Response plan to IRAP's MMPR report recommendations

Ref no	Subject	Status, Lead, Action taken/planned
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. 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. 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.	Lead - NOMS. Status – completed There are currently no plans to disband the MMPR national team. There is a NOMS policy on job rotation which applies to all staff employed by NOMS. However, it is has not effected members of the MMPR national team, who will continue their role as trainers for the foreseeable future. Where a member of staff is to be rotated under the interchange, a suitable replacement will be identified and trained to the required standard prior to a member of the team moving, if there is a shortage of trainers, NOMS will look to recruit to ensure that there are sufficient numbers of trainers to deliver the training. NOMS are currently looking at options for the future delivery of MMPR training, and are in the early stages of putting together a proposal for the delivery of a non-cascaded model of training, which would involve the national trainers delivering training directly to staff working in STCs and under-18 YOIs.
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.	Lead - NOMS. Status – ongoing The YJB's expectations around staff training are clear; it is only staff that have been fully trained and successfully assessed in MMPR who can be involved in incidents of restraint. Any staff not trained in MMPR, including those on detached duty, should never be involved in restraint incidents. NOMS has a number of measures in place to manage the deployment of detached duty staff who are not trained in MMPR (where there is a shortage of staff), and minimise their involvement in restraint incidents. For example, detached duty staff working at Hindley are briefed on the key aspects of MMPR, including the differences between the physical techniques in MMPR and C&R, and medical advice. Detached duty staff are deployed in areas of the establishment where restraint incidents are less likely to occur. Detached duty staff should never be involved in planned interventions and in the limited circumstance where it is absolutely necessary for them to be initially involved in a restraint responding to a spontaneous incident (e.g. a fight or assault) they should be relieved by a MMPR trained member of staff at the earliest and safest opportunity. The likelihood of this occurring will be reduced by the ongoing recruitment drive in the under-18 YOIs, with a number of vacancies already being filled.

		HMIP's review of the MMPR implementation programme is time limited as its findings will be based the period of the review. It is not HMIP's role to monitor this matter as inspectors but it is something that they can review during routine inspections where it is considered an issue.
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. 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. 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). 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.	Lead – NOMS, YJB. Status – ongoing The YJB are in the process of appointing the new medical panel, including the reappointment of previous IRAP sub-panel members, and in addition the YJB and NOMS hope to appoint experts with operational experience of working with young people with particular needs such as ADHD. The new panels' remit will widen to include additional responsibilities such as ad-hoc support to NOMS and the independent medical advisor. Interim arrangements for the review of SIWS incidents have been in place since the IRAP sub-panel dissolved in April 2014. A meeting to review SIWS incidents took place on 2 June and it is envisaged that the IRAP sub-panel will continue this function, until the new panel has been appointed.
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. 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). 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).	Lead – NOMS, YJB. Status – ongoing Dr Ian Maconochie's, Independent medical advisor to NOMS, has been commissioned to do some further work on petechiae i.e. its causes and consider its relevance to restraint. It should be noted that this issue is limited to a small number of misapplications. The majority of incidents involving the head hold do not result in SIWS. The new medical panel will have remit to monitor progress in this area. The YJB has commissioned research looking at alternative ways to hold the head. The YJB and NOMS will consider any relevant learning identified from the research. The MMPR national team are putting together the annual review of SIWS incidents, which will include data on the percentage of head holds resulting in petechiae. HMIP representatives currently sit on the RMB, and the annual review is expected to be presented to RMB members in September 2014.

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). 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.	Lead – NOMS, YJB. Status – completed The training delivered by the MMPR national team and MMPR coordinators covers the associated risks with the misapplication of the head hold technique. In response to the head hold research commissioned by the YJB, the MMPR national team will consider its findings and the operational feasibility of using any alternatives ways of teaching the head hold technique to reduce the possibility for misapplication. This is identified as a likely cause of a serious injury and warning sign occurring. Any changes to the way the head hold is taught by the MMPR national team will be reflected in the MMPR training manual and delivered to staff. Appropriate governance arrangements are in place to ensure that this issue is looked at nationally by NOMS as part of the review of SIWS incidents, and locally by individual establishments i.e. through their weekly use of force meetings.
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. 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. 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 byHMCIP when that organisation conducts the review that is detailed in Section 8 (paragraphs 155-157).	Lead - YJB. Status – completed Data related to each incident of SIWS will be available on the annual review of SIWS incidents. See recommendation 4 for more details and how HMIP will be engaged on this.
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	Lead - NOMS. Status – ongoing As part of the work planned on updating the MMPR use of force forms, NOMS will consider the feedback from the IRAP and ensure that the form is amended to include a counter signature on Part

