all incidents, note actions that are seen as required and to follow-up on these actions. A monthly strategy meeting is held at that STC to review all matters pertaining to restraint including any exception reports. The weekly meetings are open to attendance by the Local Authority Designated Officer (LADO) and the advocacy service provided by Barnardo's.

77. A number of databases of incidents are kept by: the MMPR Coordinators; the head of care; the head of safeguarding; and the healthcare team. An information officer has access to all of them to collate data. All managers said

they were confident that they are able to identify any trends or patterns that may emerge.

78. All the managers with whom the member of IRAP spoke were positive about the implementation of MMPR. This applied particularly to the inclusion of behaviour management as part of the restraint training. While the induction programme for new staff had always included a degree of training in behaviour management, it had been separate from training on restraint. Managers said that relating the two enabled staff to make the links, " … it really helps them to get it". There was a view expressed that the confidence staff had developed in restraint had impacted positively on their general dealings with the children.

79. The staff of Oakhill STC endeavour to involve children in in developing and improving their practice. This is achieved by the staff using a debriefing process that takes a restorative approach through which children have opportunities to express their views and feelings and have them taken into account by the staff. These views are not collected or collated in any way. Two children are also invited to the monthly review and monitoring meetings at which they are given opportunities to ask or answer questions about restraint.

80. The MMPR Coordinators said their opinion was that the transition to MMPR had been relatively smooth for Oakhill STC because the pre-existing QA and recording systems were already akin to those needed for MMPR and they had the advantage of learning from the experience of staff at Rainsbrook STC. They expressed the view that MMPR provides a higher standard of training and that the manuals are tools that they use on a day-to-day basis.

81. The MMPR Coordinators (who are also operations managers) described the measures they take to feedback to senior managers and line managers any concerns they have about incidents in which restraint is used and how records are kept to ensure that remedial action is taken. These measures are monitored through the weekly meetings to ensure that any actions are followed-up and reviewed.

82. There is no formal feedback pathway from this establishment to the MMPR National Team. Rather, formal notification of incidents is conducted by reporting to the YJB. However, the MMPR Coordinators told the member of IRAP that they had a high level of support from the MMPR National Team's trainers and that they are able to contact the national trainers on an ad hoc basis for information and advice.

83. The head of safeguarding in the STC did not think that there had been a major impact from the transition to MMPR. She described a period in which the number of allegations had risen, but her view was that they were not related to

implementing MMPR. She believed that they been the result of a particular group of children who were resident at the time. She told the member of IRAP that she had put in place specific staff training to address the issue.

84. Her observation was that there was not a high level of staff anxiety about the new system of restraint, and that staff use the new holds confidently. She also said that she believed that, because staff had more confidence in the techniques, they were also more confident in using diversion and de-escalation measures.

85. She described the complaints system in place. All complaints that relate to restraint are passed to the safeguarding staff and there is an initial discussion with the LADO. If a complaint contains an allegation, the YJB monitor is also notified. Initial follow-up is conducted by the relevant case worker unless there is deemed to be an allegation or a child protection issue. Young people can ask for an advocate to support them, but this is not routinely offered.

86. The head of safeguarding told the IRAP member that the safeguarding database is designed to flag up complaints related to restraint, and notifications of them are also sent to each relevant child's youth offending team (YOT) worker and parents / carers. She said that her perception is that the complaints related to restraint that also included an allegation were, on the whole, made after a head hold had been used.

87. The data seen by the member of IRAP indicated that there had been three exception reports since January 2014. In all three, the warning sign was petechial rash that had developed after a head hold had been used and the duration of the restraint had been for more than 5 minutes.

88. The manager of the safeguarding section at Oakhill STC maintains a spreadsheet logging the names of all of the staff who are involved in each incident in which restraint is used and any concerns about their practice or attitudes related to restraint. The safeguarding manager told the IRAP member that she is confident that this enables her to detect any trends or patterns of behaviour.

89. The YJB monitor also noted that the transition to MMPR had been a smooth one. She said that she believed that staff are more confident in applying holds and using techniques. She said that the use of force (see the Observations below) is now kept to a minimum and staff apply quickly the proper technique after the start of an incident in which restraint is used. Her view is that, previously, staff would just "hold on" in whatever way they had first taken hold of a child.

90. The monitor's opinion was that the impact has been more about the new systems of scrutiny, monitoring and quality assurance than the change in actual restraint techniques.

91. The monitor said that the head hold is only used in particularly violent incidents or to prevent spitting.

92. The healthcare section of the staff provides 24-hour cover by using the nursing team. The head of healthcare was a registered children's nurse and the team included a learning disability and mental health nurse, and general nurses. There is a weekly GP clinic and psychiatric services from St Andrew's Hospital. All children are seen within 30 minutes of an incident in which restraint is used and members of the healthcare team are involved in debriefs. The GP sees the child within 24 hours if an exception report is created because warning signs have been observed.

93. The head of healthcare had attended the MMPR training and was encouraging the other healthcare staff to attend. The healthcare team does not have any direct involvement with the MMPR Coordinators in relation to training,

94. In her opinion, MMPR has increased the knowledge and confidence of staff. She told the IRAP member that she believed that there is a clear understanding among the staff that a child saying that he or she can't breathe must be treated as a warning sign.

95. The member of IRAP was told that the healthcare staff and MMPR Coordinators work together to scrutinize events after each incident in which restraint has been used. Staff of the healthcare team always inform the coordinators of any health issues that can impact on using restraint with particular children. While the MMPR Coordinators decide on whether or not certain holds should be used, both parties sign off the care plan. The healthcare lead said that she was confident that they could 'veto' a hold if necessary, but that this circumstance had never arisen.

Observations and Comments on this Visit

96. The recording form for incidents in which restraint is used is called 'Use of Force'. It categorises separately both use of force and MMPR. In response to a question about this, the IRAP member was told that the term 'use of force' was used to enable recording of any 'hands on' actions used before a MMPR hold could be applied. While this is understandable, because there is almost always a period at the beginning of any incident in which staff are in the process of getting hold, this approach has the potential to skew data collation. It was

unclear to IRAP whether or not other establishments also use a similar dual categorisation.

