Independent Restraint Advisory Panel

# A REVIEW
# OF
# RESTRAINT SYSTEMS
# COMMISSIONED FOR USE WITH
# CHILDREN WHO ARE RESIDENT
# IN
# SECURE CHILDREN'S HOMES

June 2014

# FOREWORD

Secure Children's Homes (SCHs) provide vital, safe places for extremely troubled and troublesome children. They should protect the children who reside in them and the public. Children placed in SCHs may be the victims of abuse and exploitation, or are placed therein because of their offending. In many cases, they fit into both of these categories. Usually, they have complex arrays of needs including those in the domains of psychosocial care, relationships, behaviour problems and mental ill health as well as neurodevelopmental disorders that include intellectual disabilities. Most have had extremely disrupted experiences of education and have achievements in basic learning skills that are a long way adrift of those of their peers who are not in need of secure accommodation.

The role of SCHs remains substantially invisible despite the important service they provide. There is little information about them in the public domain and the public knows little about the work they undertake or the differences they may make for particular children. SCHs provide accommodation not only for younger children, but they are also an important component of the criminal justice system. They are required to provide care for children and young people who are most vulnerable as a consequence of their past experiences, problem behaviour and sustained failures in meeting their needs. Often, they are required to care for children and young people when other forms of custody would not be able to make adequate arrangements to safeguard and/or treat them while also protecting the public.

Physical restraint of children and the safety of all children and of the staff who care for them remain important, difficult, and challenging subjects. The membership of the Independent Restraint Advisory Panel (IRAP) overlaps with that of the former Restraint Advisory Board (RAB). Members worked to the terms of reference set by the Department for Education (DfE) and the Ministry of Justice (MoJ).

Despite their backgrounds and experience, none of the members of IRAP could have predicted the complexity that we discovered when, with our stakeholders, we started to explore aspects of the use of physical restraint and disengagement techniques in the 17 SCHs across England and Wales.

IRAP's work, which is expanded in the final chapter of this report, has taken place at a time of great change for the whole of the secure estate. We carried out this work at a time when unprecedented attention was and still is being afforded to use of restraint across the lifespan and in education services, healthcare, criminal justice, social care and the immigration service.

The topic of restraint and its practice can be highly charged. Furthermore, it should be understood in the context of the daily working lives of practitioners across the services. Practitioners who choose to work in this field want to deliver best care for a group of children who are both vulnerable and challenging in equal measure and at the same time. Therefore, first and foremost, IRAP wishes to emphasise that, in all its contacts with, and visits to each and every SCH, its members have seen clear evidence of the enthusiasm, skills and efforts of the staff who work within them.

We wish to thank all the stakeholders who have so willingly engaged with us. We recognise that our work has taken a considerable amount of time from their busy lives. Especially, we wish to thank them for their continuing patience when we have returned to them for clarification or new information as we learned more from another part of the system. We appreciate their cooperation and generosity of time and spirit when we have asked what, at times, may have seemed obvious and/or irrelevant questions.

While using semi-structured templates to ensure as far as possible consistency and coverage, we have also progressed in our interviews to ask in-depth questions. We did so to best ensure that we can make a critical analysis of what is happening across and between this complex pathway of delivery of restraint and disengagement in SCHs.

This report outlines gaps of a range of types that have evolved unchecked over time, and also risk in the whole system. This is highlighted not to attribute any blame, but to demonstrate how IRAP has endeavoured to listen to people in many parts of the system. We have endeavoured to look at as many elements of the system as we could. This has enabled IRAP to draw together findings from a diversity of enquiries in a comprehensive way. The intention of IRAP's members was to understand better how the system has drifted since 2000 when the DfE and the Department of Health (DH) in England commissioned the British Institute for Learning Disabilities (BILD) to develop a code of practice[1]. We acknowledge that subsequent investigations, not least the independent review conducted by Smallridge and Williamson in 2007[2], set out to create a more ordered approach to the use of restraint with children and young people.

In IRAP's opinion, it was and remains important that the governments of England and Wales should support development of an ethical governance framework to underpin future progress in delivering best and safest child-centred physical restraint across the SCH sector. No doubt, some readers will be disappointed that IRAP has not

[1] http://www.bild.org.uk/our-services/books/positive-behaviour-support/bild-code-of-practice/

[2] http://webarchive.nationalarchives.gov.uk/20130401151715/https://www.education.gov.uk/publications/eOrderingDownload/Review%20of%20restraint.pdf

produced a defined and bespoke system of restraint for this sector. But, first, there has to be an understanding of and commitment to an agreed ethical governance framework, if the whole system is to achieve that objective. That may require changes in many elements of this system, including, potentially, current regulations.

IRAP did not set out to glean information about use of restraint across the whole of the child sector, which includes children's homes, foster care and all types of education settings covering children from age 3 through to 18. However, while gathering information from commissioners, local authorities (relating to both social care and education provision) and from organisations that provide training on restraint, we have also received information about other education and childcare systems. Therefore, we cannot ignore it. We have fed this back to the DfE working group and we refer to this matter in Chapter 7, as part of our duty of care and have included a section in our summary and recommendations that addresses some of our concerns.

IRAP has to advise that ethical governance frameworks for use of restraint and disengagement techniques with children should be reviewed across the whole system and not just in and for SCHs. Indeed, we question whether or not such a coherent framework exists in a connected way with the intention of reducing the risk of harm and use of restraint. We recognise that this may be deemed to be outwith the remit of IRAP. We also recognise the autonomy of schools when they decide on their practice, but believe that we have a fundamental 'duty of care' to draw attention to the importance of ethics and values.

Having initially considered how we could involve children and young people resident in secure care in this process without being either intrusive or awakening possible past traumas in their life, we reached a stage in our work at which we decided the best way forward was to invite children and young people to meet with us. They have volunteered with appropriate consents. On the days of our visits, they have been given full, thoughtful and caring close support from staff at each unit. We developed for this component of our work, as with all other aspects of our task, a semi-structured set of questions (see Annex Q).

As always, the young people whom we have interviewed, however chaotic and whatever their behaviours that have led to their admissions, have shown fundamental insights into their own dilemmas and of those people who care for them. There is a great deal to be learned from this and we want to thank every one of them for agreeing to be interviewed by 'strangers'.

Finally, as chair of IRAP, I have been privileged to work with a team of people whose hard work, knowledge, insight and skills have been invaluable. I am particularly keen

to thank Pam Hibbert who, after our deputy chair stood down, has undertaken a multitude of tasks. I also want to thank the civil servants who, at every stage, have been so helpful.

My sincere hope is that this report will enable the key government departments to come together with local authorities to develop a governance framework to deliver the safest possible use of physical restraint and disengagement techniques in SCHs. The aim must be to reduce the use of restraint to an absolute minimum. Safety should be driven by consistency and relational security, together with combined evidence-based and values-based approaches to care, education and designing and delivering intervention programmes. The common end is to help vulnerable and challenging children and young people to return to communities and families and to lead positive social and healthy lives.

**Professor Dame Sue Bailey**
**Chair of the Independent Restraint Advisory Panel**

**June 2014**

# CONTENTS

# CHAPTER ONE: INTRODUCTION, CONTEXT AND TERMS OF REFERENCE

## Introduction and Context

1. Seventeen years ago, Sir William Utting suggested a framework for safeguarding that should apply to all children who live away from home, including children who are deprived of their liberty[3]. In the intervening years, there have been other reviews and inquiries specifically addressing issues relating to use of restraint.

2. This matter has been subject to a huge degree of scrutiny and inquiry by a range of government departments, and there is in place varying policy, guidance and regulations, with some degree of duplication, and, occasionally, contradiction. Relevant documents in place, or work in this area that is currently being undertaken, include:

   - Local reviews and developments of mental health and learning disability services arising from the findings and recommendations contained in the Winterbourne View report [4], and subsequent work being undertaken by the Royal College of Nursing at the request of England's Minister for Health and Social Care[5].
   - The work being carried out by the Borders and Immigration Section of the Home Office.
   - Work on implementing Minimising and Managing Physical Restraint (MMPR) in Young Offender Institutions (YOIs) and Secure Training Centres (STCs) and the accompanying guidance on safeguarding processes and governance arrangements[6].
   - The continuing work of Children's Commissioners and of other organisations and people who lobby on this issue including, for example, the Howard League and Inquest.

[3] People Like Us: a review of the safeguards for children living away from home. Department of Health 1997.
[4] Winterbourne View Hospital: Department of Health Review and Response. Dec 2012 https://www.gov.uk/government/publications/winterbourne-view-hospital-department-of-health-review-and-response
[5] http://www.rcn.org.uk/newsevents/press_releases/uk/rcn_consulting_on_new_guidance_on_alternatives_to_the_use_of_restrictive_practices
[6] http://www.justice.gov.uk/youth-justice/custody/behaviour-management

- The review of care and practice in open children's homes that is being conducted presently by DfE[7].
- The work of the Independent Advisory Panel on Deaths in Custody on common principles for the use of restraint[8].
- DfE guidance on the Use of Reasonable Force in schools[9].
- The updated guidance relating to the Children Act 1989 relating to children's homes[10].
- The intercollegiate health care standards for children in secure settings[11] that were published in 2013, which include standards for health care professionals in relation to the use of restraint.
- The policy framework from MoJ on the use of restraint in the secure estate[12].
- The YJB code of practice for behaviour management[13].

3. The formation of the Independent Restraint Advisory Panel (IRAP) in 2012 followed on from the work undertaken by the Restraint Advisory Board (RAB) on use of physical restraint in Young Offender Institutions (YOIs) and Secure Training Centres (STCs).[14]

## The Terms of Reference for IRAP

4. The terms of reference (Annex A) for IRAP outline two main tasks. They are to:
   - Support the implementation of Minimising and Managing Physical Restraint (MMPR)[15] to STCs and YOIs.
   - Assess the quality and safety of systems of restraint commissioned for use on children in Secure Children's Homes (SCHs).

5. In order to facilitate achievement of these two objectives, the MoJ and DfE drew up a memorandum of understanding for the work in relation to children in SCHs

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7 http://webarchive.nationalarchives.gov.uk/20131027134109/http://www.education.gov.uk/childrenandyoungpeople/families/childrenincare/a00224323/quality-child-homes-report

8 http://iapdeathsincustody.independent.gov.uk/news/iap%E2%80%99s-common-principles-on-the-safer-use-of-restraint-published-today/

9 http://www.education.gov.uk/aboutdfe/advice/f0077153/use-of-reasonable-force/use-of-reasonable-force---advice-for-school-leaders-staff-and-governing-bodies

10 http://www.education.gov.uk/aboutdfe/statutory/g00222870/children-act-1989-childrens-homes

11 http://www.rcpch.ac.uk/cypss

12 http://www.justice.gov.uk/downloads/youth-justice/custody/mmpr/use-restraint-policy-framework.pdf

13 http://www.justice.gov.uk/downloads/youth-justice/custody/mmpr/behaviour-management-code-of-practice.pdf

14 http://www.justice.gov.uk/downloads/youth-justice/custody/mmpr/mmpr-restraint-advisory-board-report.pdf

15 http://www.justice.gov.uk/youth-justice/custody/behaviour-management/minimising-and-managing-physical-restraint

(Annex B). IRAP established separate working groups for the two areas of work. This report covers IRAP's second task.

6. The definitions of key terms, and restraint and disengagement in particular, are included in the Glossary at Annex C.

7. Restraint systems are commissioned separately by each local authority and from a range of different providers. The authority for local authorities' governance, quality assurance and monitoring of restraint is provided by child welfare legislation, primarily the Children Act 1989 and its accompanying guidance, regulations and standards, and through inspections carried out by the Office for Standards in Education, Children's Services and Skills (Ofsted).

8. Some local authorities contract with the Youth Justice Board (YJB) for their SCHs to provide placements for children who are involved in the criminal justice system. Therefore, those SCHs are also subject to the reporting requirements, guidance and scrutiny of the YJB and the MoJ. Other government departments and arms length bodies that have an interest in SCHs include the DH and NHS England, which provide services in the SCHs, and the Home Office for children who are detained by the police and transferred to SCHs under the provisions of the legislation and codes of practice relating to the police and criminal evidence (PACE).[16]

9. In order to establish the current situation with regard to how restraint systems in SCHs are commissioned and the governance processes relating to them, IRAP commenced the work with evidence gathering from:

- Relevant governments departments and arms length bodies: DfE, MoJ, YJB and NHS England.
- Ofsted as the relevant inspectorial body.
- Local authority children's services managers with responsibility for SCHs.
- Local Safeguarding Children Boards.
- Secure Children's Homes.
- Health care providers in SCHs.
- Organisations that provide training for staff of SCHs on restraint (abbreviated to providers of training or providers in this report) and any medical experts they use to advise them.
- The British Institute for Learning Disability (BILD).

[16] https://www.gov.uk/police-and-criminal-evidence-act-1984-pace-codes-of-practice

10. We gathered information by means of initial questionnaires (and subsequent supplementary written questions) followed by face-to-face interviews using semi-structured frameworks to give consistency.

11. Two formal seminars were held with representatives from local authorities. Attendees came from children's social care, and education organisations and people who have responsibilities for commissioning systems of restraint for use by local authorities. We asked them to address specific questions on oversight and commissioning of training for staff on restraint and disengagement.

12. Additionally, IRAP examined the policy context, and commissioned reviews of findings from research that is available in the literature on: use of restraint with children in SCHs and behaviour management. Also, IRAP conducted semi-structured interviews with children and young people who were resident in SCHs in February and March 2014.

13. The DfE also established a stakeholder reference group to provide expert opinion and advice to IRAP. Members were drawn from Ofsted, the Association of Directors of Children's Services (ADCS), the YJB, MoJ, NHS England, and from the Secure Accommodation Network (SAN) that represents managers of SCHs, both those that only accommodate children who require welfare placements and those that have contracts with the YJB to accommodate young people who are remanded or sentenced by the criminal justice system.

# CHAPTER TWO: THE POLICY CONTEXT

## Introduction

14. In 2011, the report of the Restraint Advisory Board (RAB) to the MoJ[17] set out a set of principles that should govern use of physical restraint on children. They are presented in Chapter 2 of this report. IRAP takes the view that these same principles should underpin the use of restraint in SCHs, regardless of the system or restraint techniques used.

15. Use of physical force on children who are detained by the state is governed by legislation, regulations and guidance in several areas:

- Child care: international conventions, domestic legislation and relevant regulation and guidance.
- Criminal and common law relating to improper use of aggression and the right to self defence.
- Employment legislation and regulations and guidance.

## Child Care

16. International conventions on children's rights[18] and, particularly, the provisions that relate specifically to children who are deprived of their liberty[19] require that children should be treated with dignity and respect while incarcerated and they should not be subject to cruel, inhuman or degrading treatment. The conventions contain some specific references to the use of restraint and the roles of managers and medical practitioners.

17. Rule 52 of the United Nations Rules for Juveniles Deprived of their Liberty places a responsibility on medical practitioners to report to the authorities responsible for safeguarding if they believe that any conditions of the child's detention will be injurious to their psychological or physical health. Rule 64 of the same convention requires that restraint should only be used in exceptional circumstances and when all other control methods have been exhausted and failed.

[17] Assessment of Minimising and Managing Physical Restraint (MMPR) for Children in the Secure Estate. http://www.justice.gov.uk/downloads/youth-justice/custody/mmpr/mmpr-restraint-advisory-board-report.pdf
[18] United Nations Convention on the Rights of the Child. (Ratified by the UK in 1991) http://media.education.gov.uk/assets/files/pdf/u/uncrc%20%20%20full%20articles.pdf
[19] United Nations Rules for the protection of Juveniles Deprived of their Liberty. http://www.un.org/documents/ga/res/45/a45r113.htm

18. The Children Act 1989 established the welfare principle. It requires that any interventions should promote and safeguard the welfare of the child, and be in their best interests. Subsequent regulation and guidance[20] has specific sections on SCHs and use of restraint. Chapters 2 and 4 of the Children Act 1989: Guidance and Regulations, Volume 5: Children's Homes cover the governance of SCHs and the circumstances in which restraint may be used, forbids the use of deliberate induction of pain and requires use of restraint to be part of an overall behaviour management strategy. Staff training and competency is also covered, laying out the requirement that, '*Before being expected to use any specific method of restraint, staff will need to demonstrate that they fully understand the risks associated with the technique concerned'.*

19. Section 11 of the Children Act 2004[21] requires all agencies that work with children to take all reasonable measures to ensure that the risks of harm to children's welfare are minimised and, to take appropriate actions to address any concerns about a child's welfare.

20. It should be noted that there are differences in the circumstances in which restraint can be used between the three types of establishments in the secure estate (YOIs, STCs and SCHs). SCHs may only use restraint to prevent:

    - Injury to any person (including the child who is being restrained).
    - Serious damage to the property of any person.
    - Absconding, but only when there is no alternative method.

21. In addition to these circumstances, restraint may also be used in YOIs if there is a ' … *risk to the good order of the establishment'*[22]. In STCs, the additional circumstances in which restraint can be used do not include 'good order', but it may be used to prevent a child from, ' … *inciting another trainee to do anything specified (injuring himself or others or damaging property)'.*[23]

22. The YJB has also produced a code of practice in relation to children who are detained under powers given by criminal justice measures. That code of practice is intended to apply to all establishments across the secure estate.[24] In most areas, this code reflects the principles contained in the international conventions and domestic legislation in relation to behaviour management, staff training, risk assessment and proportionality.