	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. (ii) 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.	1b.
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. 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.	Lead – NOMS, YJB. Status – ongoing The MMPR implementation programme in STCs and under-18 YOIs is expected to be completed by the end of 2015. The timescales for each establishment is dependent on a number of factors, such as practical challenges around resources. The YJB is working closely with all establishments using MMPR to help imbed the system in local practice. For example through the monthly incident review meetings attended by the YJB and national team, where a selection of restraint incidents are reviewed on CCTV and written feedback is provided to establishments with recommendations aimed to improve the way incidents are managed. Through this exercise, the YJB is also monitoring progress made by individual establishments overtime and have noted improvements to local practice since the introduction of MMPR.
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.	Lead – NOMS, YJB. Status – ongoing Feltham will receive the same level of support as all other establishments currently using MMPR, to ensure that the system is fully embedded in local practice i.e. the same governance arrangements in place for the monitoring and scrutiny of restraint related practice such as incident review meetings and weekly use of force meetings. See response recommendation 8 for more details.
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. 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. 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.	HMIP to respond.
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.	Lead – NOMS Status – completed NOMS will not give specific examples for pain inducing techniques as they are endless factors that could influence an individual's decision to use pain. Ultimately it is the individual that must justify that decision based on the law and what they believed to be the "Immediate risk of serious physical harm". There is a danger if we give examples that staff will interpret this to be that they can use pain

	IRAP's opinion is that the MMPR National Team should review this aspect of the training provided for staff.	in all these situations where in some instances it is not warranted. We discuss medical risk factors that could contribute to the risk of serious harm so that staff can make an informed decision. Justification for use of pain needs to be from the individual and not because they were told that they were allowed to do it by a National Trainer which is what will happen if specific examples are issued.
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, the senior managers reported their perceptions that there had been an increase in the use of restraint and injuries to young people's heads. 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.	Lead – YJB. Status – completed The YJB would dispute that there has been an increase in the use of restraint and injuries to young people's heads. This is just a perception, and there is currently no evidence available to substantiate this. Should there be any concerns around injuries to the head, relevant governance arrangements are in place to address any concerns and issues locally by establishment (i.e. weekly use of force meetings) and centrally by the MMPR national team (i.e. review if SIWS). It is the responsibility of individual establishments to ensure that staff are supported properly, particularly new staff. Establishments should also take measures to reduce the high turnover of staff.
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. 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.	Lead – YJB. Status – ongoing The YJB are currently planning on piloting the use of body worn camera to improve CCTV coverage across the estate. The features include both visual footage and audio. A six-moth pilot at Feltham and Rainsbrook is due to commence in October 2014.
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. 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. 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.	Lead – NHS England. Status – ongoing All healthcare staff working in STCs and under-18 YOIs have the option to attend the full MMPR training course. A bespoke training course for healthcare staff is being delivered by the national team as part of the roll-out programme for each establishment. As part of the training, healthcare staff are familiarised with each of the MMPR techniques and what to do during medical emergencies, and on observing warning signs and symptoms (i.e. petechiae). To improve the training offered to healthcare staff, NOMS are currently considering the proposal to involve healthcare staff in the refresher training delivered to operational staff i.e. to take part in practical scenarios and manage incidents in their role as healthcare staff. Discussions are ongoing with NHS England about the best approach to ensure that healthcare staff get the appropriate training.
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	Lead – YJB. Status – completed We have checked this with Oakhill STC and the establishment have clarified that there is no double counting of restraint incidents. Incidents are either recorded as a use of force or MMPR. If use of force is followed by an MMPR technique, the incident will always be recorded as an MMPR incident.

	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.	
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.	Lead –YJB. Status – completed The incident did involve the use of the head hold however, the allegation referred to was not based on the use of the head hold technique but excessive force used by staff on the young person during the incident.
17	The monitor [who attended Oakhill STC] said that the head hold is only used in particularly violent incidents or to prevent spitting. 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.	Lead –YJB. Status – completed The head hold technique is only used to prevent spitting when the young person starts to spit. It should not be applied in anticipation of the young person spitting.
18	IRAP has noted that, when the techniques are beingused 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.	Lead – NOMS Status – completed MMPR Training currently covers all risk factors and the accumulative risks if more than one of these factors are present. It is also relayed in the SIWS response to establishments if more than one risk factor is present which is why some Young People have Individual Handling Plans adapted to reflect this
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.	Lead – NOMS, YJB. Status – completed This will be included in future response plans to the IRAP's review of SIWS.
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.	Lead – NOMS, YJB. Status – completed As per IRR recommendation 39, our expectation is that under MMPR all young people will receive a post-incident restraint debrief within 48 hours of the incident. The government's expectations around restraint debriefs are also set out in the MMPR roles and responsibilities document, published on the justice website: www.justice.gov.uk/downloads/youth-justice/custody/mmpr/minimising-managing-physical-restraint.pdf Relevant governance arrangements are in place to ensure establishments able to pick up if a young person has not been debriefed.
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.	Lead – NOMS Status – ongoing See response to recommendation 7. There are sometimes disparities between Part 1a and Part 1b of the use of force forms. This is because Part 1a is usually completed immediately after an incident but Part 1b is completed some time after the incident (i.e. an injury or warning sign is reported at a later stage or identified following an assessment of the young person by healthcare).