97. Staff of the healthcare team are involved in the weekly and monthly monitoring and review meetings and use their database to check for patterns and trends. The healthcare lead expressed her view about three exception reports that petechial rash (haemorrhages) can be caused by individual factors and was not necessarily linked to the head hold and duration of the restraint. She did not think that there had been enough of these incidents at Oakhill to cause her alarm.

98. IRAP recommends that this data is looked at across the establishments because the frequency of this combination may not be sufficient to trigger concern in a single unit, but could or should do if this pattern were repeated across the estate. It anticipates that this is taking place. In Section 7, IRAP recommends that an independent external medical panel is constituted to continue the role of monitoring 'exception reports' involving SIWS (paragraphs 147-149). Therefore, IRAP recommends that that body should review the aggregated data related to petechial rashes (haemorrhages) reported through the SIWS system. In addition, it recommends that the conclusions from the analysis of the aggregated data are reviewed by HMCIP when that organisation conducts the review that is detailed in Section 8 (paragraphs 155-157).

99. It is IRAP's opinion that the head hold is a high-risk technique. As a consequence, IRAP remains concerned if it is being used to prevent spitting in situations in which the degree of problematic behaviour would not otherwise necessitate it.

Observation of MMPR Refresher Training at Hindley YOI

100. A member of IRAP visited Hindley YOI in April 2014. This person observed refresher training on MMPR that was being undertaken by six front line staff for first time. The session was conducted by two 'in house' MMPR Coordinators, supported by two members of the MMPR National Team of trainers. The IRAP member was told that this support was offered because the coordinators had not yet run an initial training session. The session was videoed for use as a learning tool by the MMPR National Team.

101. The day was a mixture of questions and dialogue, demonstrations from instructors, and scenarios, with the opportunity for reflection after each activity. The national MMPR instructors said that the scenarios had been developed in conjunction with managers at Hindley to reflect local issues and incidents that they thought were likely to occur in the establishment.

102. Both the morning and afternoon session commenced with a warm up exercise. This appeared appropriate in that it was short, tactile and fun and got participants to interact.

103. The instructors (both from the National Team and 'in house') were enthusiastic and, on the whole, confident in their presentation. Prompts or interventions by members of the National Team with the 'in house' coordinators, were made discreetly and sensitively so as not to undermine their authority.

104. The balance between activities (questions, flip chart work, scenarios and reflection) was good given the large amount of material covered, and there were sufficient breaks to prevent staleness in the participants.

105. The participants appeared to the member of IRAP to be relaxed and engaged. This observer noted a number of occasions when participants asked for clarification, and some in which they acknowledged difficulties in becoming adept in certain techniques.

106. The scenarios were as realistic as possible, in that participants were given only basic information and the members of the National Team took the part of children and, as much as was safely possible, struggled against the holds imposed.

107. In the view of the IRAP member, the demonstration of techniques and scenarios gave a good focus on de-escalating holds as soon as safely possible and not just maintaining a hold because it was the first one applied.

108. Furthermore, the observer's opinion was that the behaviour management learning was reinforced in all the scenarios.

Observations and Comments on this Visit

109. The opinion of IRAP's visitor is that the trainers should consider whether it would be useful to do some random selection of participants in question and answers sessions rather than only ask questions of the group as a whole. This could assist them in identifying staff who may need extra input.

110. Based on observations, the IRAP member was concerned about the potential to misapply the head hold, and, in particular, about how easy it is to pull a young person's head forward rather than merely guide it while he or she is being restrained. This could result in the restrained person's head being held too low and that might, in turn, risk compressing his or her chest area and / or raise the risk of staff misapplying the trigger hold to the neck rather than to the

chin. This hold was used in a number of the scenarios and the visitor observed these events during this training course. The trainers did correct participants when they applied the hold incorrectly, but the opinion of the IRAP member was that more emphasis should have been placed on the high risk associated with this technique.

111. During this course, the change from an incident in which restraint is used to a medical emergency was the subject of a scenario as well as questions about warning signs. The technique demonstrated and used in the scenario was that of moving the subject from a floor restraint (either supine or prone) into the recovery position while maintaining a hold. This took about 5 to 7 seconds, and the participants were then told that this was the point at which they should assess and make a decision as to whether to release the holds. The observer noted that the trainers did address the option of 'letting go' as a first option but only when prompted, and the emphasis was on the recovery position being "a very safe position to assess".

112. The 'in house' coordinators raised the issue of staff from other prisons, who had not been trained on MMPR, being used in the YOI's. They cited not only staff from the young adult facility in the Hindley YOI, but also prison officers from nearby adult prisons, such as that in Liverpool, being drafted in when necessary. They acknowledged that this had happened recently as a result of staff shortages (34 staff down) but, presumably, this must also be an issue for other YOIs too. IRAP recommends that NOMS should address this issue and that Her Majesty's Chief Inspector of Prisons (HMCIP) should monitor this matter and NOMS findings.

113. The IRAP member had the opportunity for a short discussion with one of the 'in house' MMPR Coordinators about the practice used in monitoring and reviewing incidents in which restraint had been used. He told the IRAP member that they review all incidents in which restraint occurs and attend the weekly review meeting with senior managers. They have set up an Excel spreadsheet system that allows them to log and flag all members of staff who are involved in restraint and, therefore, to look at trends and patterns.

114. Any concerns about use of restraint are initially addressed by the MMPR Coordinators with the members of staff concerned and the coordinators provide advice and extra training if that is required. The MMPR Coordinator told the member of IRAP that, if there is a greater degree of concern and the coordinators feel that they have been unable to improve the practice of particular staff members, they refer the matter to the safeguarding team, which takes any further action that is deemed necessary.

SECTION 6: GOVERNANCE

115. The RAB's opinion was that, prior to the introduction of MMPR in YOIs and STCs, the systems for data collection and the data collected about use of force were inadequate and not conducive to effective monitoring and analysis. Therefore, RAB's opinion was that the data and those systems did not provide the support for good governance at local or national levels.

116. IRAP's opinion is that good systems of governance, through which accurate and pertinent information is reported, are vital to effective decision-making on a raft of matters that include behaviour management plans and activities, population management and staff training.

117. IRAP agrees that the data collected prior to implementation of MMPR were insufficient and inconsistent in most cases, and the system did not form the basis for an effective database. As a result, detailed analysis was not possible.