[20] Children Act 1989: Guidance and Regulation, Volume 5. Children's Homes. http://www.education.gov.uk/aboutdfe/statutory/g00222870/children-act-1989-childrens-homes
[21] Children Act 2004. http://www.legislation.gov.uk/ukpga/2004/31/contents
[22] The Young Offender Institute Rules. 2000
[23] Secure Training Centre Rules 1998
[24] Managing the behaviour of children and young people in the secure estate: Code of practice. http://www.justice.gov.uk/downloads/youth-justice/custody/mmpr/behaviour-management-code-of-practice.pdf

23. However, there is one area of difference that reflects the differing governance of the three types of secure estate establishment. The YJB's code allows for deliberate pain induction in '*exceptional circumstances'*. It should be noted that, currently, this is only applicable in YOIs and STCs. Furthermore, this provision could be seen as contrary to the recommendations of the joint inspectors[25], who, in their inspection report of 2005[26] recommended that the relevant government departments should, ' … *issue one agreed set of principles for the use of control methods in all settings where children are cared for, including secure settings'.*

## Criminal and Common Law

24. In England and Wales, there is a common law principle that any person has the right to act in defence of themselves or others. However, this common law principle also requires that any person using this defence must be able to prove that they considered the action taken was reasonable in the circumstances and at that time. In addition, there is also criminal legislation that allows for people to use, ' … *such force as is necessary in the circumstances in the prevention of crime, or in the effecting or assisting in the lawful arrest of offenders or suspected offenders unlawfully at large'.*[27]

25. However, reasonable force is difficult to define. In its guidance, BILD says, ' … *views of what is acceptable can change over time. This defence cannot be used to justify immoderate or excessive chastisement'.*[28]

## Employment Legislation

26. Employment law is varied and frequently complex. Relevant legislation includes the Health and Safety at Work Act 1974 and its accompanying guidance and regulations, the Employment Rights Act 1996 and the Control of Major Accident Hazards Regulations 1999.

27. These statutes contain requirements that employers have duties to ensure that staff are properly trained and competent to carry out their duties, and that the

[25] Comprising: Commission for Social Care Inspection, Her Majesty's Chief Inspector of Schools, Her Majesty's Chief Inspector of Court Administration, Her Majesty's Chief Inspector of Probation, Her Majesty's Chief Inspector of Constabulary, Her Majesty's Chief Inspector of Prisons, Healthcare Commission, Her Majesty's Chief Inspector of the Crown Prosecution Service.
[26] Commission for Social Care Inspection, on behalf of the joint inspectorate steering group (2005) *Safeguarding Children – the Second Joint Chief Inspectors' Report on Arrangements to Safeguard Children*. London: Commission for Social Care Inspection.
[27] Criminal Law Act 1967 Section 3 (1)
[28] Physical Interventions: A policy context. BILD publications 2008. p. 29

work place is a safe environment. However, there may be differing perspectives in relation to use of restraint. BILD argues that, ' … *on the one hand there is a requirement to prevent dangerous occurrences in workplaces (which may be used to justify their (physical interventions) use). On the other hand there are requirements to keep employees safe (which imply that if staff use them they must be able to apply them properly and safely)'.*[29]

28. It should be noted that, while the Welsh Government has reviewed and amended some regulations and guidance pertaining to the Children Act 1989 to make it appropriate to Wales, the regulations and guidance relating to SCHs is still awaiting review. Presently, youth justice legislation, policy and guidance are not devolved matters although responsibilities for education and healthcare are devolved.

[29] Ibid. p.33

# CHAPTER THREE: IRAP'S FRAMEWORK OF ETHICS AND VALUES

## IRAP's Framework of Ethics

29. IRAP decided to adapt the ethics framework previously espoused by the RAB for the work relating to using restraint in YOIs and STCs. That ethical framework is underpinned by five key values:

- **Children's status**

  Anyone who is under 18 years of age and in public care or detained by the state is a child. As a matter of law, they retain the same protection provided by domestic and international legal frameworks that is otherwise afforded to children who are not in custody. The welfare of children is of paramount importance, and this principle must remain at the forefront in caring for and managing children who are detained by the state. Children should have a say in how they are cared for and managed, and be able to voice confidentially and independently any concerns that they may have about their care including restraint.

- **Use of restraint**

  Use of force must always be necessary, proportionate and in accordance with the law. Using force always carries a potential for harm to any child who is restrained, but these risks must be kept as low as is reasonably possible. The techniques and holds used to restrain children must be developed and applied as part of an effective overall strategy for managing their behaviour.

- **Restraining children involves special considerations**

  Restraint, and the techniques that are used when restraining children, must not be used as punishment. Its use must arise from the requirement to protect people. Restraint and its use should not be understood and applied from an adult perspective. It should be taught in the context of what we know about the physical and psychosocial development of children and young people. This means that systems and techniques must be informed by: the physical and physiological attributes of children as human beings who are continuing to develop; the wide differences that arise in how children understand their circumstances; what is happening to them and what is asked of them; and the wide variations that arise in children's behaviour and in their emotional responses from the impact of their past experiences and the narratives in their personal lives prior to their being in secure accommodation and the needs to which these developmental perspectives give rise.

- **High quality training is essential for safer restraint**

  The quality and frequency of training is vital to practicing restraint safely. Training must be child-focused and must enhance staff skills in de-escalation and diversion to minimise any need to have recourse to restraint, and it must be repeated regularly to maintain fidelity of practice with the techniques that are taught.

- **A safe system of restraint requires effective governance**

  Each organisation and every establishment that uses an authorised restraint system must demonstrate robust governance arrangements. Governance is the means by which the managers of each establishment are accountable for, and provide assurance that all of the key elements of a restraint system are operating as intended and to specified standards.

30. Recognition of the importance of the concept of values in determining how public services are planned and delivered is not new. The concept has been developed and implemented in areas with diverse agendas such as healthcare and prisons. IRAP advocates values-based practice because, as applied to using physical force, these approaches to bringing values and principles into practice openly are intended to help managers to resolve conflict by recognising, supporting and working with a balance of legitimately different perspectives.

31. All practice in SCHs, including use of physical force on children, should be underpinned by an ethical framework which can be defined as:

    *The values that describe the desired behaviours of organisations and the people who work in them, and which are as demonstrated in the way that people work, and in the operations and activities of all relevant organisations*.

32. IRAP believes that the values that the RAB adopted, and from which it developed the principles and criteria for assessing restraint systems that are presented to it for possible use, are germane not only to use of physical force in SCHs, but also to other activities in the public sector.

33. Therefore, IRAP's core values are that:

    a. Child-centred principles and a strong ethical framework must underpin any system that allows use of physical force with children.

    b. Everyone, whether children or young people and staff, matters equally and people should be treated fairly and with respect.

    c. The interests of each person should be the concern of all. Minimising the risk of harm to children or groups of people and staff is of core concern.

d. The needs of groups of people should be considered and balanced with the needs and circumstances of each child, recognising that decisions about intervention with one child also affect the group of children and the staff of the establishment.

e. On each occasion, the decision to use physical force to restrain a child should be based on the best interests of that child.

## Values-based Practice

34. Values-based practice[30] is intended to enable people to make decisions that are based on both the facts (the evidence that pertains to particular situations) and on the values held by the people who are involved in those decisions. At its root, values-based practice recognises that every person has a set of values, whether they recognise them consciously or not. Thus, every interaction in the secure estate, as all human interactions, can be described as a meeting of values. Often, negotiation of these values is an unconscious part of every conversation, event or interaction.

35. The values that arise most frequently in SCHs include those of:

- The children, and the families and communities from which the children have come.
- The staff and the organisation for which they work.
- The people who are responsible for commissioning the work and practices of each establishment together with the local authorities.
- The arms length bodies, and the government departments that are responsible for the policy that underpins the role and functioning of each SCH.

36. The children bring with them their own values and those of the communities from which they have come when they enter an SCH. Individual employees have their personal values and are called on to present and enact the values of their employers and of the relevant authorities. Thus, even though some parties are not present, it might be said that there is a wider array of values in play in each interaction between a child and a member of staff within the SCH. These values include those of absent authorities and staff that are communicated through each establishment's operational policies, governance structures and

[30] Williams R, Fulford KWM. Values-based and evidence-based policy, management and practice in child and adolescent mental health services; Clinical Child Psychology and Psychiatry 2007; 12:223-242.

attitudes. As a result, it is likely that varied, sometimes divergent, values influence people's experiences of, the feelings and opinions they have about, and the decisions they make in each situation. It should not be assumed that everyone shares the same set of values even if they say little or give few clues as to their feelings and opinions.

37. Values are less likely to arise as a point of discussion, debate or disagreement when there is conscious or unwitting agreement about the values that are invoked by particular events or circumstances. However, when there is a difference in the values held by the various people who are involved, those differences may become more noticeable, influence their understanding of events, and lie behind disagreements. The opinion of IRAP is that conflict can escalate not only because the facts of a situation are contested, but also because certain events evoke strong feelings when there is a clash between different people's values and expectations of each other; and can lead to attribution of intent or causation.

38. Values-based practice is intended to help staff to recognise and work towards resolving situations in which divergent values arise inevitably. Therefore, it is, highly relevant to the work involved in caring for, supporting and managing children. Everyone can benefit from having knowledge about how values operate and influence personal agendas in social settings. There are also skills involved in working with diverse values in order to achieve agreed decisions and greater rather than less harmony. Adopting a values-based approach should assist the staff of the SCHs to ensure that their use of restraint meets the requirements of proportionality and effective risk management that IRAP espouses as key objectives of a safer restraint system.

39. Values-based practice and IRAP's framework of values and principles are intended to enable staff to be more confident in their approaches to adjudging when and how to use physical force, and exercising their own responsibility and accountability. This explains why IRAP is making overt in this report its values and the principles that it has adapted from them for decision-making and governance of the use of restraint in SCHs.

## A Systematic Approach to Decisions about Restraint

40. Making judgements and decisions in many situations involves complex processes. When faced with conflict, staff have to decide quickly on the best course of action. They are faced with:

    - Assessing the situation accurately, effectively and rapidly.

- Taking into account divergent views.
- Making analyses of the risks and benefits of different courses of action.

41. Often, people who exercise judgments in such challenging and/or emotionally charged situations are not aware of, or able to describe fully the experiences, transactions, non-verbal observations, knowledge and values that influence their decisions. Many people who are involved in situations that are characterised by high anxiety and/or conflict say afterwards that they acted 'on instinct'. However, instinct is not an inherent attribute and it is very hard to define and measure. Probably, instinct is used to describe learned behaviour that is based on prior knowledge, previous experiences, and past assessments of similar situations.

42. Making decisions in another person's 'best interests', a concept established in law and professional practice, is complex, as is the balance between the interests of individual persons and groups of people. IRAP considers that the following five guiding points assist staff to ascertain what a child's best interests are. Decision-makers should:

    a. Take into account all the relevant factors that it would be reasonable to consider, not just those that they think are important, or which reflect what they would prefer to happen;

    b. Make every reasonable effort to involve and enable the children to take part in decision-making on matters that concern them;

    c. Not act on preconceived ideas or negative assumptions;

    d. Not act on or make decisions that are based on what they would want to do if they were the person about whom the decision is being made; and

    e. Be able to explain the decisions that they have made about each child's best interests, giving their reasons for reaching those decisions and identifying the particular factors they have taken into account.

## Effective Decision-making about Whether or Not to Use Restraint

43. IRAP has examined how its values, and the principles that are derived from them, can be applied to effective decision-making. It has adapted previous work to identify the following elements of good practice in decision-making against which to assess the evidence about using restraint:[31]

[31] Developed from the Welsh Health Circular WHC (2007) 076: an ethical framework for commissioning health services to achieve the healthcare standards for Wales. Cardiff: Welsh Assembly Government, 2007.

- **Openness and transparency**

  Decision-making processes, including the evidence and arguments on which they rely, should be open to scrutiny.

- **Inclusiveness**

  All parties who are affected by the processes and decisions, that is, children, staff, trainers and managers, are able to express their views.

- **Respect**

  The restraint system and the techniques within it should reflect respect for the needs and the human rights of each child. This means that restraint is understood as only one small part of a comprehensive programme for helping children with their behaviour and that it is used within a wider programme for managing their behaviour. This also means that staff members know how to assess what is in the best interests of each child or young person and are able to apply that knowledge.

- **Proportionality**

  The restraint system and its techniques and their effects must be proportionate to the risks posed by each situation.

- **Accountability**

  Each organisation is accountable for ensuring that only staff members who are fully trained to do so use restraint techniques in which they have been trained, and that the training properly equips them to assess risks proportionately and to match the techniques used to the risks presented in each incident.

- **Reasonableness and lawfulness**

  Staff are able to: justify against an ethical values framework each decision they make to use restraint; and explain how they employed use of the minimum force that was necessary; and, hence, that their decisions to use restraint are lawful.

- **Effectiveness and efficiency**

  The techniques that are taught to staff are effective in protecting each child from harm.

- **Exercising a duty of care**

  When deciding whether or not to use force and which restraint techniques to employ, the primary focus is the safety of the children who are involved. This means that staff are trained in the skills to minimise the need to resort to

physical restraint, and to use well, safely and consistently the physical interventions that are included in the restraint programme.

- **Reviews and complaints**

  Children must have the confidence to use fair and credible complaints procedures. They should be given opportunities to use independent advocacy to enable them to express their opinions and experiences with regard to how they are cared for and managed, and about their experiences of restraint.

# CHAPTER FOUR: AN OVERVIEW OF THE FINDINGS FROM IRAP'S MEETINGS AND VISITS

## Four Areas of Evidence Gathering

44. In the course of scoping its task, IRAP identified four key areas for evidence gathering in relation to current practice, management, reporting and governance relating to use of restraint in SCHs. IRAP determined that it required information from:

- Government departments, inspectorates, arms length bodies, local authorities and SCHs.
- Providers of training for staff on restraint.
- Staff who deliver healthcare services (hereafter, healthcare providers) in SCHs.
- Medical experts who advise providers of training on restraint.

45. IRAP also commissioned a review of relevant research (see Chapter 4) and of the policy context (see Chapter 6).

## Collation of Evidence from Government Departments, Inspectorates, Arms Length Bodies, Local Authorities and SCHs

### Methodology

46. The aim of the questionnaires and visits was to establish base-line information about: the restraint systems that were in place in SCHs; the arrangements for commissioning those restraint systems; the arrangements in place for commissioning training on restraint for the staff of those SCHs; the governance for use of restraint; data collection reporting requirements; and the relationships between SCHs, training providers and local and central governments.

47. The questionnaires were devised by the Chair, Deputy Chair and an IRAP member with support from the secretariat in the MoJ and DfE. They were sent to:

- Two government departments: the MoJ and the DfE.
- An arms length body: the YJB.
- The inspectorial body for children's homes, including SCHs: Ofsted.

- The Directors of Children's Services (DCS) in the 16 Local Authorities that provide an SCH.
- The managers of the 17 SCHs.
- The Chairs of 15 Local Children's Safeguarding Boards (LCSB)[32].
- The Chief Executive of an NGO that runs an SCH.

## Findings from the Questionnaires

48. The response rate to the questionnaires was almost 100%. All government departments, children's services and SCHs returned the questionnaires, as did 14 out of 15 of the LCSBs.

49. While the questions asked of each agency had common themes, there were variations in specific questions relative to which agency was responding.

50. IRAP identified from its initial analysis of the results that it required answers to supplementary questions from staff of SCHs. Managers of 11 establishments responded to these further enquiries.

51. IRAP members visited all SCHs and asked a series of semi-structured questions. They asked supplementary questions following the visits and all SCHs responded.

52. We present briefly below and in summarised form IRAP's core conclusions from its scrutiny of the completed questionnaires.

*Government departments and arms length bodies*

Key gaps

53. IRAP has identified important gaps from responses of the government departments and arms length bodies to its members. They are:
    - Neither DfE nor YJB monitors the appropriateness of specific restraint systems in place in SCHs, either generically or for their use with particular children.
    - Each department derives information about restraint from a range of reports. There is variation in the circulation of the reports. The sources include:
        - Inspection reports from Ofsted.

[32] One Local Authority and one LCSB have two SCHs and in Wales the DCS and Chair of the LCSB is the same person.

- Reports from independent visitors as required under Regulation 33 of the Children Act 1989.
- Collations of data sets provided by the separate SCHs on their use of restraint, single separation, child protection and complaints.
- Monthly reports from SCHs.

- IRAP was offered no evidence to indicate that 'raw' data from reports of particular incidents are routinely examined by the YJB or DfE.
- IRAP was told that Ofsted does, as part of its inspections, sample this raw data and, when it does so, it cross-references incident reports on restraint, single separation, safeguarding and complaints.

54. As a result of the responses from the government departments and arms length bodies, as reported to its members, IRAP has come to the view that there are important gaps in the responses of the government departments and arms length bodies. They are:

- There are gaps in the feedback loops with no mechanism for cohesive or direct links between the central authorities, the local authorities, the SCHs and the training providers.
- Government departments are unable to identify explicit standards that govern restraint systems or reporting mechanisms.
- There does not appear to IRAP to be any formal cross-departmental analysis or learning from data that is presently collected.

*Policy responsibilities*

55. DfE has responsibility for policy formulation in regard to:

- Looked After Children (LAC).
- The regulatory and policy framework for children's homes, including SCHs.
- Managing the approval process for SCHs (they must all be approved by the Secretary of State for Education).
- Safeguarding children.

56. The MoJ has no formal responsibility for policy for SCHs.

57. Ofsted has legal powers to regulate and inspect children's homes, including SCHs in statute and the statutory regulations.

58. The YJB has no formal responsibility for policy, but seeks to influence policy through its responses to consultations and direct comment to DfE and the Secure Accommodation Network (See Glossary in Annex C for a definition of SAN).

59. NHS England has responsibility given by the Health and Social Care Act 2012 to commission health services for children held in SCHs in England.

*Coordination with the wider landscape of the secure estate*

60. Staff of DfE have been members of various groups that are coordinated by the YJB and they have recently commissioned research into the secure 'welfare' market.

61. Commissioning decisions made by the YJB are agreed with Ministers in the MoJ. Ofsted inspects SCHs. The YJB commissions secure beds in SCHs from local authorities.

*Collection and use of data*

62. Ofsted receives notifications of 'serious incidents' from SCHs that are required by statutory regulation. They include: notifications of events that raise concerns about: child protection; serious illnesses or accidents that are suffered by any child; and any serious complaint. These notifications are the only data that is required by statutory regulation. These notifications are used to identify particular concerns in order to facilitate discussion between Ofsted, the SCHs and the local authorities and to identify any measures required to address these concerns.

63. In turn, DfE receives information from Ofsted that is based on the notifications that it receives from SCHs and which give particular cause for concern, either in relation to the safety and well-being of particular children or following serious incidents, allegations or complaints.

64. Ofsted scrutinises and evaluates the quality of reports made pursuant to the requirements of Regulation 33. This regulation was introduced in the Children Act 1989 and was designed to provide independent oversight of children's homes outwith the line management responsibility[33].

[33] http://www.legislation.gov.uk/uksi/2001/3967/regulation/33/made - it should be noted that changes made to these regulations will come into force from April 2014.

65. Ofsted sees up-to-date collated information on restraint, single separation and complaints as components of inspections of the facilities it inspects. However, it does not carry out any comparative analysis of the data gathered during its inspections.

66. The YJB receives monthly reports containing data and contextual information from those SCHs with which it has a contract. The data includes that on restrictive physical intervention, single separation, assaults, complaints and child protection incidents.

67. The YJB is notified when Ofsted publishes the reports on its inspections. Also, the YJB can have access to monthly reports that are produced pursuant to Regulation 33, if necessary.

68. Representatives of the YJB told IRAP that it uses data to: inform its monitoring function; take action to improve or address poor performance; share effective practice; and inform commissioning decisions.

*Standardisation, safeguarding and accountability*

69. DfE does not identify or define any standard system of restraint, particular techniques or reporting mechanisms across the systems in place in SCHs.

70. DfE has formal responsibility for safeguarding all children. However, operational responsibility for safe implementation of restraint systems lies with each organisation that provides an SCH. The responsibilities of DfE lie only in ensuring that the regulatory and guidance frameworks are designed to deliver safe care.

71. YJB has a 'Risk and Review' process in place that involves it in reviewing data after incidents have occurred. The process includes a mechanism to identify actions that are required. Feedback is given to SCHs and monitoring visits are adjusted accordingly to monitor whether the actions required are being taken.[34]

72. Ofsted monitors SCHs through inspections and it has statutory powers to require actions. Feedback is only to SCHs although all inspection reports are available on the Ofsted website. Ofsted told IRAP that it is the decision of each SCH as to whether findings are fed back to providers of training.

[34] This applies only to the ten SCHs with which the YJB have a contract.

## Findings from the Questionnaires, Visits to SCHs, and the Supplementary Questions and the Roles and Relationship of SCHs with LSCBs

*Definitions of restraint*

73. IRAP found that the definitions of restraint used by the SCHs were varied and derived from a number of sources. Some units used the terminology that was set out in YJB forms and publications. Others based their definitions on principles found in the Children Act 1989, or followed advice provided by Ofsted in relation to recording and reporting restraint, or specific requirements or recommendations made by Ofsted following an inspection.

74. In IRAP's opinion, there was an absence of shared terminology and that has resulted in inconsistencies and lack of clarity. On the basis of extracting key words from definitions used by SCHs, the definitions provided to IRAP had one or more of the following features:

- Use of force to overpower: 2 SCHs.
- Any physical intervention: 4 SCHs.
- Any physical intervention of a young person against his or her will: 1 SCH.
- Any physical intervention to prevent risk (of harm) or damage: 5 SCHs.
- Physical interventions to prevent actions continuing: 1 SCH.
- Resistance against a hold: 3 SCHs.
- Restrictive physical intervention: 2 SCHs.

*Commissioning and decision-making*

75. IRAP found that, in almost two thirds of the SCHs, the SCH manager and the local authority manager of children's services worked jointly to commission the restraint systems they used and the training they provided for their staff. One had involved the local safeguarding lead. Only one SCH reported using a tendering process for its, then, current system and seven managers reported that the system had been the one in place when they took up post. Further exploration of this during site visits made by IRAP members indicated that, in some SCHs, commissioning of training on restraint for SCH staff had been exempt from the usual arrangements and time scales for commissioning used by the local authorities.

76. At the time of the site visits made by IRAP, none of the SCHs had changed its provider of restraint training in the three years prior to IRAP's enquiries. The

current restraint system had been in place for eight years or more in nine of the 11 SCHs that replied to the supplementary questionnaire.

77. While it was unclear to IRAP whether or not all SCHs had a regular review of the provider of the system, all told IRAP that they undertook some sort of internal review on an annual basis.

78. At the time of IRAP's site visits, seven training organisations were providing training on restraint in the SCHs. In eleven local authority areas, the same system was commissioned for use in all children's homes. However, a number of SCHs reported that adaptations were made to the system to fit the specific needs of the SCH. Two SCHs had developed their own training, and, in both cases, it was based on material from one of the seven providers. These two SCHs were subject to the same structured interview as were the other providers (see the appropriate section in this chapter). Since the site visits, IRAP has been informed that one SCH has changed its provider. IRAP does not assert that this has not happened in other SCHs in the interval.

79. Five SCHs commissioned a 'whole behaviour management system' from their provider, eight commissioned a restraint system with diversion, diffusion and de-escalation techniques, and three commissioned a restraint system only. One SCH commissioned another configuration.

80. These variations led to differences in recording and reporting (see also the previous section in this chapter on collection and use of data). Some SCHs recorded any physical contact including, for example, applying a guiding hand to encourage a child to move, in their restraint statistics.

*Medical risk assessments*

81. In their responses to the relevant questionnaire, 15 of the 17 SCHs told IRAP that the system they used had been subject to a medical risk assessment. Information gathered during the visits to SCHs made by members of IRAP indicated that there had been some misunderstanding about this question with confusion between medical risk assessments of each child and medical risk assessments of the techniques used in restraint.

82. It would appear from the information gathered during the visits to SCHs that:

- Four believed their provider had undertaken a medical risk assessment of the techniques, but had not seen it.
- Six did not know whether their provider had undertaken a risk assessment.

- One assumed that BILD accreditation of the provider of training included medical risk assessment.
- One had seen a letter confirming that a medical risk assessment had been undertaken, but had not seen the assessment.
- Two had copies of a medical risk assessment but did not use it in training their staff as the in house instructors (see the section in this chapter on training in restraint and disengagement techniques) thought it to be too complex.
- Two had copies of a medical risk assessment.
- One told IRAP that the 'in house' psychologist and psychiatrist carried out the medical risk assessment of its restraint system.

*Serious incidents*

83. IRAP's enquiries with the SCHs revealed that the definitions, criteria, and methods used to record and report serious incidents were derived from a variety of sources including Ofsted, the YJB and local reporting requirements. There were significant variations in key words used in the responses from SCHs:
    - One SCH used criteria based on its experiences of Ofsted inspections.
    - Six reported and recorded all restraint incidents as serious.
    - Three reported and recorded incidents involving restraints as serious if there had been significant injury to a child or staff member, or if there were concerns about child protection.
    - Two reported and recorded as serious any incident which led to either disciplinary action or a capability review of the member of staff involved.
    - Two reported and recorded as serious any incidents in which there was non-compliance with internal policy and procedures.
    - One reported and recorded incidents as serious if there was deemed to be a high level of risk presented by or to anyone in the establishment.

*Training in restraint and disengagement techniques*

84. All SCHs operated a cascade system of restraint training meaning that the external provider trained instructors from among the staff of the SCHs who then trained all other staff. In some cases, the training offered by these in house trainers was conducted in conjunction with a trainer provided by the external provider agency.

85. Initial training varied from 3 to 8 days and the average was 3.3. days. Refresher training was undertaken annually, as a minimum, in all SCHs and, while the duration was measured in hours by many SCHs, the length varied from 1 to 5 days with an average of 2 days. These figures were less for those staff who were trained in breakaway techniques only (e.g. ancillary staff who had no direct role in caring for the children).

86. IRAP was told that no staff of any SCH were trained in any restraint techniques which involved deliberate induction of pain. However, three establishments said that they did train staff in breakaway techniques that might induce pain (e.g. sternum rub, mandibular angle technique [MAT], thumb flexion and knuckle push). All these establishments stated that these techniques had not been used during the tenure of the current manager.

87. All SCHs identified head holds and restraint in the prone position as causing the highest risk. Nine SCHs trained staff in a technique to control the heads of children who are being restrained. Others described 'managing' or 'protecting' children's heads (e.g. by use of cushions). Restraint in the prone position was seen to be undesirable and only to be used where the risk was high. The SCHs told IRAP that the staff of four SCHs had had specific training in restraining children in the prone position, 3 SCHs had trained their staff in techniques to move children from prone to sitting or upright and several referred to 'going to the floor' or 'managing' children on the floor, but did not train their staff in a technique to take children to the prone position.

88. Only one SCH had specific training for its staff in techniques to remove a weapon because, generally, this problem was seen as a matter for the police. Police involvement was reported as relatively rare: 5 SCHs reported to IRAP the need to call the police in the last two years, predominantly to remove weapons from children. Ten SCHs had a specific joint protocol with the police (either unit specific or as part of a general local authority protocol). Three reported that they would try, when possible, to ensure that the police had any relevant specific medical information.

89. Members of IRAP asked a series of questions about:

- How SCH managers selected which techniques their staff should be trained to undertake.
- Whether their training provider was able to offer bespoke training.
- Injuries incurred as a result of incidents in which restraint had been used.

Again, there were wide variations in the responses to these questions.

90. Responses to the questions about selection of techniques ranged from: *'rely on the provider to select'; 'there is a county-wide approach to selection*'; '*we train in all techniques offered, but the manager decides which ones to use'; and 'we have criteria and agree jointly with the provider'.*

91. Only two respondents said that their training provider would not provide bespoke or individual techniques if requested. Six had requested these packages in the last year. The reasons cited were: removal of weapons; pregnancy; a specific physical condition; and a change of the physical environment in the unit.

92. Injuries to children related to incidents in which restraint had been used varied in number and type. Seven responding SCHs reported no injuries sustained by children over the last year; three reported between one and three minor injuries; and six reported between 10 and 57 injuries. Respondents also reported on injuries to staff where numbers were greater. Nine reported between four and 109 injuries related to use of restraint.

*Data collection*

93. IRAP found huge variations in data collection by SCHs with respect to format of reporting and which agencies were the recipients. In response to the question, '*what data on restraint do you collect',* SCHs identified 43 different fields. Most commonly mentioned were: duration; type of hold; number of incidents; injury to staff; and injury to child.

94. Data on restraint was reported by SCHs to a maximum of 11 separate persons or agencies. SCHs reported a high level of duplication of information requested but in different formats.

95. At a central government level, the YJB and Ofsted were most frequently cited.

96. Local agencies to which the SCHs reported providing data on restraint included:

- The Local Authority Designated Officer or LADO (an identified officer in the local authority who receives notification of child protection incidents).
- Visitors pursuant to Regulation 33.
- Relevant line managers.

97. SCHs reported that the data they collected was used internally to identify trends, triggers for incidents and to assist with developing policies and plans that are intended to minimise use of restraint.

*Relationships with Local Safeguarding Children Boards (LSCB)*

98. IRAP was told that the formal relationships between LSCBs and SCHs were exercised predominantly by the LADO becoming involved when an incident or complaint was reported. A number of LSCBs reported to IRAP that they visited the SCH regularly. But in most cases, the contact was conducted by managers through their chain of reporting or by relationships with the LADO.

99. The managers of two SCHs were members of the LSCB or a sub-group of it. Each SCH provided an annual report to the LSCB for the area, which included information about use of restraint. LSCBs that have secure establishments in their areas that hold contracts with the YJB are required to report annually to the YJB on use of restraint.

## Collation of Evidence from Providers of Training on Restraint

### Methodology

100. Gathering evidence from providers of training on restraint was undertaken in two stages: circulation of a base line questionnaire; followed by structured interviews with each of the providers.

101. Members of IRAP prepared the questions with support from the secretariat in the MoJ and the DfE. Questions that were supplementary to each formal question were used to expand on responses, to gain greater clarification or to elicit further information.

102. The interview panels consisted of varying numbers of IRAP members, including the Chair. Representatives of the DfE and staff of the MoJ attended all interviews in an advisory capacity.

103. Seven providers were identified and it should be noted that one SCH had developed its own training programme. Therefore, IRAP also interviewed staff from that SCH as training providers. All providers sent representatives to attend the interviews. They were a mix of directors, founders, managers and, usually, more than one instructor.

104. In each instance, a designated member of IRAP recorded the provider's responses with the intention of facilitating collation and analysis of responses and to enable IRAP to make comparisons of the information provided with the SCH's responses to the baseline survey questionnaires and that gained by IRAP members during their visits to SCHs.

105. The training providers were also asked to demonstrate physically their taught techniques to the panel.

106. At the start of this process, IRAP learned that two SCHs had developed their own systems of restraint training. IRAP decided to interview them as training providers using the same format as with all others. Subsequently, one of these SCHs decided to commission an external provider and IRAP then interviewed that provider.

## The Training Providers and the Training they Provide

107. IRAP found that providers of training on restraint have become established in a range of ways. Most have been in existence for some time with one or two having been established for over 20 years.

108. Their training models stemmed from different origins. They include those based on restraint of adults. Most drew on use of restraint in custodial institutions and/or NHS settings. All providers told us they had developed specific child-centred models and that their training includes behaviour management if the purchaser wished to receive it, but they may be commissioned to provide training on restraint and disengagement techniques only.

109. The employment model was also varied with some providers directly employing their trainers while others have developed a franchise model.

110. While all the providers told us they required their trainers to have '*a relevant background',* there were no specific qualifications or skills cited. The initial training for trainers varied from a minimum of five up to eleven days depending on the level of instructor. All but one stated that update training was compulsory to maintain instructor status. The frequency and duration of update training was reasonably consistent at around five days annually.

111. IRAP found that training schedules vary, but all providers offer initial and refresher training. Their schedules are dependent on the requirements of the commissioner. The assessment of trainees is predominantly by observation and was said to cover attitudes, physical skills, and use of the techniques. None of

the providers reported that they had specific 'pass or fail' criteria, but almost all said they would report concerns to the commissioners of their services, which then make decisions about whether individual staff members should be involved in restraint.

*Physical skills*

112. IRAP observes that the providers of training used a variety of terms for techniques, core skills and underpinning principles when describing the techniques they taught. There were variations in the numbers of techniques and skills that the training providers told IRAP that they teach (between 7 and 50 core skills). IRAP's observations of the techniques that the training providers demonstrated to it suggest that these variations may lie more in the teaching methods used by the providers (i.e. how techniques are broken down) rather than in the number of different techniques.

113. No providers told IRAP that they taught skills for deliberately inducing pain as part of a programme of restraint for use in SCHs. However, they acknowledged that children might experience pain accidentally as a consequence of staff using some techniques. One provider said that it did teach pain-inducing techniques as part of training on breakaway techniques.

114. The training providers told IRAP that none of them taught techniques for holding children's heads. However, a number described methods for protecting the heads of children during their restraint. IRAP queries whether or not this might indicate some differences of interpretation between the training providers and between the providers and staff of the SCHs about what constitutes a 'head hold' because some SCHs did report that they use them.

115. Four of the providers said that they taught techniques that are designed to forcibly move children by, for example, lifting. One could offer training in removing weapons, if requested to do so.

116. It was unclear to IRAP from the responses of the providers as to whether or not they all routinely take the requirements of the Statutory Guidance and Regulations to the Children Act 1989 into account when developing their training programmes.

*Risk assessment*

117. IRAP observed that not all of the training providers that it met had included medical advice in their risk assessments of the restraint techniques they taught.

Two appeared to IRAP to have had no medical or risk assessment panel. The representatives of one provider told IRAP that the techniques it used were from another provider. Therefore, that provider had assumed that those techniques had been medically assessed. The providers which had involved medical experts said that amendments to techniques had occasionally been made as a result of their assessments. One provider said that the medical assessment was advisory only and that the organisation's director decided whether or not the risk was acceptable.

118. It was unclear to IRAP from the responses of the providers as to whether or not they take into account the requirements of the Statutory Guidance and Regulations to the Children Act 1989 when developing their training programmes. The providers told IRAP that they comply with health and safety requirements when training staff. Most told IRAP that they collect data on any injuries incurred by staff during training sessions.

119. All providers stated that they taught staff about the risks posed by restraint, including those of positional asphyxia, warning signs and excited delirium, and the need for personal handling plans for each child.

120. However, most providers did not show IRAP a risk assessment based on variables such as age, gender, weight and height. The providers tend to see this as the responsibility of the purchasers of their services as they do about any decision about which techniques to use when restraining each child. All providers taught the warning signs of distress during a restraint and advised trainees that restraint should be stopped if warning signs were observed. But, IRAP did not think that any of the providers it met taught a clear order or form of words to indicate the need to release a child from restraint and instigate action when the situation changed from one requiring restraint to a medical emergency.

*Accreditation*

121. Six of the eight providers that IRAP met had been through the BILD accreditation process. Some providers were unsure of the formal status of BILD as an accreditation body and one provider of training stated that it had sought accreditation through BILD because its commissioners expected it.

122. Most providers reported that any changes to course content and/or teaching techniques could be made through internal processes, although this could be supplemented by an update to BILD. There was unanimous agreement that there was no validation process for trainers.

## Key Findings

123. All providers trained staff in a wide range of settings for children of all ages and for adults. Some offer training to parents and, in particular, to foster parents. They stated that their work in SCHs accounted for a very small percentage of their work overall.

124. Many of the key findings from our meetings with training providers align closely with the findings from the baseline survey questionnaires and visits to SCHs. Therefore we do not duplicate these findings in this section of our report but supplement them with additional further observations and comment.

125. In our opinion, training of staff of SCHs across England and Wales lacks a consistent, structured approach and shows a diversity in training of techniques, and of audit, review and monitoring processes.

126. We found that there are misconceptions about accreditation processes, and some providers, SCHs and local authorities lack understanding of the process offered by BILD (see the section relating to BILD in this chapter).

127. The information provided to IRAP has led it to conclude that, within training on restraint, there is a lack of a coherent approach to policy across relevant government departments and no clear and comprehensive accreditation structure of either the learning methods or the techniques taught.

128. IRAP believes that, in some cases, there has been a dilution of techniques and that they may have been amended to suit local circumstances but without further assessment of the risk they may present to validate the changes.

129. IRAP also identified what it thought was an unquestioning assumption by some commissioners of training that medical risk assessments had been carried out by providers of training.

130. The reports to IRAP indicate that the training providers consider that the commissioners should be ultimately responsible for monitoring the use of their techniques with the children in the care of their SCHs. The training providers met by IRAP cited some examples of being consulted by managers of SCHs on specific circumstances or cases.