118. Recommendations 20 and 21 in the RAB's report call for significant changes to the incident management system to be introduced. Its documentation should be linked to central collection of data with mechanisms being developed to facilitate analysis of the data and changes at local and national levels based on the analyses.

119. The Government accepted these recommendations and wholesale improvements have been implemented. A new 'Use of Force' form has been devised and is in use. It must be completed for every incident in which force is used and requires much more detail than its predecessor. It is a nine page document which sounds rather cumbersome and bureaucratic but is, in fact, a reasonably user-friendly form that provides a great deal of information about each incident. That includes: details of the young person; the staff involved; the build up to the incident; the type of force used; the specific techniques used; the duration of the incident; any warning signs observed; and any injuries that may have occurred.

120. IRAP appreciates that the form is still subject to further review as a part of the roll-out of MMPR. However, IRAP has noticed several aspects of the form that it recommends are improved. First, Part 1B is the section that is used to record serious injuries. However, that part comes after the place on the form at which a senior manager signs it off. Second, IRAP found no place on the form at which to record: the name of the person who completed it; when; or how the information came to light. Consequently, IRAP recommends that this part of the form is reviewed with some urgency.

121. IRAP was pleased to note the involvement of the young people in developing and improving practice in the use of MMPR. Young people are given the opportunity, and should be encouraged, to take part in the debrief that must follow every incident. Ideally, an external advocate should represent the young person, if they wish, as some young people may be intimidated by the process or are unable to articulate their feelings without assistance.

122. Young people who are resident in STCs may also complain to the YJB monitor on-site about their treatment and, if so, their complaints are investigated.

123. A recent improvement in the complaints procedure now permits a young person who is resident in an STC to complain to the Prisons and Probation Ombudsman if they are dissatisfied with the internal responses. The option to complain to the Prisons and Probation Ombudsman has been available for some years to young people in YOIs.

124. Local quality assurance and scrutiny procedures are in place in line with the YJB's guidelines. At Rainsbrook STC, for example, weekly 'Use of Force' meetings review all incidents during the past week, including the documentation, CCTV footage, if available, and they consider any learning points that arise from incidents.

125. Monthly review meetings are also held and include the YJB's on-site monitor, members of the YJB's project team and members of MMPR National Team as well as local managers. The purposes of the monthly review meetings are to: provide further local quality assurance; identify trends; identify training needs; identify changes to techniques that are required; and consider any other relevant matters.

126. Completed 'Use of Force' forms are forwarded to the YJB and NOMS to be logged onto the new MMPR database to provide data to support further analysis and quality assurance activities. Additional information is sought from the secure establishments if that is required.

127. Monthly reports from the database are reviewed by the YJB and NOMS and quarterly reports have been received by IRAP. These quarterly reports are also loaded onto the Ministry of Justice website and are, therefore, available for public scrutiny.

128. This report was drafted towards the end of the first quarter of 2014. At that time, members of IRAP were told that the new database that was being used following implementation of MMPR was rather limited in scope due to the progress that had been made by then with rolling-out the training and implementation of the new system (see Table 1 on page 12 of this report).

However, it is likely that a much more comprehensive range of information will be available in due course that can be used for comparative purposes, policy decision-making and research.

129. A document outlining and explaining the Quality Management Framework for MMPR (MMPR QMF) was drafted by the YJB in early 2014. IRAP's opinion is that implementation of its contents will add to the overall governance of MMPR in the longer-term. The MMPR QMF is a holistic approach to all aspects of the work of the MMPR National Team, providing a comprehensive framework of processes and policies. The framework is needs-based, mandatory for all team members and clearly defines the roles and responsibilities of all parties.

130. The MMPR QMF will be particularly beneficial when new staff join and should lead to continuous improvement of all aspects of the MMPR National Team's work. It is likely to be of benefit to everyone who is concerned with achieving a consistent approach to the governance of the MMPR system. Consistency of approach is likely to be beneficial to the YJB, NTRG, YOIs and STCs by the QMF acting as a reference document on policy. IRAP understands that the intention of the YJB is to review the framework document on a quarterly basis.

131. The RAB recommended that a specially recruited and dedicated team within NOMS should carry out training of staff of the STCs and YOIs in MMPR. The purpose of this recommendation was to ensure not only consistency of skills development, but also to establish a learning and feedback loop that would remain throughout use of MMPR.

132. As IRAP concludes its work, it understands that consideration is being given to disbanding the current MMPR National Training Team within the next two years. IRAP's opinion is that this plan is a matter of concern. While any team is likely to and, arguably, should experience changes of personnel, IRAP is concerned that disbandment of the MMPR National Training Team could compromise the learning and development that it sees as essential to ensure that MMPR remains a safe and effective system.

SECTION 7: SERIOUS INJURIES AND WARNING SIGNS

133. Any completed 'Use of Force' forms that report serious injuries or warning signs (SIWS) generate 'exception reports'. In turn, this action triggers a process of investigation / review that is undertaken by: the staff who are responsible for internal quality assurance at each establishment; the YJB; the MMPR National Team of trainers and their independent medical adviser; and, until IRAP's dissolution, medical experts from IRAP. The development of 'exception reports' and the review process summarised here has been and remains a significant feature of the roll-out programme.

134. An IRAP sub-panel consisting of medical experts (the IRAP Medical Panel) met regularly with representatives of MoJ, the MMPR National Training Team, and the local YJB monitor at a number of venues since the process started. These are the 'SIWS Meetings' that are referred to in this section and elsewhere in this report. The intention for them has been to discuss the reports that the members of the meetings wished to review in more detail following the internal scrutiny process.

135. The sub-panel has reviewed all relevant information including 'Use of Force' reports, internal review documents and CCTV footage of the selected incidents. Key issues have been identified and recommendations have been made to the YJB and MoJ following these review meetings. Subsequently, the YJB and MoJ drew up an action plan to deal with each recommendation made.

136. In IRAP's opinion, these meetings and the actions that they have generated have been a successful part of the exception reporting review process. IRAP's opinion is that this process has been and is essential in the continuing monitoring of MMPR in order to provide further safeguarding of the interests of young people who are subject to physical restraint.