## Collation of Evidence on the Roles of Healthcare Professionals in SCHs

### Methodology

131. IRAP sought evidence of the current position and responsibilities of healthcare professionals in SCHs in relation to use of restraint. Two sets of questionnaires were developed and sent to:

    - The healthcare lead for each SCH.
    - Each SCH manager.

    The questionnaire for healthcare leads was developed and circulated with assistance from colleagues in NHS England.

132. The questionnaires for healthcare leads were completed in relation to nine SCHs, and twelve SCH managers completed the separate healthcare questionnaire.

### Key Findings from the Evidence from Healthcare Professionals and Managers of SCHs

133. The questionnaires were designed to identify the views of healthcare professionals about their roles in relation to use of restraint and the views of managers about information sharing, accountability and responsibility. Questions covered the lead healthcare role, the responsibility for use of restraint, and any associated medical risks and information sharing and communication.

134. There were wide variations in the people who were identified as the healthcare leads in SCHs. Of the nine questionnaires completed by healthcare professionals; the head of health was identified as:

    - Nurse (5).
    - Psychiatrist (1).
    - Form completed by GP but unclear whether they identified themselves as head of health (2).
    - No head of health (1).

135. There were also differences in healthcare professionals' views about with whom responsibility lies in relation to any medical risks of restraint. The responses from healthcare professionals indicated that:

- Two respondents saw healthcare professionals as responsible.
- Two identified the service manager or other social care staff as responsible.
- One respondent said that healthcarers shared the responsibility with the safeguarding team.
- The issue was unclear in the responses from the remaining four healthcare professionals.

136. Conversely, the responses from the 12 SCH managers were unequivocal. While a number of them identified input from healthcare and other staff in the decision-making processes, they saw themselves and their senior management team (sometimes in conjunction with the instructors employed to train staff on restraint) as having the ultimate responsibility for use of restraint.

137. IRAP asked healthcare professionals and SCH managers about the communications and sharing of health information relevant to using restraint. Of the nine healthcarers who responded, only two said they were always consulted about behaviour plans for particular children, six said they were sometimes consulted, and one had never been consulted.

138. SCH managers said they obtained medical information from the referral documents and initial health assessments, and all 12 SCH managers indicated that they shared concerns about any risk that might arise from using restraint holds with healthcare professionals.

139. Healthcare professionals were asked about their roles following a restraint incident. Respondents said that there is involvement of a healthcare professional:
- After all restraints (3).
- Only in the case of injury (4).
- Only from psychologist (1).
- One response was unclear about this matter.

## Collation of Evidence from Medical Experts

### Methodology

140. A number of the providers of training on restraint indicated that they had access to a medical expert, both routinely and as needed, to assess the techniques they teach. Therefore, IRAP sent a questionnaire to all of the experts who were identified by the providers to ask them to outline their skills and backgrounds

and to explain in detail the process they used to assess the restraint skills. IRAP received a response from one medical expert.

## Key Findings

141. When discussing the risk assessment process (RAP) used by him or her, the responder expressed the opinion that he or she ought to consider the environment / context within which the skills were applied and that to simply rate the physical skill was inappropriate; to this end he or she always spends time with the providers discussing these matters. The risk assessment, which expresses risk as "likely", "unlikely" and "remote", covers risks to people who restrain others and to the persons who are restrained.

142. Risk, as presented to IRAP by this informant, is considered across a broad perspective and considers specific vulnerabilities of the client group in question such as its age (young people / older people) and whether or not members of a client group have learning disabilities. The responder recommends that all new / amended skills undergo the RAP, but the decision lies with the clients (the providers of training on restraint).

143. The respondent highlighted that there was a paucity of research into physical restraint and risk. Therefore, his or her risk rating is based on "common sense", "physiological principles" and "use of force reporting".

144. An area of consideration within the RAP is the staff involved and their defined roles. Risk may be reduced if roles are clear and if restraint is seen as a dynamic process. Particular areas of greater risk are stairs, transport, doorways and spontaneous violence.

145. In relation to serious injuries and warning signs the responder highlighted two events, excited delirium and positional asphyxia, and said that he or she seeks to ensure that training providers were correctly informed about them. The RAP must not view physical restraint in isolation but consider the particularities of the clinical environments, individual triggers, and antecedents for violence, its physiological and psychological impacts, and it must never be punitive or 'educational'. In his or her opinion, audit, monitoring and feedback on PR skills are not driven by the medical experts but by the providers. The responder told IRAP that providers contact him or her when they want an opinion on a skill. Usually, this occurs if there has been a complaint or a change in practice. Examples of circumstances in which the responder's feedback has been implemented following reporting of adverse incidents include removal of the 'nose bar' technique and the technique of forward flexion in the sitting position.

146. In respect of a question about who has the responsibility for approving PR skills / techniques for use with young people, the responder expressed the opinion that medical experts could not approve but identify the relative risks of each skill set, and that each organisation must approve the PR skills that they wish to use based on its medical expert's recommendations

## The Role of The British Institute for Learning Disabilities (BILD)

147. Local authorities, SCHs and training providers all made reference to accreditation by the British Institute for Learning Disabilities (BILD). It was clear to IRAP that many of its informers see BILD's accreditation process as a mark of quality assurance.

148. BILD is an NGO that was established 40 years ago with the aim of helping to develop organisations that provide services and people who support people who have learning disabilities. It is funded by membership subscriptions.[35] In 2000, following a number of serious incidents in which restraint had been used, BILD was commissioned by the DH and the DfE to assist in drawing up guidance and a code of practice relating to use of restraint. The initial code of practice focused on safe delivery of interventions but, since then, had evolved to focus more on behaviour support and reducing the levels of restraint in a variety of settings and covering all age groups. BILD created an 'accreditation' scheme from these developments. Application for accreditation is voluntarily funded and is not subject to any statutory or regulatory requirements. There is a charge to organisations that wish to go through BILD's accreditation process.

149. A Board of Trustees oversees BILD. The current chair was previously chair of the Commission for Social Care Inspection (now the Care Quality Commission) and trustees are from a range of backgrounds in education, healthcare (including psychology and psychiatry), and social care. The chair of trustees is also the chair of the 'accreditation' panel.

150. BILD provided IRAP with copies of its code of practice and other documents and a representative from BILD met with IRAP members to expand on these materials and the role of BILD.

151. The code is applicable to training for staff who work in services for children and adults, and for parents and carers. BILD states that it ' … *has been written to take account of the need to provide accredited training across a variety of settings'.* The settings it lists include secure and semi-secure facilities. The code

[35] http://www.bild.org.uk/about-bild/aboutbild/

lists a number of principles that training providers which adopt the code should accept as underpinning principles. They include:

- Providing evidence that staff receive appropriate training.
- Demonstrating that delivering training reflects the individual needs of the children and young people or other service users.
- Evidencing an appropriate support framework that is underpinned by implementing good policies.

152. BILD stated that, at the time of its representative's meeting with IRAP in 2013, there were 36 organisations that hold BILD accreditation. That person estimated that there were approximately 650-700 providers of some sort of restraint training. Of the 36, approximately one third are large, commercial training organisations and the other two-thirds are made up of small-scale providers.

153. The material provided by BILD indicates that the 'accreditation process is in reality a measurement of compliance with BILD's code of practice. It ' … *provides the criteria of assessment for those training organisations that apply to the BILD Accreditation Scheme'.*

154. The material provided to IRAP by BILD did not give information about any mechanisms that BILD uses to measure providers that apply for accreditation against BILD's criteria, or whether and how it monitors compliance with its code of practice. The BILD representative acknowledged that the process is not an accreditation in the true sense of the word, and that there is a number of gaps in relation to compliance and monitoring. BILD expressed concern about the lack of any regulation of the restraint training 'industry' and its representative told IRAP that he would welcome an exploration of how better oversight and accreditation could be achieved.

# CHAPTER FIVE: A REVIEW OF RESEARCH CONDUCTED FOR IRAP

## Introduction

155. In October 2013, IRAP commissioned the Childhood Wellbeing Research Centre (CWRC) to conduct two scoping reviews of the literature to support its work. The first review was of the literature on use of restraint and the second was on positive behaviour management and behaviour support. This chapter provides an orientation to the nature of the two reviews of the literature that were conducted for IRAP by the CWRC.

## Use of Restraint

156. The CWRC has offered IRAP a brief summary of relevant literature that has been published since 2008. The intention was to ensure that IRAP's work built on, rather than reproduced, key pieces of work that have already been undertaken (for example, Di Hart's (2008) study of physical restraint in SCHs).

157. The review considers the literature in six areas:

- The views of young people and staff about restraint.
- Use of physical restraint in children's care settings.
- The physical effects of restraint.
- Alternatives to and reduction of restraint.
- Early intervention and risk factors for people who are likely to be restrained.
- Ethical issues and rights relating to restraint.

158. The review has identified limitations and key gaps in the evidence:

- Different definitions of restraint, and studies of children in different settings beyond the secure state (including, for example, psychiatric hospitals), make it difficult to compare findings across the literature.
- There are significant gaps in the evidence on the children and young people who have been restrained. Studies that do address the topic largely study children and young people as a homogenous group. Further research is needed to: understand why physical restraint takes place; obtain a more nuanced picture of the subjects' experiences of restraint; assist with understanding who is likely to be restrained based on gender, ethnicity and needs (for example, history of abuse, mental health).

- There are few studies that: look at physical restraint in SCHs; examine the physical effects of restraint on children specifically; or research training of staff to deliver physical restraint.
- In the UK, Laura Steckley and Di Hart are the main authors who have published work about children and young people and physical restraint as used across the secure estate. Since 2008, the former has written many papers that are based on one qualitative study that explored various aspects of restraint.
- Most studies of physical restraint of children in the UK are qualitative and use interviews, discussion groups with children and young people, and staff members. There is a paucity of robust quantitative data, and no centralised data collection mechanism to document the prevalence, cause, and effects of restraint.

## Positive Behaviour Management and Behaviour Support

159. Overall, the search demonstrated a paucity of UK based studies that explicitly or solely focus on positive behaviour management (PBM) or positive behaviour support (PBS). The UK studies that have been identified for this review refer to elements of PBM and do not predominantly focus on PBM or PBS. As such, they do not present detailed analyses of the topics.

### Key Themes Emerging from the Review

160. The literature on Positive Behaviour Support (PBS) primarily stems from the USA and refers to an integrated, whole person approach to behaviour management. PBS appears to be a more developed technique in the USA and has been critically explored in the juvenile justice setting. A number of theoretical pieces that explore definitions and its roots are presented. However, elements of PBS such as milieu therapy that encompasses all parts of daily experience, are evident in commentaries by practitioners in the UK (e.g. Vanderwood, 2006), and terms such as positive behaviour facilitation (Olive, 2004) shares many like characteristics with PBS and PBM.

161. The literature from the UK predominantly draws on forms of PBM. However, this is not explicitly referred to as such in the text and more generic terms such as 'behaviour management techniques' are most frequently used. PBM is not explored in any depth, or in its own right, within these studies on the secure children's estate. In addition, a small number (n=3) of evaluations of specific interventions in the UK have been conducted (one YOI and two for foster carers).

162. The literature on PBM is predominantly embedded within studies that address restraint, reducing reoffending, and young people in custody. From these few studies, positive behaviour management techniques cited include rewards schemes including points based systems, reinforcement of unwanted behaviours (DfE, 2013), role models, and building positive relationships between staff and young people (YJB, 2011). In addition, one study highlighted good practice in a number of other European countries that have led to reduce numbers of young people reoffending, including motivational interviewing and more comprehensive risk assessments that focus on the needs of young people (Kidson, 2013).

163. The handful of studies conducted in the UK that refer to positive behaviour management techniques, have explored staff and young people's perceptions of positive behaviour management techniques, especially reward schemes (Kennedy, 2010, Gyateng et al., 2013; YJB, 2011). Young people were generally found to be happy with reward schemes and were clear about what constituted expected behaviour (Kennedy 2010). However, some staff raised concerns about leadership, the need for coherence and consistency in behaviour management approaches, and effective training

## Limitation and Gaps in the Evidence Base

164. There is a general lack of evidence on the use, implementation and effectiveness of PBS and PBM across the children's secure estate in the UK. The few studies that this review found contained small samples, mainly qualitative, with the exception of one that used mixed methods.

165. Both staff and young people's experience of PBM/PBS in the evidence base is thin: more so for the latter group.

166. There is a gap in the research on the different forms of behaviour management across the secure children's estate. There is also a gap in the research on what techniques are effective in what type of setting (i.e. SCH, YOI, STC).

167. Some evidence from the USA suggests that young people in the juvenile justice system have multiple needs (e.g. learning difficulties, behavioural problems) and would significantly benefit from PBS interventions to match their complexity of need. This review found no research detailing the complexity of need of young people across the secure estate in light of appropriate behaviour management techniques.

168. Evidence suggests that a positive relationship between staff and young people is a key factor in effective behaviour management (Gyateng, 2013). Further research is needed to explore this in light of the development of PBS techniques.

# CHAPTER SIX: AN OVERVIEW OF THE FINDINGS FROM IRAP'S INTERVIEWS WITH CHILDREN AND YOUNG PEOPLE RESIDENT IN SECURE CHILDREN'S HOMES

## Methodology

169. Members of IRAP interviewed 58 children resident in 6 SCH's – one accommodating children on welfare orders only, the other 5 accommodating both those on welfare orders and those remanded and sentenced in the criminal justice system and placed by the YJB. The interviews were conducted using semi-structured questions covering three main themes:

- Definition and information – what do children think restraint is, what information are they given about the use of restraint and what do they know about staff training
- Experiences – the child's experience of restraint in current and previous placements, their experiences of any injuries and of being de briefed following a restraint; whether they had any health issues which might be affected by restraint and whether they had ever complained about a restraint incident.
- Beliefs and feelings – why children feel they were or weren't restrained, their feelings during and after a restraint, whether it mattered who restrained them, what would happen if restraint was not used, and how they would wish to be treated when angry or upset.

170. The interviews were recorded and collated by an IRAP member and reviewed externally by Dr Di Hart, a freelance consultant in youth justice and welfare and author of a number of reports in these areas. Her views and comments have been incorporated in this report.

## Characteristics of the Children who were Interviewed

171. IRAP's members interviewed 41 boys and 17 girls. The main factual findings are:

- Status: 17 welfare orders; six remanded; 23 sentenced DTO; two sentence recall; 10 sentenced under powers given by Section 90/91.
- Ages: One twelve year old; four thirteen year olds; 12 fourteen year olds; 19 fifteen year olds; 14 sixteen year olds; and eight seventeen year olds.

- Ethnicity: Five Asian; three African-Caribbean; two East European; two mixed heritage and 46 white.
- Six children reported having asthma and using inhalers; 16 children had some sort of learning/developmental/neurological disability or difficulty including Asperger's and ADHD; two children reported taking medication for depression and three reported physical health issues (NB some children declined to give health information).
- 62% were experiencing their first placement in a secure setting.
- 28% reported that they had experienced care in open children's home/EBD school/mental health unit (NB not all children who were interviewed shared information about their previous experiences).
- 20 children reported that they had never been restrained in any setting (other than by the police); 13 reported only being restrained in their current secure placement; 16 reported being restrained in both current and previous placements and nine reported not being restrained in current placements but had in previous placements.

## Definitions and Information

172. The majority of children interviewed initially gave the reasons why they are restrained as a response to this question: *'if someone's a risk'; 'to stop you hurting someone'; 'if there's going to be a fight'.* 37% used term such as *'hold'; 'grabbed, 'pinned down'* when describing restraint and around 24% made reference to *'force'; 'control and restraint'; putting hands on' and 'physical management'* when answering this question. Just over 30% described restraint as being used to prevent harm or ensure safety, using terms such as '*to help you'; 'being a risk', 'a risk to others or self'.*

173. Around 65% of the children remembered being told that restraint would be used, as part of the induction process. Some reported being verbally told; others that it was written information in some sort of induction pack. Of the remaining 35%, around half could not remember if they were told or given information. Some reported not reading induction packs. Only three children could recall being told anything about what sort of restraint would be used: *'they tell you about holding and being taken to your room';* The information given was focused on what sorts of behaviour would lead to restraint or other sanctions: *'it would be used if I was a risk to others; ''if I kicked off'; 'if you fight'; 'told us how to be good and behave'.*

174. Most children cited 'managers' as being in overall charge of restraint, although several also mentioned the in house instructors. No child gave a definitive answer as to who was in charge during an incident. Some thought it was the first member of staff on the scene, others that it was the duty senior, however the majority response was that no one in particular was in charge: '*it's team work'; 'they all pile in'.*

175. All knew or presumed that staff were trained in restraint, but very few knew what that training constituted. A small percentage talked about staff '*going into the gym',* and *'practicing on each other'.* There was less certainty about training in behaviour management, with most making the presumption but no specific knowledge.

## Children's Experiences of Restraint

176. Those children who reported experiencing restraint in different settings identified some differences in restraint but the majority felt differences were more accounted for by the individual circumstances and the relationships with staff. Children were able to identify when restraint was justified for safety reasons, but were also clear that restraint was used at times when, in their view it was not necessary: '*just because they refused to go to bed'; 'I saw a kid restrained for not using the right bowl, it wasn't right'; 'grown men shouldn't be restraining 12 year olds'; 'I feel it's unfair when not needed'; 'When a kid's lippy but not aggressive'; 'they should sometimes just be separated and not restrained'*.

177. A significant number had either experienced or witnessed both injuries and feeling unwell during a restraint. The injuries described were almost all minor – bruises, red marks, carpet burns etc. Children described experiencing or witnessing others feeling breathless, nauseous, sweating and anxious. The most significant finding is that almost universally the children do not tell staff at the time. Reasons for this are varied: *'too angry'; 'too breathless'; 'there's no point'; 'when you can't breathe staff didn't notice'.*

178. The predominant feeling reported when being restrained, was that of anger. *'just angry', 'I'm welfare but get treated like a criminal'; 'just angry 'cos I get restrained for things like not going into dinner (at an EBD school).* A small number of children reported feeling safe or protected when witnessing restraint on others: *'I feel safe and calm'; 'glad it's not me'.* Others did report feeling anxious when witnessing restraint: *'anxious and worried in case it gets out of hand'; 'I want to go and calm them down but know I can't'.*

179. The majority of children had never made a complaint about a restraint incident and felt that they had had no reason to complain: *'nothing to complain about'; 'every time I've been restrained it's been necessary'.* A small number had not complained because they believed there was no point and nothing would be done: *'no 'cos nobody would do anything'; 'pointless, they don't go anywhere'; 'I don't think anyone would take it seriously'.* 15% of children reported making formal or informal complaints in the SCH, in a children's home, an EBD school and in one case a mental health unit. Six children who had made a complaint believed that nothing had happened as a result: *'nothing happened, they just look out for themselves'; 'at school I told the police, but they said staff were allowed to hurt us'.* Three children felt their complaint had been taken seriously and dealt with to their satisfaction.

180. Over 85% of children reported having been restrained using handcuffs either by the police or when being moved from court to cells. The majority of children did not want handcuffs to be used in an SCH either for practical reasons: '*there's no point, you can't go anywhere'; 'it's a lot calmer here (than a previous experience in an STC) so they're not needed';* or because they were just inherently unsuitable: *'It's a children's home not a jail'; 'it would make the lads worse'; 'it's not right for younger children'; 'it would make you feel you'd done something wrong'.* About 17% of children felt there could be some justification for the use of handcuffs in an SCH: *'they could be used here when they (staff) can't manage'; 'better than being held on the floor'; 'staff could pay attention to the person and not the holds'; 'some kids want to keep going and hurt staff'; 'to stop someone being badly hurt'.*

181. About 46% of children reported some sort of health (mental or physical) or developmental / neurological problem that could affect a restraint. Most felt that staff knew about these issues and a small number told us that these issues were addressed in their care plan: '*care plan says to avoid the chest and only hold arms and legs*'.

182. The majority of children were able to describe some sort of de-briefing activity taking place. Almost 50% referred to being taken to their room as standard practice following a restraint incident and a number reported being kept confined for longer periods either in their room or in a restricted area: *'You're taken to a high risk room and kept there until you agree to RJ and calm down'; 'taken to their room and depending on how serious can be from 1 to 5 days'.* A number of children saw the de brief process as being about sanctions: *'talk about punishment and next actions'; 'they talk to you about being good and losing points'; 'they decide what punishment e.g. group segregation'; 'you always lose points'.* Over 90% of the children described staff talking to them

during the de-briefing process, and most saw this as helpful: *talk things through and how to resolve and make it better'; 'they listen and calm you down'; 'you can put your point of view'.* Children clearly saw some staff as more caring and helpful than others in the de-briefing process: *'sometimes get a chance to put your side, depends on the staff'; 'some staff sit and comfort you, some don't care'; 'they bring you water and fruit'.*

## Children's Beliefs and Feelings

183. Those children who had not experienced restraint on the whole attributed this to their own self-regulatory ability: *I avoid other young people who talk about me'; 'I'm level headed'; I don't get into situations that deserve restraint'.* Others felt that they had something to lose: *'it's not worth it 'cos they take things off you'; I'm on top points and I don't want to lose them'.* A very small number felt that staff interventions were instrumental in not getting restrained: *'They let me go to the gym'; 'I've got good relationships with staff'.*

184. Children's fighting with each other was cited as the most common reason for the use of restraint, followed by self-harm and assaulting staff. A number of children demonstrated an understanding of some of the issues that could impact on behaviour that led to restraint: *'they might be struggling or have things going on at home'; 'they're younger or have ADHD'; 'they're only here for a short time so have nothing to lose'; 'I get frustrated 'cos I'm locked up'.*

185. The majority of children reported that their predominant emotion during a restraint was that of anger or frustration: *'I hate it I can't move, I'm stuck, all my power and freedom is taken away'; 'angry 'cos I didn't think I'd done anything wrong'*. They described getting angrier at the beginning of a restraint incident and for most, calming down only occurred after they had been removed to their room: '*afterwards I feel upset'; 'I calm down 'cos there's no point in fighting back, they calm me down'.* Some children did not like being put in a room that had been stripped of all belongings, which could prolong their anger: '*hate the high risk room, it makes me more angry'; 'angry for a long time, especially if my room is stripped'.* A number of children described a 'coming down' experience and feeling disappointed and sorry: *'but I get sad 'cos I know I'm going to be in my room for a couple of days'; 'afterwards feel sad and upset'*. About 10% of children talked of feelings of panic and/or claustrophobia when being restrained. *'before, fuming and angry, during panicky, shaking and claustrophobic. Afterwards emotional, sorry apologizing felt rubbish and guilty'.* Four children described feeling safer during a restraint incident: *'safer when restrained, I even wanted it'; at the psychiatric unit I felt angry and violated, here I felt safer'; 'it feels safe … protected'; 'feels like I'm being controlled, but that's OK'.*

186. When asked what would happen if restraint couldn't be used, the initial response from all interviewees was that fighting would increase, people would be hurt and the unit would not be a safe place, some also thought children would escape. On reflection several children also commented that there might in fact be less trouble as children would be reluctant to 'wind people up' or make threats if they thought staff would not be able to intervene to protect them from any retaliation.

187. Around 25% of the children felt that gender was an issue when being restrained. Some felt that men should not restrain girls because of the impact of possible past abuse or exploitation: *'I've agreed with staff here that men don't restrain me'; 'no girl wants to be restrained by a man, it affects your emotions'; 'if sexual exploitation is an issue and a man grabs you it could be major'.* For some, particularly boys, the gender issue was different: '*I don't think women should restrain, if it was me I'd calm down 'cos I wouldn't want to hurt them'; 'it's good having a mix, but some men can be a bit macho', 'some kids will stop if it's a woman but not for a man'.* About 15% of children thought the size and strength of the person restraining was a factor: *'men are stronger than women'; 'with big kids… sometimes strength is needed'; 'some people don't know their own strength and weight'; 'if it's a big lad then it needs stronger staff'*.

188. As may be expected, how children wished to be treated to help them deal with their emotions and any behaviour reflecting their anger or anxiety, was varied. Most felt that at some stage, talking things through with a trusted adult was of help but often preferred to be left alone to calm down before this happened. Some wanted staff to actively check how they were feeling and others wanted interventions to divert or distract them.

## Summary

189. These findings indicate that children do acknowledge that restraint is needed to safeguard them, other children and staff from harm. However, they are clear about when restraint is appropriate and properly used and when they perceive unfair or unwarranted use. There are a number of issues arising from the interview findings:

- A number of children referred to their care plans containing information about methods of restraint which should or should not be used on them' and some referred to staffs ability to 'spot the signs' when they were getting distressed and/or angry. Dr. Hart notes that '*A good behaviour management plan would include: situations that lead to the child getting stressed; triggers for them losing control; warning signs that they might be losing it; strategies for*

*calming them down etc'.* Proactive planning should include strategies for avoiding the use of restraint and not just what methods should be used.

- It would appear that although children on the whole know that staff were trained in restraint techniques, there was virtually no knowledge of what these techniques were or what was and was not allowed. It may be that the lack of this information contributes to the low number of complaints in relation to the use of restraint and the view that complaining is ineffective and/or pointless.
- Almost no children mentioned the role of advocates in relation to the use of restraint, although all the SCHs have an advocacy service in place. A significant number of children related debriefing measures to decision about sanctions etc. Dr. Hart says: *'The involvement of advocates could be a useful safeguarding strategy … . it wouldn't need to replace debriefing with staff but would introduce an element of independent support and scrutiny. This could improve accountability and drive up standards'.*
- All the children described some sort of separation after a restraint incident, most commonly being taken to their room. Some of the children also described being restrained while moved into their rooms and some talked of restraint being used as a response to refusal to do something. These seem to be rather 'grey' areas in terms of allowable reasons for restraint as set out in the Children Home's guidance and regulations. While it may be perfectly acceptable to give children the space and time to calm down following an incident; the routine use of separation, particularly if it is associated with punishment is questionable. It was of particular concern to note that one child spoke of routinely being kept in a room or other confined area for up to two days.

# CHAPTER SEVEN: GOVERNANCE

190. Throughout its work, IRAP has reported regularly to the working group established by DfE that has provided a forum for debate and exchange of views and ideas, as well as the expert advice of the members. However, the fundamental principle underpinning the working group was to ensure that, when critical issues were identified by IRAP they were dealt with where possible, by way of an immediate action plan, rather than waiting for any recommendations from this final report.

191. The key action taken as a result of the evidence that IRAP collected was to ensure that local authorities were given the opportunity to hear and discuss the emerging findings. Subsequently, DfE arranged two regional meetings held in Rochdale and London in November 2013 that were aimed at Directors of Children's Services or their representatives. Seventy-four representatives from children's services in local authorities attended the meetings. They included staff from special education departments, safeguarding services and people whose jobs are to commission services.

192. At the meetings, Professor Bailey addressed major concerns that IRAP had identified within the processes and practices of local authorities. They included:

- Highlighting the lack of clarity about where responsibility for restraint rested.
- Issues relating to commissioning of restraint.
- The lack of systematic collection of restraint data that could be used to inform and educate practice to minimise restraint.

193. Attendees at both meetings drew attention to the lack of a proper governance framework for using restraint on children (in any settings) and the multiple and, sometimes, confusing guidance and regulations that might apply in different settings.

194. Attendees provided confirmation that recording requirements differed depending on the recipient and that SCHs were burdened with unnecessary duplication. Recipients at the local authority level include LSCBs, LADOs, line managers, and health and safety or occupational health professionals. As regards the purposes of recording restraint, for example, there was a belief that was commonly expressed in those meetings that Ofsted requires use of the guiding hold to be recorded as restraint, but another understanding that the MoJ and YJB do not. IRAP also noted that there was no consistency of terminology

and definition with regard to use of the terms restraint, disengagement and single separation.

195. A number of attendees expressed concern about practice in schools for children who have Educational and Behavioural Difficulties (EBD) and they cited examples of use of both restraint and segregation where they were unsure of the governance and regulation. They observed that SCHs are subject to a degree of scrutiny and monitoring that is not a requirement in other establishments.

196. There was a consensus that Directors of Children's Services should be ultimately responsible for commissioning of training for their staff on restraint and use of restraint. The attendees' opinions were that, in practice, where the responsibilities lay was sometimes unclear because responsibilities may be delegated to, in some cases, the managers of establishments.

197. IRAP asked attendees some specific questions in relation to commissioning of training for staff on restraint (See Annex P) and attendees' responses indicated that:

- They knew that staff in SCHs, open children's homes and, in some cases, foster carers were trained in restraint and disengagement techniques, but there was less knowledge and certainty in relation to other establishments such as schools.
- Monitoring of implementation of taught techniques was predominantly exercised through reviews by staff's line managers and visits as are provided for in Regulation 33 to the Children Act 1989 as amended.
- Approximately half the respondents said that their local authorities had a process in place for dealing with incidents when actions taken to restrain children did not match the techniques that had been taught.
- Respondents were not always sure that there were robust risk assessment processes in place with regard to the restraint techniques that are used. Some of the attendees commented that, where there was a process, it was internal only (either to the SCH or within the line management framework).
- Several people cited their dependence on the provider of their training having undertaken a medical risk assessment.
- The attendees expressed a lack of certainty as to whether the risks presented by individual children were assessed against the restraint and disengagement techniques. This was clearer in relation to children resident in SCHs for which positive behaviour plans were cited by attendees as a tool,

but the staff of other establishments, such as open children's homes and schools, appeared to IRAP to have less knowledge about risk assessment.

198. A number of attendees expressed a view that there should be a cross-government approach to use of restraint on all children regardless of the setting.

# CHAPTER EIGHT: SUMMARY OF FINDINGS AND RECOMMENDATIONS

## Introduction: The Context within which Restraint in SCHs Sits

199. Seventeen years ago, Sir William Utting suggested a framework for safeguarding that should apply to all children who live away from home, including children who are deprived of their liberty[36]. In the intervening years, there has been a number of reviews and inquiries specifically addressing issues relating to use of restraint.

200. This matter has been subject to a huge degree of scrutiny and inquiry by a range of government departments, and there is in place varying policy, guidance and regulations, with some degree of duplication, and, occasionally, contradiction. Relevant documents in place, or work in this area that is currently being undertaken, includes:

- Local reviews and developments of mental health and learning disability services arising from the findings and recommendations contained in the Winterboune View report[37], and subsequent work being undertaken by the Royal College of Nursing at the request of England's Minister for Health and Social Care[38].
- The work being carried out by the Borders and Immigration Section of the Home Office.
- Work on implementing Minimising and Managing Physical Restraint (MMPR) in Young Offender Institutions (YOI) and Secure Training Centres (STC) and the accompanying guidance on safeguarding processes and governance arrangements[39].
- The continuing work of Children' Commissioners and other organisations and people who lobby on this issue including, for example, the Howard League and Inquest.

[36] People Like Us: a review of the safeguards for children living away from home. Department of Health 1997.
[37] Winterbourne View Hospital: Department of Health Review and Response. Dec 2012 https://www.gov.uk/government/publications/winterbourne-view-hospital-department-of-health-review-and-response
[38] http://www.rcn.org.uk/newsevents/press_releases/uk/rcn_consulting_on_new_guidance_on_alternatives_to_the_use_of_restrictive_practices
[39] http://www.justice.gov.uk/youth-justice/custody/behaviour-management

- The review of care and practice in open children's homes that is being conducted presently by DfE[40].
- The work of the Independent Advisory Panel on Deaths in Custody on common principles for the use of restraint[41].
- DfE guidance on the Use of Reasonable Force in schools[42]
- The updated guidance relating to the Children Act 1989 relating to children's homes[43].
- The health care standards for children in secure settings[44] that were published in 2013, which include standards for health care professionals in relation to the use of restraint.
- The policy framework from MoJ on the use of restraint in the secure estate[45].
- The YJB code of practice for behaviour management[46].

201. During the course of its work, IRAP identified risk gaps that pertain to using restraint and disengagement techniques on children in a variety of other settings, including open children's homes, and residential as well as mainstream schools and schools for children who have special needs. Indeed, it could be argued that the recommendations made here in relation to SCHs are pertinent not only across the child welfare sector, but to all children whatever their age and in whatever setting they may find themselves and in which restraint may be used.

202. Use of restraint in Secure Children's Homes is subject to a much greater degree of scrutiny and monitoring than in many other settings in which children may be restrained. Nonetheless, IRAP has identified a number of concerns about potential risks in relation to using restraint with children who are accommodated in SCHs.

40 http://webarchive.nationalarchives.gov.uk/20131027134109/http://www.education.gov.uk/childrenandyoungpeople/families/childrenincare/a00224323/quality-child-homes-report
41 http://iapdeathsincustody.independent.gov.uk/news/iap%E2%80%99s-common-principles-on-the-safer-use-of-restraint-published-today/
42 http://www.education.gov.uk/aboutdfe/advice/f0077153/use-of-reasonable-force/use-of-reasonable-force---advice-for-school-leaders-staff-and-governing-bodies
43 http://www.education.gov.uk/aboutdfe/statutory/g00222870/children-act-1989-childrens-homes
44 http://www.rcpch.ac.uk/cypss
45 http://www.justice.gov.uk/downloads/youth-justice/custody/mmpr/use-restraint-policy-framework.pdf
46 http://www.justice.gov.uk/downloads/youth-justice/custody/mmpr/behaviour-management-code-of-practice.pdf

# IRAP's Findings and Recommendations

## General Findings

203. Policy and practice for the SCH sector come under the auspices of four government departments. They are: the DfE for social care; the MoJ for children who are detained by the criminal justice system; the Department of Health for healthcare (including mental health and care relating to people who have learning disabilities), and the Home Office for children who may be detained by the police and transferred to a SCH under the PACE Codes of Practice.

204. There is a wide range of regulations, guidance and practice advice from all these departments, and the YJB has attempted to put in place measures to increase consistency in the SCHs with which they have a contract. Notwithstanding the work done by the YJB to promote consistency for children placed by them across the secure estate[47], no department was able to identify coherent standards governing restraint systems or reporting mechanisms across the SCH sector.

## Findings Relating to Recommendations 1, 2 and 3

205. The operational responsibility for SCHs lies with local authorities, as does the responsibility for commissioning training for the staff of SCHs on restraint and disengagement techniques. Again, there were wide variations in line management arrangements and accountability, and in the commissioning arrangements.

206. In particular, IRAP found there was a lack of clarity as to the responsibility for ensuring that any restraint system commissioned had been assessed for the safety of the package and the techniques that constitute it, and its appropriateness for the environment provided by the particular SCHs in which the package is used. Most commissioners and operational managers saw the responsibility as lying with the training providers. While training providers were clearer about their specific responsibilities, we found no instances of structured and regular feedback on injuries to children who had been restrained or other concerns between the SCHs, the commissioners, and the training providers.

207. Evidence from BILD and training providers raised our concerns about the lack of regulation, quality assurance or monitoring of restraint training. The training providers told us that they train staff in a diverse range of settings for a wide age range of service users. But, readers should note that IRAP was told that

[47] Young offender institutions, Secure Training Centres and SCHs who contract with the YJB.

training in SCHs accounts for less than 0.5% of the whole market across all age ranges and settings.

208. All of the providers seen by IRAP had spent many years developing their training methods and programmes, using a variety of sources to review and update them. Some providers train frontline staff directly, and others used a 'cascade' method in which they train instructors who then provide training within the SCHs.

209. The evidence presented to IRAP by providers of training on restraint, and information from BILD indicated to us that there is no universal understanding or methodology for 'accrediting' training for restraint and disengagement techniques. Providers used a range of measures to assess training, ranging from NVQ qualifications to tools that they had developed within their organisations. Similarly, there was no universal use of any adult learning theories or methods; some providers did award a qualification in Preparing to Teach in the Lifelong Learning (PTLL) when training staff who would become instructors, but others did not use any adult learning models to underpin their training. A number of providers employed trainers directly, but several operated a franchise model, which IRAP thinks provides more potential for skills drift.