137. Already, IRAP is able to recognise patterns that are developing in the 'exception reports' relating to using the MMPR techniques in operational settings. Already, some modifications have been made. A problem was recognised, for example, with using the head support technique with young people who have asthma. This has resulted in the development of posters, increased awareness among the healthcare staff at Rainsbrook STC, and improved recognition of the need to optimise asthma control.

138. A wide spectrum of practices has been seen using the CCTV footage. Some staff have clearly followed the training they have received with regard to use of de-escalation prior to the implementation of low level techniques. On other occasions, what appeared to be relatively minor incidents escalated to major

restraint scenarios that, perhaps, could have been dealt with very differently. In this regard, IRAP recognises that, without the benefit of audio in addition to the video, the observations and analysis are based on incomplete evidence. IRAP's experts have also seen unauthorised techniques being used, but they have noted that, when this has occurred, appropriate responses have been taken that have ranged from further training to, in the more flagrant cases, disciplinary action being taken.

139. As this report recognises, although viewing the CCTV footage is useful, it has limitations. The first is a lack of an audio track and a second is the position of the cameras that means that it has been rare to see an incident from beginning to end. Many incidents that have generated 'exception reports' also appeared to have occurred within the young people's bedrooms and CCTV does not cover them.

140. IRAP has noted that, when the techniques are being used within an operational setting, its members have begun to see the concept of accumulative risk factors coming into play for young people who are running into difficulties. Examples include prolonged use of a technique (specifically head control), obesity, and other predisposing health issues. This is a matter that should be taken into account by modifying the MMPR training.

141. IRAP's opinion is that the 'SIWS Meetings' have been an essential element of reviewing the implementation of MMPR and particularly so in relation to its practical application and physical impact on young people. Several themes have become apparent from the SIWS 'exception reports'.

- The young person's head was found to have been held in the instances of all of the 'exception reports' reviewed.
- Video footage of one incident, showed that staff applied the head hold either before or at the same time as the arm holds and the 'SIWS Meetings' did not see a graduated response in which the subject's arms were held and then the head hold applied, as necessary, to offer the support that was thought to be necessary.
- In nearly all cases, the physical restraint holds were left applied long after the young person had stopped struggling, and the 'SIWS Meetings' did not see a de-escalation of holds that matched the young person's behaviour.
- It should be noted that the YJB / MoJ reviewed the findings from the 'SIWS Meeting' at Rainsbrook STC and provided a response plan. Most of that plan involved the MMPR National Training Team in making recommendations to establishments. However, that plan did not include any action to ensure that the recommendations are carried out.

142. Most importantly, the SIWS Meetings observed several cases of petechial bruising. This sign is an indication of vascular compromise. It would appear that the vascular compromise is occurring during the application of the head hold. Several RAB members and current IRAP members did and still do hold strong reservations about the head hold technique in the MMPR system. In its report[3], the RAB established the principle that all physical restraint techniques should possess inherently room for error in application. Little to no vascular compromise would be expected when the MMPR head hold is applied in a static classroom / laboratory situation. However, IRAP's opinion is that when the head hold technique is applied in operational contexts where young people struggle, and there are size differentials between staff applying the head hold and the young person, the presence of the petechial bruising suggests that vascular compromise is occurring. Thus, there appears to IRAP to be evidence emerging to support the RAB's previous concerns.

143. Although the significance of petechial haemorrhages is now being brought into question in regards to clinical significance, IRAP's experts are of the view that this clinical sign cannot and should not be ignored given its longstanding significance within the exception reporting process as well as the way in which it is viewed in child protection proceedings.

144. When the SIWS Meetings reviewed the 'exception reports', there appeared to be a common theme of staff receiving debriefing but not the young people. The failure of young people to receive debriefing should be reviewed.

145. On reviewing the 'exception reports', there appeared to be one example of a form being amended after initial completion. While this is but one example, it suggested to IRAP that managers should ensure that further examples do not occur. Also, IRAP has noted that there were significant mismatches between different types of documents with early warning signs being recorded on some and not others. Some of this may be due to the delays between the incidents occurring, the clinical signs developing, and young people being seen by members of the healthcare staff.

146. When reviewing the 'exception reports', it was often difficult to follow the time line of events, from what was written as it happened and what was recorded after a period of investigation, this situation requires attention to aid the staff who audit the events to seek clarity as to who did what, where and when.

147. Since IRAP was dissolved, the medical experts from the panel no longer have any involvement in the process of 'SIWS Meetings'. Therefore, IRAP

[3] Restraint Advisory Board. Assessment of Minimising and Managing Physical Restraint. National Offender Management Service. London 2011. Section 2.28.2

recommends that an independent external medical panel is constituted to continue the role of monitoring 'exception reports' involving SIWS.

148. Such a panel would add to the quality and depth of governance of MMPR by providing an additional layer of transparency in monitoring the use of force and advising on medical matters that arise from the use of MMPR and its continuing evolution. IRAP makes a specific recommendation for the work of this panel with regard to reviewing aggregated data on petechial haemorrhages in Section 5 (paragraph 98).

149. IRAP recommends that interim arrangements should be made while the recommendation in paragraph 147 in this report is considered so that there is no period of time when the quality assurance mechanism for use of force in the STCs and YOIs is without an independent external medical panel.

SECTION 8: NEXT STEPS

150. IRAP has completed its planned duration. Therefore, it is bringing its work to a close. It has followed the work streams agreed in the MoU in support of the implementation of MMPR in YOIs and STCs and considered the actions taken following the Government's responses to the 37 recommendations of the RAB report.

151. Some of the RAB's recommendations were implemented almost immediately. Others required actions in the medium-term and several require longer-term work.

152. There has been a significant change during IRAP's tenure in the approach to managing young people in the secure estate for people who are under 18 years old. This is not just because of changes to systems for physical restraint and its governance, but, also, has occurred as a consequence of the changed context on which MMPR is founded. MMPR does not reflect solely a policy change or a change of operational procedures. In addition, it has involved a significant culture change, particularly in YOIs in which C&R had been in place for many years.

153. During visits made by members of IRAP, some senior managers and staff of the STCs and YOIs have told them that their opinions are that MMPR will take at least three years to become fully embedded in the culture of establishments.