**Recommendation 1**

**As a matter of urgency, the local authorities and the NGO that run SCHs should develop a single set of principles and requirements, with an ethical and values-based governance framework to underpin commissioning of training of their staff in restraint and disengagement for use in SCHs. The requirements should include the preferred qualifications particularly in relation to adult learning models and methods. This framework should take account of, and build on, where necessary, policy and guidance already in place[48].**

**Recommendation 2**

**Every local authority or the NGO should ensure that the person who is the nominated Responsible Individual for their SCH understands their responsibilities and accountability in relation to commissioning training in restraint and disengagement for their staff. This responsibility must include that for robust monitoring and quality assurance to ensure that the system commissioned is as safe as possible for use with children, and**

[48] http://iapdeathsincustody.independent.gov.uk/news/iap%E2%80%99s-common-principles-on-the-safer-use-of-restraint-published-today/ ; http://www.justice.gov.uk/youth-justice/custody/behaviour-management;

**that it is reviewed regularly and amended when necessary. While this function may be undertaken by, or in conjunction with other managers the accountability for it cannot be delegated.**

**Recommendation 3**

**The Department for Education should establish an expert group to oversee and assist with developing and implementing the governance framework that IRAP recommends. The group should include representation from DfE, DH, MoJ, Home Office, the Welsh Government, NHS England, Ofsted, the YJB, the Association of Directors of Children's Services and the Secure Accommodation Network. The DfE may wish to consider incorporating into this expert group expert medical advice from the medical Royal Colleges.**

## Findings Relating to Recommendation 4

210. The evidence suggests to IRAP that there are substantial variations in the values and terminology that underpin use of restraint and disengagement in SCHs. IRAP found a myriad of differing definitions of restraint, serious incidents and other terms in common usage and which are, ordinarily, believed to have a common understanding. Notwithstanding all the guidance and regulation relating to practice in SCHs, these variations occurred across the SCHs, between different professional groups that work within the SCHs, between the local authorities, and between the government departments.

**Recommendation 4**

**The Department for Education should develop, in consultation with local authorities, standard definitions and an agreed common language to describe restraint and its practice, and incidents that involve restraint. This task should take into consideration the work in this area that the YJB has undertaken already.**

## Findings Relating to Recommendation 5

211. IRAP identified gaps in feedback loops in a number of areas. They were between: government departments; commissioners and people and authorities that are responsible for practice in SCHs; and commissioners and training providers. Scrutiny and monitoring of practices, including use of restraint and disengagement techniques has five components:

- Local line management.

- Ofsted inspections.
- CQC.
- Regulation 33 visits[49].
- YJB monitoring, if relevant.

212. The evidence gathered by IRAP from line managers and SCH managers indicates that there is a lack of clarity and consistency at local levels as to who holds responsibility for restraint. Ofsted acknowledges that there are risk gaps in its inspection processes arising, not least, from it relying frequently on self-reporting and / or other reports such as those from the Regulation 33 visits. Ofsted told IRAP that it takes the view that it would be beneficial if there was more congruence between the expectations of DfE, in relation to policy and inspections, the YJB, as contractors, and local authorities, as commissioners. Rationalisation of data requirements and commissioning standards could, in Ofsted's view, minimise the burden on SCHs and ensure greater consistency in monitoring and analysing information on use of restraint.

213. While Ofsted inspects child care and education provision in SCHs, monitoring and scrutiny of healthcare providers falls within the remit of CQC which, IRAP understands, has not previously been involved in this sector. Already, there is a model for joint inspections developed for the STCs and Ofsted believes that this could assist in developing a model for use in SCHs. It takes the view that a single inspection body for all children held in security would be problematic and, not least, because it would require primary legislation.

214. A number of stakeholders told IRAP that they believed that differing inspection bodies and regimes were unhelpful. In particular, the representatives from local authorities who attended the two meetings expressed the view that a single inspection body would enable them to take a more consistent approach to both safeguarding and governance.

215. Notwithstanding the view of Ofsted, IRAP does support the argument for establishing a single inspection body for all children who are deprived of their liberty, regardless of the setting in which they are placed. IRAP takes the view that the issues for safeguarding children who are placed in closed, secure institutions are so different from those for children who receive other regulated services, that a different inspection regime to that for other children's services is necessary. IRAP's opinion is that, while children take different pathways into secure services, whether for their welfare, because they have broken the law, or

[49] http://www.legislation.gov.uk/uksi/2001/3967/regulation/33/made - it should be noted that changes made to these regulations will come into force from April 2014.

because their mental health requires it, their vulnerabilities and needs for safeguarding are universal.

**Recommendation 5**

**Consideration should be given to establishing a single inspection body for all settings where children are deprived of their liberty. As a minimum, there should be a consistent and universal approach and framework for all agencies and their staff that have inspection functions for these settings.**

## Findings Relating to Recommendation 6

216. Evidence from medical professionals and SCH managers demonstrated to IRAP that there is a lack of clarity as to who holds and discharges the responsibilities for identifying health concerns. Health care staff hold vital information that might impact on use of restraint and disengagement techniques on particular children, and this information is not always shared in a timely and effective manner.

**Recommendation 6**

**NHS England and NHS Wales should ensure that all healthcare professionals who provide services for children in SCHs are aware of the intercollegiate healthcare standards in place for children in secure settings[50] and, in particular, that they have a clear understanding of their roles and responsibilities in identifying any medical risks (physical and / or psychosocial) associated with using restraint, both generally and for particular children.**

## Findings Relating to Recommendation 7

217. SCHs are required to collect a range of data for different audiences at local and central government levels. The evidence provided for IRAP about topics relating to the data that SCHs were required to collect was characterised by wide variations in the type and format of data collected dependent on the recipient of the required data and there was duplication. Data collection requirements necessitate SCHs to provide similar data in up to 40 separate fields and to as many as 12 different recipients. But, IRAP found little evidence of robust and /

[50] Health Care Standards for children and young people in secure settings. June 2013 Royal College of Paediatrics and Child Health. London. http://www.rcpch.ac.uk/cypss

or routine analysis of the data and IRAP was told that SCHs received little, if any, feedback on the data they provided.

218. The evidence also demonstrated to IRAP a lack of clarity regarding the role of LSCBs in relation to use of restraint in SCHs. IRAP found a wide variation in what information LCSBs requested or received and how they then utilised this data or followed up on any issues arising from their reviews of the information.

**Recommendation 7**

**There should be a requirement for the Department for Education to work with local authorities (including LSCBs), YJB, and Ofsted to establish: what are the essential data that are required from SCHs; the purposes for which they are collected; how the data is analysed; and what information should be fed back to commissioners and providers to improve practice. These data requirements should be subject to periodic review.**

## Findings Relating to Recommendation 8

219. The duty to safeguard and promote the welfare of children is universal and it crosses central and local government. IRAP believes that the governance and accountability for using restraint should also be universal to avoid risk gaps, duplication, confusion and waste of resources by repetition.

220. Almost all of the children resident in SCHs who were interviewed by IRAP had received other regulated services and / or had been resident in other types of establishments including EBD schools and open children's homes. They told IRAP of their experiences of restraint in those services and described practices that would not be acceptable in SCHs and which appeared to IRAP to be incompatible with the guidance and regulations relating to the Children Act 1989 as amended.

221. A number of attendees at the meetings that IRAP held with representatives of the local authorities also expressed their concern about restraint practices in other services. They felt there was a lack of clarity about the quality assurance and monitoring of the use of restraint in these services.

222. The providers of training on restraint told IRAP that that they are commissioned by a wide range of agencies to provide restraint training in residential and non-residential settings and for children of all ages. Their perception was that commissioners were not always clear about their requirements and they did not

necessarily give the provider the right information to enable them to assemble the most appropriate training packages.

223. IRAP's opinion is that the need for a governance framework for using restraint in SCHs that is outlined in the first of IRAP's recommendations is equally applicable to using restraint on children in other services. IRAP's opinion is that the duty to safeguard children and ensure robust governance of any physical interventions used with the children who receive a service from the state should be a cross governmental responsibility.

**Recommendation 8**

**A cross-governmental body should be established that is charged with monitoring and reviewing restraint of children of all ages who are in receipt of regulated children's services.**

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# ANNEXES

# Annex A to: A Review of Restraint Systems Commissioned for Use with Children who are Resident In Secure Children's Homes

# Independent Restraint Advisory Panel Terms of Reference

## 1. Background

I. The Government has established the IRAP for two purposes:

- To assess the quality and safety of systems of restraint commissioned for use on children in Secure Children's Homes (SCHs).
- To support the implementation of Minimising and Managing Physical Restraint (MMPR) to Secure Training Centres and Under-18 Young Offender Institutions

## 2. Status and relationship with government

I. The IRAP has been given the status of an ad hoc advisory body by the Cabinet Office for a period of 18 months to two years maximum commencing 23 April 2012 (the date Ministers agreed the appointments).

II. The IRAP has no statutory role or delegated powers. Its function is to provide independent, dispassionate and expert advice to the Restraint Management Board in the Ministry of Justice (MoJ) and the Department for Education. The Restraint Management Board (RMB) and Department for Education (DfE) (for the purposes of *function1*, below) will consider the terms of any recommendations made by the IRAP ahead of those recommendations going to Ministers.

III. The Youth Justice Policy Unit (MoJ) will act as the sponsor unit to the IRAP.

IV. Ministers are not obliged to accept the recommendations made to them by the IRAP.

## 3. Support for IRAP

I. The IRAP will be supported by staff within the DfE and the MoJ as necessary for the Panel to fulfil its agreed functions falling within each Department's respective responsibilities.

## 4. Functions

1. As required by the DfE, assess the quality of the commissioning of the various restraint systems (including training) currently used in SCHs and the quality and safety of the resultant restraint practices in each SCH. A joint working agreement will be drawn up and agreed between DfE and IRAP setting out how this process will be managed.

2. Advise the RMB on progress with implementation of MMPR, particularly regarding key recommendations for changes to the restraint system approved by the Minister.

3. Analyse MMPR data from medical and risk management perspectives to advise the RMB

on whether MMPR is meeting its primary objectives.

4. Take account of national/international medical evidence regarding restraint techniques and report findings to the Restraint Management Board.
5. Undertake research as agreed with the Restraint Management Board.
6. Reassess physical restraint techniques and medical advice as agreed with the Restraint Management Board.

## 5. Cross-departmental arrangements and Finances

I. IRAP is an official MoJ Arms Length Body.

II. In order to complete *function 1* (above) IRAP will be supported by staff within DfE who has overall responsibility for SCHs.

III. Funding for the IRAP will be managed jointly by DfE and the Sponsor (MoJ).

- Funding for *function 1* will come from DfE.
- Funding for *functions 2 – 6* will comes from MoJ

## 6. Expenses

I. The Chair, Deputy Chair and Panel Members of the IRAP may not incur expenses on behalf of, or in relation to, the IRAP without prior agreement with the secretariat and sponsor. If expense is incurred without prior agreement, the member may be liable for the full cost incurred.

## 7. Media, communications and correspondence with third parties

I. All enquires from the media or third parties should be directed to the sponsor in the MoJ.

II. Members of the IRAP should not speak publicly on behalf of the IRAP unless authorised to do so by the Sponsor.

## 8. Panel and Panel members

I. The Chair and Deputy Chair have been appointed by Ministers. Their appointment is subject to the terms and conditions outlined in their letters of appointment. The Ministerial appointments to the IRAP will follow the Commissioner for Public Appointments Code of Practice for best practice based on proportionate equivalence.

II. Panel members are recruited jointly by the Chair of the Panel and Sponsor within approved budgets. It may be necessary to recruit further panel members on an ad hoc basis should matters arise that require additional expert advice.

III. Any further recruitment will be managed by the Sponsor in consideration with the Chair. There is no limit to the number of panel members who may be recruited within approved budgets. The chair will ensure that each panel member has the relevant expertise to make an informed decision.

IV. Membership of the panel should include experts drawn from physiotherapy, paediatrics,

psychiatry, operational practice and other relevant disciplines.

## 9. Terms of Appointment

I. All panel members are required to observe the guidelines on public appointments issued by the Cabinet Office.

II. Panel members are appointed subject to certain requirements. The terms of appointment of IRAP members are attached in Annex A.

## Annex A to Terms of Appointment for IRAP Members

**EXPECTATIONS AND GUIDANCE:**
**Terms of Appointment for IRAP Members**
**Introduction**

This document sets out the general principles governing the way in which the IRAP panel member should conduct himself/herself during his/her period of appointment. It also details the time commitment expected, the honorarium for the post, guidance on travel and subsistence and other expectations.

### I. Probity

The Chair and members of the IRAP are expected to be committed to the seven principles of public life (see Annex B) and to perform their duties with integrity. They will also be expected not to bring their position or the IRAP into disrepute.

On confirming their intention to become a panel member of the IRAP, panel members were asked to disclose whether they had held office in, or spoken in public in support of any political party which fields candidates at elections during the last five years. If panel members should do so during their term as a member, they should provide details of their activities to the Chair via the Secretariat to the IRAP.

### II. Gifts and Hospitality

Panel members are expected to ensure that acceptance of gifts and hospitality can stand up to public scrutiny. Gifts should be declined wherever possible, and any offers should be reported to the Chair via the Secretariat to the IRAP. Where it would be ungracious or otherwise difficult not to accept, panel members should inform the Chair via the Secretariat to the IRAP of the gift.

### III. Membership of other NDPBs / Public Bodies

In confirming panel member status, members will have supplied details of membership of Non-Departmental Public Bodies (NDPBs) and other public bodies. If panel members join such a body in any capacity while serving as a panel member of the IRAP, panel members should notify the Chair via the Secretariat. While membership of other bodies is not prohibited, it should not be capable of interfering, influencing or being seen to influence their work as a panel member of the IRAP. If panel members are unsure of the status of a particular body with which panel members may be associated they should consult the Chair via the secretariat to the IRAP.

## IV. Conflicts of interest

You must declare any personal or business interests, which may, or be perceived to, influence your judgements in performing your functions upon accepting a position as a member of the IRAP. These interests will be included in a register of interests maintained by the IRAP and you must ensure that your entries are kept up to date. Should a particular matter give rise to a conflict of interest a member is required to inform the Chair of the IRAP in advance and withdrawn from discussions or considerations of the matter.

You are encouraged to register your own non-pecuniary interests and interests of (close family members and) persons living in the same household which are closely related to the activities of IRAP.

## V. Time Commitment

The time commitment for panel members is expected to be around 12 to 20 days per year starting from 1 February 2012. It is not envisaged that the work will be evenly distributed throughout the year.

A proportion of the time will be during the normal working hours (e.g. meetings). However, some IRAP work will involve reading; research, preparing papers etc. and this can be done at evenings and during weekends.

There is an expectation that members will attend IRAP meetings. In addition, a general willingness to attend other, ad-hoc meetings is expected if necessary.

## VI. Fees and Expenses

The Chair, Deputy Chair and Panel members receive an honorarium as set by Ministers. Panel members should note that membership of the Panel is **not** to be considered as paid employment.

## VII. Reasonable travel expenses and subsistence

Panel members are entitled to claim for those travel costs necessarily and actually incurred on IRAP business at the normal public service rates. Where no extra expense is incurred, no reimbursement is due. Members must always use the most efficient and economic means of travel.

*MoJ Financial controls & restrictions: First class travel*

This applies to all MoJ staff. Arms Length Bodies will adopt the same approach to be implemented locally.

The new travel and subsistence policy introduced into the Ministry of Justice in April 2010 contained restrictions on using first class travel. The policy states that staff travelling by rail/air should, irrespective of grade, travel standard class. However, the policy does recognise that in certain cases (e.g. when accompanying a minister or where a member of staff has special needs) and with prior management approval, first class travel may still be booked.

## VIII. Performance

The Chair shall monitor the performance and effectiveness of panel members and may, at his/her discretion, raise the issue of a panel member's performance with the Head of the Youth Justice Policy Unit if s/he has any concerns.

## IX. Pension

The honorarium for panel members is non-pensionable.

## X. Period of Appointment

Your re-appointment will be up until 31 January 2014.

## XI. Extension and Termination of Appointment

Members are appointed for an initial term stated above, and subject to satisfactory performance.

The Secretary of State for Justice may terminate the appointment of a panel member at any time if s/he is satisfied that the panel member, since his/her initial appointment, has:

a. Failed satisfactorily to perform his/her duties;
b. Become, for any reason, incapable of carrying out his/her duties;
c. Been convicted of any criminal offence;
d. Conducted himself/herself in such a way that it is not fitting that s/he should remain a panel member of the IRAP

The Chair and members may resign at any time and should where possible give 3 months notice in writing to the Head of the Youth Justice Policy Unit.

## XII. Security and Confidentiality

The provisions of the Official Secrets Act 1989 will apply to the Members of the IRAP in respect of official information acquired in the course of their appointment, and will continue to apply after the appointment has ended. The appointment will be subject to an appropriate level of security clearance and a check of any unspent convictions as defined in the Rehabilitation of Offenders Act 1974.

Members of the IRAP must take all practicable steps to ensure the security and confidentiality of all and any records to which they have access during the course of their appointment. This requirement extends to any environment in which the members may be working, including working at home, staying in a hotel or travelling between destinations.

## XIII. Political activity

You are not expected to occupy paid party political posts or hold particularly sensitive or high roles in a political party. Subject to the foregoing, you are free to engage in political activities provided that you are conscious of your general public responsibilities and exercise a proper discretion, particularly with regard to the work of the IRAP.

You are expected to inform the Secretary of State of any intention to accept a prominent position in any political party and to understand that the appointment may be terminated if the Secretary of State feels that the positions are incompatible.

If you accept a nomination for election to [House of Commons etc] then you will resign the appointment.

# Annex B to: A Review of Restraint Systems Commissioned for Use with Children who are Resident In Secure Children's Homes

# Memorandum of Understanding

Memorandum of Understanding between the Department for Education ("DfE") and the Independent Restraint Advisory Panel ('IRAP') v 0.4

## Introduction

This Memorandum of Understanding outlines the ways in which the Department for Education ("DfE") and the Independent Restraint Advisory Panel ("IRAP") will work together to support the IRAP's review of the restraint systems that are in operation in secure children's homes (SCHs).

## Background

SCHs must comply with the full range of Regulations and National Minimum Standards (NMS) that apply to all children's homes. They must meet the individual physical, emotional, health, social and educational needs of all the young people in their care – whether these young people are detained on welfare grounds (s. 25 Children Act 1989) or whether they are sentenced to custody.

DfE is the government department with lead responsibility for safeguarding children and has policy responsibility for children's homes, which include SCHs.