154. There may well be some truth in the opinion that the culture change that the RAB recommended will take several years as change is a notoriously slow process in large organisations. Furthermore, MMPR had gone live and been fully implemented in only four establishments as this report was being drafted. This gives an indication of how long the full process might take. It would appear that MMPR is not to be implemented in Feltham until near the end of 2015, which will, inevitably, present further problems to the process of culture change.

155. IRAP is to have no further role in supporting the roll-out programme. However, it understands that HMCIP has been commissioned to carry out a review that focuses on the implementation and impact of MMPR in STCs and YOIs relating to its use with children and young people who are under 18 years old.

156. Such a review will give a further opportunity to examine the work carried out by all parties to devise, implement, manage and monitor MMPR and to confirm, or otherwise, that the governance systems put in place are robust. IRAP makes a particular recommendation for that review in paragraph 98.

157. Given that the HMCIP review may take place at a time when roll-out is still not fully complete, it is IRAP's opinion that HMCIP should keep the process under regular review over a longer time scale in order to test the sustainability of MMPR.

SECTION 9: SUMMARY OF RECOMMENDATIONS AND MATTERS FOR FURTHER CONSIDERATION BY THE MINISTRY OF JUSTICE, THE YOUTH JUSTICE BOARD, THE MMPR NATIONAL TEAM AND HER MAJESTY'S CHIEF INSPECTOR OF PRISONS

Introduction

158. This report contains recommendations in many of the sections in it. In particular, Section 8 on Next Steps as well as the Chairs' Foreword draws attention to a number of those recommendations but not to all of them. Consequently, this Section brings together not only the recommendations from the report, in Table 2, but also, in Table 3, the matters to which this report draws attention because IRAP believes that further work is or may be required to attend to them. Therefore, the Chair's Foreword, Section 8 and this Section should be considered together as providing a summary of key matters that arise in this report.

159. The summaries of recommendations in Table 2 and the matters for further consideration listed in Table 3 are quotes from the text in this report. The right hand columns provide the location in the report of each quote. If the same, or very similar text is used in several places in this report, the table contains the quote from the first paragraph in which it occurs and the right hand columns show all of the locations at which the same or very similar wording is to be found.

160. IRAP has included this section and the tables in it to assist readers to draw together IRAP's commentary on similar themes from across this report. However, IRAP stresses that reading this section should not replace readers going through the report in detail to identify the full set of recommendations made by IRAP and its concerns.

Recommendations

161. The first of two tables in this section draws together the recommendations made by IRAP in the body of this report. IRAP presents them as particular foci for the authorities' further work in order to continue to improve MMPR, its roll-out and the governance arrangements that surround use and monitoring of MMPR.

TABLE 2: SUMMARY OF RECOMMENDATIONS				
Item Number	Recommendation	Location in this Report		
		Section	Page	Paragraph
1	IRAP strongly reaffirms the recommendation of the RAB report that a specially recruited and dedicated team within the National Offender Management Service (NOMS) should undertake training of staff on MMPR. Moreover, having observed tangible progress to date, IRAP strongly recommends that this core specialist team should be retained and maintained. IRAP's opinion is that to do otherwise would jeopardise the progress that has been made to date.	**Foreword**	**3**	**Not applicable**
	The RAB recommended that a specially recruited and dedicated team within NOMS should carry out training of staff of the STCs and YOIs in MMPR. The purpose of this recommendation was to ensure not only consistency of skills development, but also to establish a learning and feedback loop that would remain throughout use of MMPR.	**6**	**32**	**131**
	As IRAP concludes its work, it understands that consideration is being given to disbanding the current MMPR National Training Team within the next two years. IRAP's opinion is that this plan is a matter of concern. While any team is likely to and, arguably, should experience changes of personnel, IRAP is concerned that disbandment of the MMPR National Training Team could compromise the learning and development that it sees as essential to ensure that MMPR remains a safe and effective system.	**6**	**32**	**132**
2	The 'in house' coordinators raised the issue of staff from other prisons, who had not been trained on MMPR, being used in the YOI's. They cited not only staff from the young adult facility in the Hindley YOI, but also prison officers from nearby adult prisons, such as that in Liverpool, being drafted in when necessary. They acknowledged that this had happened recently as a result of staff shortages (34 staff down) but, presumably, this must also be an issue for other YOIs too. IRAP recommends that NOMS should address this issue and that Her Majesty's Chief Inspector of Prisons (HMCIP) should monitor this matter and NOMS findings.	**5**	**28**	**112**
3	Hence, IRAP's firm recommendation which is that, because its role has now finished, an independent external panel should be constituted to continue the role of monitoring 'exception reports' involving SIWS, and that any interim arrangements that are required to retain this monitoring function should be put in place.	**Foreword**	**4**	**Not applicable**

3 continued	Since IRAP was dissolved, the medical experts from the panel no longer have any involvement in the process of 'SIWS Meetings'. Therefore, IRAP recommends that an independent external medical panel is constituted to continue the role of monitoring 'exception reports' involving SIWS.	**7**	**36 & 37**	**147**
	Such a panel would add to the quality and depth of governance of MMPR by providing an additional layer of transparency in monitoring the use of force and advising on medical matters that arise from the use of MMPR and its continuing evolution. IRAP makes a specific recommendation for the work of this panel with regard to reviewing aggregated data on petechial haemorrhages in Section 5 (paragraph 98).	**7**	**37**	**148**
	IRAP recommends that interim arrangements should be made while the recommendation in paragraph 147 in this report is considered so that there is no period of time when the quality assurance mechanism for use of force in the STCs and YOIs is without an independent external medical panel.	**7**	**37**	**149**
4	Most importantly, the SIWS Meetings observed several cases of petechial bruising. This sign is an indication of vascular compromise. It would appear that the vascular compromise is occurring during the application of the head hold. Several RAB members and current IRAP members did and still do hold strong reservations about the head hold technique in the MMPR system. In its report[4], the RAB established the principle that all physical restraint techniques should possess inherently room for error in application. Little to no vascular compromise would be expected when the MMPR head hold is applied in a static classroom / laboratory situation. However, IRAP's opinion is that when the head hold technique is applied in operational contexts where young people struggle, and there are size differentials between staff applying the head hold and the young person, the presence of the petechial bruising suggests that vascular compromise is occurring. Thus, there appears to IRAP to be evidence emerging to support the RAB's previous concerns.	**7**	**36**	**142**

[4] Restraint Advisory Board. Assessment of Minimising and Managing Physical Restraint. National Offender Management Service. London 2011. Section 2.28.2

4 continued	In Section 7, IRAP recommends that an independent external medical panel is constituted to continue the role of monitoring 'exception reports' involving SIWS (paragraphs 147-149). Therefore, IRAP recommends that that body should review the aggregated data related to petechial rashes (haemorrhages) reported through the SIWS system. In addition, it recommends that the conclusions from the analysis of the aggregated data are reviewed by HMCIP when that organisation conducts the review that is detailed in Section 8 (paragraphs 155-157).	**5**	**26**	**98**
	IRAP makes a specific recommendation for the work of this panel with regard to reviewing aggregated data on petechial haemorrhages in Section 5 (paragraph 98).	**7**	**37**	**148**
5	Furthermore, given the panel's ongoing concerns about the head hold, I, as Chair of IRAP, am grateful that the YJB has afforded me the opportunity to be part of the group that is receiving interim findings from the research commissioned (on the recommendation of the RAB) by the YJB into the head hold. I urge the YJB, and IRAP recommends, that it should explore with the researcher who has been commissioned the possibility of (as is done across the field of medicine) undertaking some modeling work on how laboratory research findings can be projected out into extant circumstances in day-to-day operational practice (i.e. circumstances in which the range of cumulative risk factors that are described in Section 7 come into effect).	**Foreword**	**5**	**Not applicable**
	Based on observations [made by an IRAP member who visited refresher training at Hindley YOI, that] … IRAP member was concerned about the potential to misapply the head hold, and, in particular, about how easy it is to pull a young person's head forward rather than merely guide it while he or she is being restrained. This could result in the restrained person's head being held too low and that might, in turn, risk compressing his or her chest area and / or raise the risk of staff misapplying the trigger hold to the neck rather than to the chin. This hold was used in a number of the scenarios and the visitor observed these events during this training course. The trainers did correct participants when they applied the hold incorrectly, but the opinion of the IRAP member was that more emphasis should have been placed on the high risk associated with this technique.	**5**	**27 & 28**	**110**
6	The data seen by the member of IRAP [who visited Oakhill STC] indicated that there had been three exception reports since January 2014. In all three, the warning sign was petechial rash that had developed after a head hold had been used and the duration of the restraint had been for more than 5 minutes.	**5**	**24**	**87**

6 continued	Staff of the healthcare team [at Oakhill STC] are involved in the weekly and monthly monitoring and review meetings and use their database to check for patterns and trends. The healthcare lead expressed her view about three exception reports that petechial rash (haemorrhages) can be caused by individual factors and was not necessarily linked to the head hold and duration of the restraint. She did not think that there had been enough of these incidents at Oakhill to cause her alarm.	**5**	**26**	**97**
	IRAP recommends that this data is looked at across the establishments because the frequency of this combination may not be sufficient to trigger concern in a single unit, but could or should do if this pattern were repeated across the estate. It anticipates that this is taking place. In Section 7, IRAP recommends that an independent external medical panel is constituted to continue the role of monitoring 'exception reports' involving SIWS (paragraphs 147-149). Therefore, IRAP recommends that that body should review the aggregated data related to petechial rashes (haemorrhages) reported through the SIWS system. In addition, it recommends that the conclusions from the analysis of the aggregated data are reviewed by HMCIP when that organisation conducts the review that is detailed in Section 8 (paragraphs 155-157).	**5**	**26**	**98**
7	IRAP appreciates that the form is still subject to further review as a part of the roll-out of MMPR. However, IRAP has noticed several aspects of the form that it recommends are improved. First, Part 1B is the section that is used to record serious injuries. However, that part comes after the place on the form at which a senior manager signs it off. Second, IRAP found no place on the form at which to record: the name of the person who completed it; when; or how the information came to light. Consequently, IRAP recommends that this part of the form is reviewed with some urgency.	**6**	**30**	**120**
	When reviewing the 'exception reports', it was often difficult to follow the time line of events, from what was written as it happened and what was recorded after a period of investigation, this situation requires attention to aid the staff who audit the events to seek clarity as to who did what, where and when.	**7**	**36**	**146**

Matters for Further Consideration by the Ministry of Justice, the Youth Justice Board, the MMPR National Team and Her Majesty's Chief Inspector of Prisons

162. The table that follows draws together the matters to which IRAP suggests that a range of bodies should pay further attention. IRAP presents them as foci for

the authorities further work in order to continue to improve MMPR, its roll-out and the governance arrangements that surround use and monitoring of MMPR.

163. IRAP recognises that a number of the matters in this second table may already be in the process of resolution or subject to further scrutiny and exploration. Arguably, other items require more substantial or additional work. Unless otherwise stated, IRAP's view is that it should be for the MOJ, the YJB, NOMS and the MMPR National Team to agree which agency should lead the work on each matter.

TABLE 3: SUMMARY OF MATTERS FOR FURTHER CONSIDERATION BY THE MINISTRY OF JUSTICE, THE YOUTH JUSTICE BOARD, THE MMPR NATIONAL TEAM AND HER MAJESTY'S CHIEF INSPECTOR OF PRISONS

Item Number	Matter for Further Consideration	Location in this Report		
		Section	Page	Paragraph
8	There may well be truth in the opinion that the culture change that the RAB recommended will take several years as change is a notoriously slow process in large organisations. Furthermore, MMPR had gone live and been fully implemented in only four establishments as this report was being drafted. This gives an indication of how long the full process might take.	**Foreword**	**4**	**Not applicable**
		8	**38**	**154**
	During visits made by members of IRAP, some senior managers and staff of the STCs and YOIs have told them that their opinions are that MMPR will take at least three years to become fully embedded in the culture of establishments.	**8**	**38**	**153**
9	It would appear that MMPR is not to be implemented in Feltham until near the end of 2015, which will, inevitably, present further problems to the process of culture change.	**Foreword**	**4**	**Not applicable**
		8	**38**	**154**
10	IRAP is to have no further role in supporting the roll-out programme. However, it understands that Her Majesty's Chief Inspector of Prisons (HMCIP) has been commissioned to carry out a review focussing on the implementation and impact of MMPR in STCs and YOIs relating to its use with children and young people who are under 18 years old.	**Foreword**	**4 & 5**	**Not applicable**
		8	**38**	**155**
	Such a review will give a further opportunity to examine the work carried out by all parties to devise, implement, manage and monitor MMPR and to confirm, or otherwise, that the governance systems put in place are robust.	**8**	**38**	**156**