To date there has not been an independent systematic review of restraint systems across the SCH sector in England and Wales, to establish whether the systems in place lead to practice that is safe and appropriate for children.

## 1. Aims of the IRAP review of restraint systems in SCHs

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 Secure Children's Homes (SCHs).

b. To support the implementation of Minimising and Managing Physical Restraint (MMPR) to Secure Training Centres and Under-18 Young Offender Institutions.

This memorandum of understanding relates to:

a. IRAP's review of restraint systems in SCHs.

The aim of the review will be to advise and make recommendations as to whether these systems:

- Are properly risk assessed from a medical/physiological perspective, to minimise the chances of injury to the child or to staff managing restraint incidents;
- Are based on a clear ethical framework which is grounded in an understanding of child development and is compatible with the rights of the child; and

- Consistent with legal requirements, statutory guidance and the NMS.

In carrying out this review DfE wishes the IRAP to collate information on any national/international medical evidence regarding restraint systems, to ensure that key national/international messages about the use of restraint on children are considered.

## 2. Timescales

The work that the IRAP will undertake as part of their review of restraint systems in SCHs will comprise the following broadly sequential stages:

1. Data gathering (approx. June 2012 – February 2013)
2. Review and analysis (from September 2012 onwards)
3. Drafting a formal report (to be submitted by 20th December 2013)

Whilst the timing of these stages are flexible, the final end date of the project, 23rd April 2014, is non-negotiable. The IRAP has been assigned 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.

Stage 1 activities will include;

Data gathering

- Questionnaire for SCH managers, Local Authorities (LAs) and Charities with responsibility for an SCH, chairs of Local Safeguarding Children's Board's (LSCBs) and Government Departments.
- Site visits to SCHs.
- Review of systems for collation of data on use of restraint including Ofsted notifiable incident reports, Youth Justice Board (YJB) serious incidents reports and LA accident and incident reports.
- Structured interviews with SCH managers and staff, registered providers (i.e. senior LA managers) and restraint system /training commissioners.
- Structured interviews with restraint training providers.
- Appropriate activity with children and young people to ensure their views are represented.

If at any stage concerns are identified about the safety or ethical validity of any of the systems used in SCH then the IRAP will initiate further investigation of how the system is applied in practice, including training of staff. Information on how the IRAP will report any safety concerns is set out in section 5 of this agreement.

Activities to be included in Stages 2 and 3 will depend on the outcomes of Stage 1, but will include, as a minimum, the following;

Stage 2: Data Analysis

- Analysis of data on restraint systems including the robustness of the management systems in place for capturing and analysing data and informing changes in risk management and training as a result of such analysis.
- Analysis of good practice and critical issues for SCH, Local Authorities, DfE and the wider sector.

- Analysis of views of children and young people.

Stage 3: Reporting

- Report drafting – indicating any recommendations for further actions required by accountable bodies including Local Authorities, government departments, and other agencies (YJB; Ofsted; LSCBs).

At any stage during the project, informal feedback may be given by the IRAP to DfE about the findings of questionnaires, visits or interviews with SCHs, Local Authorities, LSCBs or restraint training providers.

## 3. Arrangements for liaison with SCHs

All SCHs have been made aware of the work of the IRAP, and have expressed their commitment to working collaboratively and supporting any visits to the SCH requested by the IRAP.

Liaison with the SCHs will be primarily through the IRAP secretariat, however individual members of the IRAP may contact individual SCHs and the Local Authorities that provide them, once the field work is underway.

The secretariat will review the quality and quantity of contact and liaison with SCHs to check that this work does not impose unnecessary and onerous bureaucratic burdens on these services.

## 4. Reporting processes and monitoring

The IRAP is accountable to the Restraint Management Board (RMB) – chaired by a Director appointed by MoJ, with DfE representation. DfE will report on the progress of the project to the RMB, and will submit both the mid point and end of project reports to the closest RMB meeting in a timely manner.

For the delivery of the DfE element of the IRAP's commission, an IRAP working group has been convened to support project management and the progress of their work. This group has membership from the following organisations:

- DfE
- Ministry of Justice
- Youth Justice Board
- Association of Directors of Children's Services (ADCS)
- Secure Accommodation Network (SAN) (x 2 representatives)
- Ofsted
- IRAP (Chair, Vice Chair plus 1 panel member)

This group will have a "critical friend" function offering support to the IRAP members to keep on task and to timescales and to assist in the management of any emerging policy issues. [The draft IRAP Working Group Terms of Reference are attached as Annex 1]

The working group meets quarterly or more frequently by agreement.

The IRAP secretariat will compile monthly progress highlight reports which will be circulated to the IRAP working group for information.

The IRAP will complete and submit to DfE, an interim report about the progress of the project by April 26th 2013. This will subsequently be submitted to the Restraint Management Board. The final report for the project will be completed and submitted to DfE and the Restraint Management Board by December 20th 2013.

## 5. Safeguarding/reporting of concerns

Should any safeguarding issues or concerns about the safety of any restraint system arise during the IRAP's field work or during the review of information, the IRAP must inform the responsible Local Authority and Ofsted to initiate the appropriate action so that children are protected. The IRAP must also inform DfE who will initiate appropriate communication with the IRAP working group members.

IRAP members will complete a reporting template during each visit to an SCH or restraint training provider. This reporting template developed with the support of Ofsted, clearly sets out how to record and report any safeguarding issues or concerns. Prior to its use, the template will be approved by DfE as fit for purpose. Completed templates will be regularly quality assured by the IRAP member responsible for safeguarding.

## 6. Admin support

Secretariat support will be provided to the IRAP by DfE to the extent of 10 working hours per week. The secretariat support includes:

- Correspondence and arrangement of meetings for IRAP members and IRAP working groups.
- Design, distribution and collation of IRAP questionnaires.
- Co-ordination of IRAP visits to SCHs.
- Project management.
- Administration of financial claims and expenses.

Policy advice from the DfE will be provided by Mark Burrows or Claire Owens as requested by the IRAP.

## 7. Outline process for managing final report

The IRAP's final report and recommendations will be submitted by December 20th 2013 to DfE and the Restraint Management Board. The report will be presented to MoJ and DfE Ministers via a formal submission process in January 2014. The Association for Directors of Children's Services (ADCS) and The Welsh Government will also be presented with the report in January 2014.

DfE intends to publish the final report and Government's response to it in summer 2014.

## 8. Document History:

| Version | Description | Date | Author |
|---|---|---|---|
| **0.1** | MoU initiated | 26.6.12 | CO |
| **0.2** | Amends made from MoJ, DfE and IRAP | 28.6.12 | CO |
| **0.3** | Comments removed circulated for agreement | 5.7.12 | CO |
| **0.4** | Amends made following YJB comments | 19.7.12 | CO |
| **1.0** | Final version approved at RMB | June 12 | CO |

### Annex 1: Terms of Reference for IRAP Working Group

# IRAP Working Group

## Terms of Reference v0.1

### 1. Remit

The purpose of the IRAP Working Group is to provide a "critical friend" function offering support to the IRAP members and assisting in the management of any emerging policy issues about restraint systems in secure children's homes (SCHs).

### 2. Membership

| Organisation | Representative |
|---|---|
| DfE | Mark Burrows<br>Claire Owens/ Jim Brown |
| Ministry of Justice | Chris Ball<br>Roshnee Patel |
| Youth Justice Board | Gary Herbert<br>Dan Shotter |
| Association of Directors of Children's Services (ADCS) | Gail Hopper<br>Matt Dunkley |
| Secure Accommodation Network (SAN) | Peter Spearman<br>Keith Smith |
| Ofsted | Lisa Pascoe |
| IRAP | Sue Bailey<br>John Crawley<br>Pam Hibbert |

DfE may invite additional persons to meetings in order to support the group and present agenda items.

## 3. Roles and responsibilities of the Working Group

The roles of the Working Group are as follows:

- Providing strategic advice and expertise to assist DfE in taking forward the project management of the IRAP review of restraint systems in SCHs.
- To assist in the management of any emerging policy issues.

## 4. Arrangements for the Conduct of Business

### 4.1 Chairing the meetings

A senior DfE representative will Chair the working group meetings.

### 4.2 Frequency of meetings

Meetings will be held face-to-face on quarterly basis, or more frequently if necessary. Times and venues will be confirmed via email or face-to-face as appropriate.

The dates of meetings are:

Monday 10th September 2012

Tuesday 11th December 2012

Tuesday 12th March 2013

Tuesday 11th June 2013

Tuesday 10th September 2013

Tuesday 10th December 2013

Tuesday 11th March 2014

All meetings to be held within the Department for Education, Sanctuary Buildings unless otherwise indicated.

Ad-hoc communications necessitating rapid response may occur as appropriate.

### 4.3 Principles

- All drafts of documentation are **shared in confidence** and not for wider circulation without the express permission of DfE;
- No surprises – attendees to be given sufficient information prior to attending in order to enable effective decision making;
- Agendas, minutes, and additional papers to be circulated in advance of meetings;
- DfE to take responsibility for minutes of meetings;
- Adequate time allowed for meetings.

### 4.4 Declaration of Interests

If any member has an interest, pecuniary or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and shall not participate in the discussions. The Chair will have the power to request that member withdraw until the issue under consideration has been completed.

All declarations of interest will be minuted.

### 4.5 Urgent matters arising between meetings

Any urgent matters arising between meetings will be referred to the working group as appropriate.

## 5. Administration

Face-to-face meetings and email will be the primary methods of communication between the DfE and the working group.

## 6. Review of Terms of Reference

These Terms of Reference will be reviewed annually or sooner if required.

## 7. Document History:

| Version | Description | Date | Author |
|---|---|---|---|
| 0.1 | ToR initiated | 26.6.12 | Claire Owens |
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# Annex C to: A Review of Restraint Systems Commissioned for Use with Children who are Resident In Secure Children's Homes

## Glossary of Terms and Definitions

| Acronym or Term | Expansion of Acronym | Meaning of acronym or term |
|---|---|---|
| ADCS | Association of Directors of Children's Services | A professional association of directors of local authority children's services |
| BILD | British Institute for Learning Disabilities | A membership organisation that provides advice and information including a code of practice in relation to use of physical restraint |
| Breakaway and / or disengagement | | Techniques that are intended to enable people to escape if they are attacked |
| De-escalation | | Measures that are designed to assist staff to assist people to reduce their arousal and consequent challenging behaviour sufficient to allow staff to reduce the requirement for, intensity of any physical interventions |
| Diversion | | Measures and techniques that are intended to assist staff to divert children from challenges to, or confrontation with others so that any requirement for restraint is reduced |
| DTO | Detention and Training Order | A custodial sentence for juveniles made in the Youth Court that is provided by the powers of the Crime and Disorder Act 1998. Half of the sentence is served in custody and half under supervision in the community |
| LSCB | Local Safeguarding Children Board | The Children Act 2004 established LSCBs. Each LSCB is a partnership that is charged with safeguarding children and holding all local agencies to account |
| MMPR | Minimising and Managing Physical Restraint | MMPR is the restraint system that is currently being rolled out for use in YOIs and STCs |
| Responsible Individual | | The person within an organisation who has legal responsibility and accountability for running children's homes, as set down in Volume 5 of the Guidance and Regulations: Homes to the Children Act 1989 |
| SAN | The Secure Accommodation Network | SAN is an overarching body that represents the staff of Secure Children's Homes in England and Wales |

| Acronym or Term | Expansion of Acronym | Meaning of acronym or term |
|---|---|---|
| Sections 90 & 91 of the Criminal Court (Sentencing) Act 2000 | Theses sections provide powers for custodial sentences for juveniles | The sentences provided by these sections can only be imposed by the Crown Court for offences which, in the case of an adult, could warrant a sentence of 14 years or more |
| The secure estate | The secure estate is a term that describes three types of secure establishments that are used to accommodate children aged 17 and under who have been detained by the criminal justice system | The secure estate consists of:<br>• Secure Children's Homes (SCHs) that are operated by local authorities and, in one case, by an NGO. They accommodate boys and girls who are predominantly the younger age group and those who are particularly vulnerable<br>• Secure Training Centres (STCs) that are operated by private contractors and accommodate boys and girls<br>• Young Offender Institutions (YOIs) that are operated by the National Offender Management Service and accommodate boys aged 15 or over |
| Welfare order | An order that is available to the family courts provided by powers in Section 25 of the Children Act 1989 | Welfare orders enable children to be deprived of their liberty for welfare reasons |
| YJB | Youth Justice Board for England and Wales | The YJB has responsibility for placements in the Secure Estate of those children detained by the criminal justice system. |

# Annex D to: A Review of Restraint Systems Commissioned for Use with Children who are Resident In Secure Children's Homes

## Agencies that Participated

### Secure Children's Homes

Aldine House, Sheffield
Atkinson Unit, Devon
Aycliffe, County Durham
Barton Moss, Salford
Beechfield, West Sussex
Clare Lodge, Peterborough
East Moor, Leeds
Hillside, Neath (Wales)
Kyloe House, Northumberland
Lansdowne House, East Sussex
Leverton Hall, Essex
Lincolnshire Unit, Lincolnshire
Red Bank, St Helens
Clayfields, Nottinghamshire
St Catherine's, Nugent Care
Swanwick Lodge, Hampshire
Vinney Green, South Gloucestershire

### Other Agencies

Association of Directors of Children's Services
British Institute for Learning Disabilities
Department for Education
Ministry of Justice
NHS England
Ofsted
Secure Accommodation Network
Youth Justice Board for England and Wales

### Providers of Training on Restraint

# Annex E to: A Review of Restraint Systems Commissioned for Use with Children who are Resident In Secure Children's Homes

# A Scoping Review of the Literature on Use of Restraint Conducted by the Childhood Wellbeing Research Centre in October 2013

**Authors: Veena Meetoo and Emily R. Munro**

## Introduction

1. The Childhood Wellbeing Research Centre (CWRC) has conducted a rapid scoping review of literature to support the Independent Restraint Advisory Panel's (IRAP) review on restraint systems that are in operation in secure children's homes (SCH). It offers a brief summary of literature published since 2008, so that it builds on, rather than reproduces key pieces of work that have already been undertaken (for example, Di Hart's (2008) study on physical restraint in SCHs).

## Methodology

2. The literature was identified primarily by using the following bibliographic databases: British Education Index, Cambridge Journals, Elsevier, ERIC, Google Scholar, Ingenta, International Bibliography of the Social Sciences, Jstor, Swetswise, Ovid (PsychInfo), PubMed and Wiley. They were accessed through the Institute of Education's library resources, and Senate House, a library that provides access to an extensive range of publications. In addition, general searches were conducted using Google.

3. Search terms were discussed at an initial meeting between IRAP and CWRC. Following this, suggested experts were contacted who provided a list of relevant terms.

4. The searches were conducted using the following terms: Child, Children, Juvenile, Young person, Young people, Adolescent, Restrain*, Restrict*, Control, Behaviour management, Secure Children's Homes, Prisons, Young offenders institute, Juvenile detention, Care settings, Children's Secure Estate.

## Findings

5. The search produced a total of 32 articles. Four articles were produced by the same author and reported on the same study. Taking this into account, there were 18 empirical articles based on primary research, seven review articles, and four commentaries and think pieces. Policy documents and literature prior to 2008 have been excluded from the review. Table 1, below, provides further details on the publications that were included.

**Table 1: Key information about publications on restraint that were included in the scoping review (from 2008 onwards)**

| | Qualitative studies | | Quantitative studies | | Evaluations of programmes and interventions | | Mixed methods studies | |
|---|---|---|---|---|---|---|---|---|
| | Secure children's estate | Other settings | Secure children's estate | Other settings | Secure children's estate | Other settings | Secure children's estate | Other settings |
| No.of studies conducted in the UK (primary research) | 6 | 1 | | | | | 1 | |
| No. of studies conducted outside of the UK (primary research) | 1 | | | 4 | 1 | 4 | | |

6. The literature has been grouped thematically as follows:

- Young people and staff views on physical restraint: literature under this theme specifically explores the views of those who have experienced and carried out physical restraint.
- Use of physical restraint in children's care settings: literature grouped under this theme explores how physical restraint occurs across the secure children's estate, including factors affecting restraint, recording of data and differences between settings.
- Physical effects of restraint: a limited number of studies exploring the effects of restraint on the body (with a focus on adults).
- Alternatives to and reduction of restraint: literature that explores training programmes in behaviour management, the place of touch and emotion, and alternative approaches to reduce the use of restraint.
- Early intervention and risk factors for those more likely to experience restraint: literature that seeks to identify which children and YP are more susceptible to being restrained with a view to minimising the need for restraint.
- Ethical issues and rights in restraint: limited number of studies exploring human rights and ethics in restraint (with a focus on psychiatric settings).

## Limitations and gaps in the evidence base

7. The views of the authors about the limitations of the literature fall into the following categories:

- Different definitions of restraint, and studies on children in different settings beyond the secure state, including, for example, psychiatric hospitals, make it difficult to compare the literature and findings.
- There are significant gaps in the evidence base on the children and young people who have been restrained, and those studies that do address the topic largely study children and young people as a homogenous group. To understand why physical restraint takes place and to obtain a more nuanced picture of experiences of restraint, further research is needed

to assist with understanding who is likely to be restrained, based on gender, ethnicity and needs (for example, history of abuse, mental health).

- There are few studies that: look at physical restraint in Secure Children's Homes; examine the physical effects of restraint on children specifically; and on physical restraint training.
- In the UK, Laura Steckley and Di Hart are the main authors who have published on children and young people and physical restraint across the secure estate. Since 2008, the former has written many papers based on one qualitative study that explored various aspects of restraint.
- Most studies on physical restraint and children in the UK are qualitative and use interviews, discussion groups with children and young people, and staff members. There is no robust quantitative data, and centralised data collection mechanism to document the prevalence, cause, and effects of restraint. This limits the evidence base.