10 continued	Given that the HMCIP review may take place at a time when roll-out is still not fully complete, it is IRAP's opinion that HMCIP should keep the process under regular review over a longer time scale in order to test the sustainability of MMPR.	**8**	**39**	**157**
11	Pain induction techniques were explicitly taught as part of the curriculum in the MMPR handbook and in the context of the sliding scale of restraint techniques related to need. The IRAP members noted that the trainers emphasised strongly that use of pain must be at the extreme end of the spectrum of intervention. However, specific circumstances that indicate the requirement for those techniques were not taught during at least one course that IRAP's members visited. IRAP's opinion is that the MMPR National Team should review this aspect of the training provided for staff.	**4**	**17**	**40**
12	Senior managers at Rainsbrook STC told the IRAP member that there was a high turnover of staff. As a consequence, many staff were young and inexperienced and, as a result, lacked confidence. Second, Second, the senior managers reported their perceptions that there had been an increase in the use of restraint and injuries to young people's heads.	**5**	**18**	**44**
	The managers expressed the view that the increase in number of restraints might have happened because the training had a strong emphasis on the legal implications of restraining young people, which, in some cases, had led to confusion as to when staff could or should intervene. The possible explanation given by the managers of this establishment to the IRAP member who was visiting was that this uncertainty had resulted in delays that had contributed to situations escalating leading, thereby, to higher levels of intervention and a greater risk of injury to the young people and / or staff who were involved.	**5**	**18**	**45**
13	Operational staff expressed their concern to the member of IRAP that CCTV footage used during debriefs could work against them in the sense that it did not include audio coverage. Therefore, situations that involved threats or aggressive comments made by young people that might provide additional justification for intervention could not be heard. Similarly, the verbal efforts of staff to de-escalate situations were not recorded.	**5**	**19**	**51**

13 continued	As this report recognises, although viewing the CCTV footage is useful, it has limitations. The first is a lack of an audio track and a second is the position of the cameras that means that it has been rare to see an incident from beginning to end. Many incidents that have generated 'exception reports' also appeared to have occurred within the young people's bedrooms and CCTV does not cover them.	**7**	**35**	**139**
14	Only the manager of the healthcare staff [at Rainsbrook STC] had received MMPR training. The IRAP member suggested that all nurses should offered training in order that they would become familiar with the holds, warning signs and the potential for emergency situations.	**5**	**19**	**53**
	No members of the healthcare staff group [at Wetherby YOI] had been trained in MMPR, but they accepted the suggestion made by the member of IRAP that the experience would give them a greater understanding of the techniques involved together with their potential to cause injuries.	**5**	**22**	**72**
	The head of healthcare [at Oakhill STC] had attended the MMPR training and was encouraging the other healthcare staff to attend. The healthcare team does not have any direct involvement with the MMPR Coordinators in relation to training.	**5**	**25**	**93**
15	The recording form for incidents in which restraint is used [at Oakhill STC] is called 'Use of Force'. It categorises separately both use of force and MMPR. In response to a question about this, the IRAP member was told that the term 'use of force' was used to enable recording of any 'hands on' actions used before a MMPR hold could be applied. While this is understandable, because there is almost always a period at the beginning of any incident in which staff are in the process of getting hold, this approach has the potential to skew data collation. It was unclear to IRAP whether or not other establishments also use a similar dual categorisation.	**5**	**25 & 26**	**96**
16	The head of safeguarding [at Oakhill STC] told the IRAP member that the safeguarding database is designed to flag up complaints related to restraint, and notifications of them are also sent to each relevant child's youth offending team (YOT) worker and parents / carers. She said that her perception is that the complaints related to restraint that also included an allegation were, on the whole, made after a head hold had been used.	**5**	**24**	**86**

17	The monitor [who attended Oakhill STC] said that the head hold is only used in particularly violent incidents or to prevent spitting.	**5**	**25**	**91**
	It is IRAP's opinion that the head hold is a high-risk technique. As a consequence, IRAP remains concerned if it is being used to prevent spitting in situations in which the degree of problematic behaviour would not otherwise necessitate it.	**5**	**26**	**99**
18	IRAP has noted that, when the techniques are being used within an operational setting, its members have begun to see the concept of accumulative risk factors coming into play for young people who are running into difficulties. Examples include prolonged use of a technique (specifically head control), obesity, and other predisposing health issues. This is a matter that should be taken into account by modifying the MMPR training.	**7**	**35**	**140**
19	It should be noted that the YJB / MoJ reviewed the findings from the 'SIWS Meeting' at Rainsbrook STC and provided a response plan. Most of that plan involved the MMPR National Training Team in making recommendations to establishments. However, that plan did not include any action to ensure that the recommendations are carried out.	**7**	**35**	**141 4th bullet point**
20	When the SIWS Meetings reviewed the 'exception reports', there appeared to be a common theme of staff receiving debriefing but not the young people. The failure of young people to receive debriefing should be reviewed.	**7**	**36**	**144**
21	On reviewing the 'exception reports', there appeared to be one example of a form being amended after initial completion. While this is but one example, it suggested to IRAP that managers should ensure that further examples do not occur. Also, IRAP has noted that there were significant mismatches between different types of documents with early warning signs being recorded on some and not others. Some of this may be due to the delays between the incidents occurring, the clinical signs developing, and young people being seen by members of the healthcare staff.	**7**	**36**	**145**

ANNEX A TO: REPORT ON IMPLEMENTATION OF THE MINIMISING AND MANAGING PHYSICAL RESTRAINT SYSTEM IN SECURE TRAINING CENTRES AND YOUNG OFFENDER INSTITUTIONS

Memorandum of Understanding between the Independent Restraint Advisory Panel and the Ministry of Justice, the Youth Justice Board and the National Offender Management Service.

Introduction

This Memorandum of Understanding (MoU) outlines the ways in which the Independent Restraint Advisory Panel ('IRAP') will work with the Ministry of Justice ('MoJ'), the Offender Management Service ('NOMS') and the Youth Justice Board ('YJB') to support the implementation of Minimising and Managing Physical Restraint ('MMPR') in under-18 Young Offender Institutions ('YOIs') and Secure Training Centres ('STCs') across England and Wales.

Background

The Government has established the IRAP for two purposes:

a. To assess the quality and safety of systems of restraint commissioned for use on children in SCHs.

b. To support the implementation of MMPR to YOIs and STCs.

This MoU relates to b. by which the IRAP has specifically been tasked with the following in their Terms of Reference:

- Advise the Restraint Management Board (RMB) on progress with implementation of MMPR, particularly regarding key recommendations for changes to the restraint system approved by the Minister.
- Analyse MMPR data from medical and risk management perspectives to advise the RMB on whether MMPR is meeting its primary objectives.
- Take account of national/international medical evidence regarding restraint techniques and report findings to the RMB
- Undertake research as agreed with the RMB
- Reassess physical restraint techniques, or assess new/amended techniques, and any associated medical risk assessments as agreed with the RMB.

Workstreams

In light of the tasks outlined above, the IRAP will be asked to:

- Monitor the implementation of approved Restraint Advisory Board (RAB) recommendations (which may include visits to establishments)
- Continue its membership of RMB (Chair to attend) taking forward any RMB agreed actions/tasks accordingly

- Receive regular data and associated analysis on the use of MMPR and provide advice, analysis and interpretation to the YJB, NOMS and MoJ
- Receive notifications of any occurrences of 'serious injuries or warning signs' and to provide advice
- Highlight to the MoJ, YJB and NOMS any good practice from other sectors that use physical restraint, including that gleaned from international evidence.
- Attend MMPR training days over the roll-out period to observe and comment on delivery.

Restraint Management Board

The RMB meets quarterly and the IRAP Chair currently attends all the meetings and receives papers accordingly. The Chair can also bring to the attention of the RMB any issues or concerns that IRAP may have, following discussion with the RMB Secretariat.

Data and Serious Injuries and Warning Signs

Nominated IRAP members will receive quarterly MMPR data. This will be supplemented by a qualitative analysis of the use of MMPR and specific information on the use of any of the pain techniques.

Nominated IRAP member/s will receive notification of any serious injuries and warning signs as a result of using MMPR. They will be invited to send their analysis and advice to Doug Weir (NOMS) via email within 5 days of receiving the report and any relevant supporting evidence (i.e. CCTV footage).

Monitoring Implementation of Restraint Advisory Board (RAB) Report Approved Recommendations

The Annex to this MoU sets out how the IRAP will monitor each of the RAB recommendations. As some of the recommendations have already been completed and others concern good practice, not all recommendations are covered by this MoU.

Research and Good Practice

Highlighting to the MoJ, YJB and NOMS any good practice observed in other sectors, including international evidence around the use of restraint for young people in custody. Sharing and promoting good practice in other sectors based on the learning to date, and this may require, for example, meeting or offering advice to the Independent Advisory Panel on Deaths in Custody.

Attending Training and Visits to Establishments

IRAP panel members will attend training days for the MMPR roll-out as well as visit establishments when necessary in line with the above work streams and in particular related to monitoring the implementation of the RAB recommendations.

Reporting

The IRAP is accountable to the Restraint Management Board (RMB) - chaired by a Director appointed by MoJ, with representation from YJB and NOMS. The MoJ is the sponsoring department for the IRAP.

The IRAP has a two-year life span as an ad hoc body after agreement with the Cabinet Office. This two year period starts from the date of the Ministerial appointments and there will be no opportunity to extend the Panel for any further period. Therefore any reports and papers following the IRAP's role in relation to MMPR must be submitted prior to 23 April 2014.

In light of the dual role of the IRAP, and the time pressures that the Panel will face in their SCH-related work and timescales, a short paper on the IRAP's findings from the implementation of MMPR will be required by 20 December 2013. The paper should cover the workstreams as outlined above and a draft report would require sign off at the RMB.

Other Support

The sponsorship and secretariat function sits with MoJ. However, as the majority of the workstreams concerns operational policy, a number of dealings may be direct with NOMS and YJB officials.

ANNEX B TO: REPORT ON IMPLEMENTATION OF THE MINIMISING AND MANAGING PHYSICAL RESTRAINT SYSTEM IN SECURE TRAINING CENTRES AND YOUNG OFFENDER INSTITUTIONS

The Members of the Independent Restraint Advisory Panel and Acknowledgements

The Members of IRAP

The members of IRAP at the time when it completed its work were:

Professor Dame Susan Bailey	Chair
Professor Gillian Baird	
Mr Richard Barnett	
Ms Pam Hibbert	SCH Lead
Mr Geoff Hughes	MMPR Lead
Dr David Perry	
Professor Richard Williams	

Professor Dame Susan Bailey thanks all of the members of IRAP for the work that they have done in discharging the roles set for IRAP.

Acknowledgments

Professor Dame Susan Bailey recognises the contributions of **Mr John Crawley** and **Dr Rosalyn Proops**. Both were members of IRAP at its formation, but their circumstances led to their retirement from IRAP in the first half of its work. Sue Bailey takes this opportunity to thank them for their valuable contributions.

Sue Bailey also wishes to recognise the work of, and the information and hugely important support provided by the officials in the Ministry of Justice, the Department for Education, the National Offender Management Service and the Youth Justice Board for England and Wales. As IRAP submitted its reports to government, they included: **Mr Mark Veljovic**, **Mr Jim Brown**, **Ms Liz Formby**, **Mr Chris Ball** and **Mr Dan Shotter**.

In addition, Sue Bailey recognises the work done by **Ms Roshnee Patel** and **Ms**

Claire Owens in the formative stages of IRAP's work. Both of them left their former teams in the Ministry of Justice and Department for Education respectively to take up other commitments during the time course of IRAP's activity. They both undertook a substantial amount of work in support of IRAP and in preparing for its many visits for which IRAP thanks them.