# A Scoping Review of the Literature on Positive Behaviour Management and Positive Behaviour Support across the Secure Estate Conducted by the Childhood Wellbeing Research Centre in April 2014

## Author: Veena Meetoo

### Commentaries from Practitioners and Good Practice Guides on Positive Behaviour Management (PBM) and Positive Behaviour Support (PBS)

1. The reviews identified: three commentary pieces by professionals that discuss elements of what could be seen as positive behaviour management (e.g. points based rewards systems, role modelling) and positive behaviour support (e.g. milieu therapy, positive behaviour facilitation). One good practice guide including a section on behaviour management that refers to reward schemes and sanctions.

| Citation of Source | Study details | Key points |
|---|---|---|
| Vanderwood J. Divisions between behaviour management and behaviour therapy: towards new directions of authority in child and youth care. Journal of Child and Youth Care 2006; 5:1:33-41. | **Nature of paper**: Commentary piece discussing frontline childcare experience on how managing difficult behaviour has become separated from the goal of therapeutic change<br>**Setting**: Childcare<br>**Location**: UK | This paper:<br>• Childcare workers mostly judge themselves by how well they control children, rather than by therapeutic results. Based on this concern, the article explores how authority can be used as therapy and not just as a means of control.<br>• Argues that the opportunity for treatment emerges through management of day-to-day behaviours of children in residential care. |

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| | | • Discusses milieu therapy e.g. using daily routines as the place for treatment, whereby all parts of daily experience such as the physical characteristics of the setting, furniture, routines, people, food, become tools for therapy and an integral part of behaviour management. In the therapeutic milieu, therapy and management are intertwined and inseparable.<br>• Identifies role modelling (e.g. staff not acting aggressively) as a form of behaviour management in that the child's destructiveness when angry is curbed, and is also treatment in that the child learns positive skills in handling anger. |
| Lombard D. Should children's homes offer good behaviour rewards to looked after children? Community Care, August 17th 2011. | **Nature of paper**: Commentary piece on using rewards as a behaviour management technique<br>**Setting**: Children's homes<br>**Location**: UK | This paper discusses the use of a points based reward system that aims to boost self-esteem.<br>• One provider uses a points based rewards system complete with its own website Anderida Care, which was the pioneer of 'A points'. This system works similarly to a loyalty card whereby young people accrue points for good behaviour and can then choose activities such as attending premiership football matches, bungee jumping and snowboarding.<br>• Providers commented that the system is tailored to each individual and their care plan. They look at coping mechanisms the young people use and create a chart with different areas of behaviour they could improve on (e.g. they can gain points for avoiding self-harming behaviour or taking a shower in the morning if this is something they do not usually do).<br>• There are no formal evaluations of the scheme but its costs effectiveness has been consistently proven (e.g. improved behaviour, less visits to hospital and police involvement).<br>• Critics argue that it is no substitute for strong relationships and does not address the underlying cause of behaviour. It does not encourage responsibility is not related to any form of normality (i.e. people in the community do not live in this way).<br>• Providers commented that this system should work alongside other therapies as a way of building independence and emotional resistance. |
| Olive EC. Practical tools for positive behaviour facilitation. Reclaiming Children and Youth 2004; 13:1:43-47. | **Nature of paper**: Article describing the components of positive behaviour facilitation<br>**Setting**: educational settings but not made explicit | • Positive behaviour facilitation (PBF) is a comprehensive approach to understanding and intervening in the behaviour of youth, examining not only the 'what' (what the child is doing to disrupt), but also the 'why' to effectively intervene in self-defeating behaviour. It aims to support or facilitate, the demonstration of positive behaviour from youth.<br>• PBF teaches strategies for resolving crisis versus traditional models of behaviour intervention, which are often narrow and reactive in nature. Traditional models tend to focus on cessation of behaviour, while ignoring the necessity for resolution conflict and teaching new behaviours to children and youth.<br>• PBF presents six tools necessary for understanding |

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| | | and intervening in the behaviour of children in order to promote the mental, behavioural, emotional, spiritual and physical well-being of children.[ng] ? adults to use techniques and strategies that can minimise inappropriate behaviours and maximise opportunities for positive, more functional behaviours. The six tools are:<br>i. Awareness and management of self encourages children to understand themselves as the foundation of behavioural change<br>ii. Knowledge of the dynamics of conflict (e.g. how stress can be transferred to adults in such situations)<br>iii. Understanding behaviour management versus behavioural change<br>iv. Therapeutic milieu (i.e. the healing environment or the climate in which the children are served)<br>v. Surface behaviour management techniques can be used by adults to restore, maintain and promote order in the environment and to increase demonstration of desirable behaviours<br>vi. Effective communication with the aim of better understanding the children. |
| NACRO. Reducing offending by looked after children. London: NACRO, 2012. | **Nature of paper**: Good practice guide commissioned by the Department of Health on reducing offending by looked after children. Includes a chapter on diverting looked after children from the youth justice system and covers promoting positive behaviour. Draws on some research conducted on looked after children.<br>**Setting/group**: Looked after children<br>**Location**: UK | Describes how effective approaches to behaviour management can promote positive behaviour and prevent troublesome behaviour from escalating into something more serious. Suggests that staff in residential care and foster carers should:<br>• Create a positive environment in which young people can feel they can talk through any problems, particularly with peers or others.<br>• Create positive activity and interactions and help young people to manage strong feelings, and to adopt pro-social behaviour.<br>• Encourage engagement with pro-social friends.<br>• Set clear, consistent boundaries outlining what type of behaviour will elicit what kind of response.<br>• Use behaviour management approaches, including reward schemes and also the use of sanctions.<br>• Develop and implement behaviour management plans.<br>• Use de-escalation techniques.<br>• Promote preventative and restorative approaches.<br>Also advocates use of restorative approaches in children's homes that is regarded as a good way of: preventing escalation or repetition of difficult behaviour; and providing an informal way of resolving problems that might otherwise be reported to the police. |

## Theoretical Discussions and Review Studies on Positive Behaviour Support

2. The review identified: three commentary pieces by professional practitioners.

- Positive behaviour support (PBS) was the main focus of the articles found that could be classified as theoretical discussions, and review studies. None was found using the term positive behaviour management.
- Four papers were classified as theoretical discussions of the concept of PBS, and two as review articles of existing empirical work.
- The literature on PBS comes from the USA, where some efforts have been made to define PBS in light of applied behaviour analysis (ABA). It originates from the field of developmental disabilities but is increasingly extending to people who exhibit challenging behaviours. It is an approach that follows the logic of persons as individuals who have specific needs, and, as a result, operates from a person centred values base. In addition, the thesis is that the concept should incorporate the multiple aspects of people's lives, including environmental variables, when designing services and interventions.
- One study focused on children and young people in part of the secure estate. Nelson *et al*. (2009) point to frontline staff and researchers as increasingly calling for PBS to better meet the complex needs of youth in the juvenile justice system, especially since a significant number of these youth have educational disabilities or diagnosed mental health conditions.

| Citation of Source | Study details | Key points |
|---|---|---|
| Anderson CM, Freeman KA. Positive behaviour support: expanding the application of applied behaviour analysis. The Behaviour Analyst 2000; 23:85-84. | **Nature of paper**: Theoretical paper describing the framework of PBS, showing its relationship with the tenets of behaviour analysis.<br>**Setting/group**: developmental disabilities and behavioural challenges<br>**Location of study**: USA | This paper demonstrates that Positive Behaviour Support offers useful suggestions regarding how applied behaviour analysts can design and evaluate effective programmes for people with developmental disabilities or behavioural challenges.<br>• Defines PBS as a framework for developing effective interventions and programmes for individuals who exhibit challenging behaviour.<br>• PBS uses a wide variety of strategies drawn from applied behaviour analysis. The framework of PBS describes both: a. a set of values regarding quality of life and the rights of persons with disabilities; and b. procedures and steps to be used when working with people who exhibit challenging behaviour.<br>• Services consistent with a PBS perspective generally are characterised by: a. operating from a person-centred values base, which encourages the individual and their families to take leading roles in making decisions regarding the types of services provided, leading to a team based approach to gather more complex and detailed information about the individual; b. recognising the individuality of each person (e.g. individualising supports for that person); and c. working towards and achieving minimal outcomes thereby focusing on multiple aspects of the individual's life to design services that result in the individual's life being qualitatively different, including assessing the environmental variables that might be manipulated to result in |

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| | | improvements (e.g. social relationships, degree of participation, person's communication strategies, and skills, and functional assessment strategies are often drawn on). |
| Johnston JM, Foxx RM, Jacobson JW, Green, G, Mulick JA. Positive behaviour support and applied behavior analysis, The Behavior Analyst 2006; 29:1:51-74. | **Nature of paper**: Theoretical paper reviewing the origins and characteristics of PBS and examines these features in the context of applied behavioural analysis (ABA).<br>**Location of study**: USA | States that Positive Behaviour Support originated in the field of developmental disabilities relating to people who were being subjected to dehumanising interventions that were neither ethical nor beneficial. |
| Carr JE, Sidener TM. In response: on the relation between applied behaviour analysis and positive behaviour support. The Behavior Analyst 2002; 25:2:245-253. | **Nature of paper**: Theoretical paper exploring the range of definitions of PBS<br>**Location of study**: USA | Concludes that Positive Behaviour Support comprises almost exclusively of techniques and values originating in applied behaviour analysis. |
| Carr EG, Dunlap G. Horner RH, Koegel RL, Turnbull AP, Sailor W, Anderson J, Albin RW, Koegel L, Fox L. Positive behaviour support: evolution of an applied science. Journal of Positive Behaviour Interventions 2002; 4:4-16. | **Nature of paper**: Theoretical paper providing definition of PBS, the background sources from which it emerged, and its critical features that makes it distinct from other approaches.<br>**Location of study**: USA | Positive Behaviour Support initially evolved in the field of developmental disabilities and emerged from three major approaches: applied behaviour analysis; the normalisation/inclusion movement; and person centred values.<br>Although PBS can be found in other approaches, its uniqueness lies in how it integrates nine critical features into a cohesive whole: comprehensive lifestyle change; a lifespan perspective; ecological validity; stakeholder participation; social validity system change; emphasis on prevention; flexibility in scientific practices; and multiple theoretical perspectives. The paper's authors comment that there will be future application to new populations. The contents reflect a more general trend from pathological models to a new positive model that stresses personal competence and environmental integrity. |
| Nelson CM, Sprague JR, Jolivette K, Smith CR, Tobin TJ. Positive behaviour support in alternative education, community based mental health and juvenile justice settings. In: Handbook of Positive Behaviour Support. London: | **Methodology and nature of study**: Review piece drawing on a number of studies on the use of PBS.<br>**Sample details**: Refer to authors' previously conducted studies on PBS. A section is devoted to PBS in Juvenile Justice Settings<br>**Location of study**: | Positive Behaviour Support is in its infancy in Juvenile Justice settings, but frontline staff and researchers are increasingly calling for PBS to better meet the complex needs of youth in the juvenile justice system.<br>A significant number of youth in the juvenile justice system have educational disabilities or have been diagnosed as having mental health conditions. The most common identified disabilities include: emotional disturbance; learning disabilities; mental retardation; and speech and language impairment. In addition, having a disability appears to have a negative effect on the length of incarceration.<br>The application of PBS can be across the multiple systems that exist in juvenile justice facilities (e.g. |

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| Springer, 2009. | USA | housing, mental health, recreation, security). Teaching young people in juvenile justice settings can be particularly challenging. Other studies have found that focussing on behaviour, interpersonal skills, and individual counselling, and creating an inclusive and respectful environment were most effective (Lipsey *et al*., 2000; Keith & McCray, 2002).<br><br>Authors refer to two reports on the effects of PBS on youth behaviour. Sidana (2006) reports on the Iowa Juvenile Home and found that, following implementation of PBS, there was a 73% reduction in the use of restraints and seclusion during a 15 month period, and a 50% decrease in behaviour referrals during a 4 year period. Clarida (2005) reported on a Youth Centre in Illinois and found no fights and a decrease in the number of minor and major infractions.<br><br>However, the authors caution that the juvenile justice system is complex with multi-disciplinary staff, competing priorities (security vs. rehabilitation & treatment), and attitudes favouring punishment over behaviour support. These features have influenced a trend towards implementation on a smaller scale, such as within education programmes. Implementing PBS further across juvenile facilities is complex because facilities may be too large and encompass a number of areas (housing, security, recreation), and work shifts and layers of supervisors make it more difficult to roll out across the juvenile justice system. In addition, the data about discipline across the systems (school discipline vs. housing data) may not support the need for PBS across all of them.<br><br>Implementation of PBS in juvenile justice settings is encouraging. This suggests that further research is needed to explore implementing PBS in alternative education settings. |
| LaVigna GW, Willis TJ. The efficacy of positive behavioural support with the most challenging behaviour: the evidence and its implications. Journal of Intellectual and Developmental Disability 2012; 37:3:185-195. | **Methodology and nature of study**: Review of studies on the effectiveness, costs and accessibility of PBS.<br><br>**Sample details**: Twelve studies were reviewed that encompassed 423 cases of PBS.<br><br>**Setting**: not specified but refers those with challenging behaviour<br><br>**Location of study**: USA | Positive Behaviour Support is viewed in this paper as the application of the science of applied behaviour analysis (ABA) in support of people with challenging behaviour. Its primary focus is on improving the quality of life of persons as a measured set of values and as evaluated by the persons receiving those services (and their families). It is a multi-element, non-linear approach designed to achieve a broad range of outcomes for people whose behaviour is challenging. These outcomes include improving person's quality of life, removing behavioural barriers that may get in the way of those outcomes, achieving lasting generalisation of both quality of life and behavioural improvements, and accomplishing these outcomes with minimal or no negative side effects. One of the main components is a functional assessment aimed at understanding the meaning or function of the behaviour from the person's point of view.<br><br>In a plan for PBS, a reactive strategy should resolve, and not escalate, the behaviour. Punishment is eliminated from a PBS plan since it usually leads to escalation. However, if unavoidable, a restrictive reactive strategy such as physical management might be used as a last resort.<br><br>This review only included studies that investigated a range of outcomes as a result of a fully developed PBS |

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| | | plan including ecological, positive programming and focused plans for proactive support and non aversive reactive strategies to reduce episodic severity, with the use of possible aversive (punitive) responses as a last resort. Studies that looked at individual components of PBS were not included.<br><br>Challenging behaviour covered in these studies included serious aggression such as self-injurious behaviour resulting in hospitalisation, physical assaults on siblings, and head butting. Most of the subjects had learning disabilities or autism.<br><br>This review found that PBS: was effective with both severe and high rate behaviour problems; was cost effective; used a methodology that was easily trained and widely disseminated; and worked in institutional settings, in which the people who have the most difficult problems are thought to be, as well as in the community. However, it was difficult to unpack which elements of the programme contribute to which outcomes, due to the multi-faceted nature of PBS. In addition, more needs to be understood about how institutional settings contribute to problem behaviour. |

## Studies on Children, Young People and the Secure Estate, Incorporating Behaviour Management (PBS and PBM)

3. The reviews identified: three commentary pieces by professionals.

- Four articles based on primary research in the UK were found that incorporated some elements of positive behaviour management across the children's secure estate. None of these studies was solely focused on positive behaviour management. The areas covered in the studies that could be classified as forms of positive behaviour management predominantly focused on rewards schemes, building positive relationships, role models, and motivational interviewing (as found in a comparative study with other European countries). These studies covered children accommodated in YOIs, SCHs and STCs.
- Reward and sanction schemes appear to be the most frequently cited forms of positive behaviour management in these studies.
- There was no evidence of any robust assessment of forms of positive behaviour management in the UK studies.
- There is a lack of research on staff and young people's views about behaviour management. It appears, from what little evidence there is, that young people are generally happy with the use of reward schemes (YJB, 2011; Gyateng *et al*., 2013), but reservations were expressed by staff about the effectiveness of these schemes when the young people are already 'off wing' or on a short term sentence. However the views of staff about the schemes highlighted: the need for a more consistent approach to administering rewards and sanctions; and the importance of relationships between young people and staff and their effects on the behaviour of the former.
- Two studies conducted in the USA used the term positive behaviour support as a more holistic approach (discussed above). In particular, their focus was the application of PBS in juvenile justice settings.

| Citation of Source | Study details | Key points |
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| IPSOS MORI. Behaviour management across the secure estate for children and young people. London: Youth Justice Board for England and Wales, 2011. | **Methodology and nature of study:** Qualitative study with staff and young people who had experienced restraint.<br><br>**Sample details:** In-depth interviews with staff (n=19) and young people (n=16).<br><br>**Setting:** Four YOIs, two STCs and two secure children's homes<br><br>**Location of study:** UK | This study follows on from Smallridge and Williamson's (2008) review of restraint. It aimed to provide greater clarity about why the frequency of use of restraint was lower in the YOI sector and suggests some possible explanations. It includes a chapter on general approaches to behaviour management across the secure estate.<br><br>**Main findings**:<br><br>This study identified three elements that are common to effective behaviour management programmes:<br><br>1. The use of rewards and sanctions scheme: Acknowledged as a central approach to managing behaviour. The ability to reward good behaviour made this scheme distinct from other tools available to staff. Both young people and staff were positive about the rewards scheme. Praise was perceived to be particularly effective. The points based system gave young people something clear to work towards and provided a clear path towards an end goal. This also evoked a sense of healthy competition. There was more scepticism expressed by staff about sanctions that can make young people feel de-motivated if regularly used. Some young people reinforced this finding. They can be less effective for young people who are already off wing.<br><br>2. Building positive relationships: Common agreement among staff and young people that positive relationships played a significant role in ensuring that the behaviour of young people was managed effectively. Positive relationships were seen to help staff understand the needs of young people and identify triggers of negative behaviour. Mutual respect was a key factor in developing positive relationships.<br><br>3. Conflict resolution and de-escalation: Staff placed importance on trying to 'talk down' young people to prevent incidents escalating, and more talking to young people without resorting to restraint. Conflict resolution was also part of the day-to-day culture linked to the idea of building relationships with the young people. Therapeutic crisis intervention (TCI) was cited as one method. Staff were positive about de-escalation and felt it was practised as widely as possible.<br><br>Restorative approaches were also mentioned. They were seen to also have a preventative purpose, based on the presupposition that working through an incident prevents similar incidents occurring in the future. Staff raised some concerns that there should be more training on this technique. |

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| Kidson H. Reducing Recidivism amongst young people in custody through welfare lead rehabilitation. London: Winston Churchill Memorial Trust, 2011. | **Methodology and nature of study:**<br>Study exploring how recidivism in young people can be reduced by learning best practices from juvenile prisons elsewhere in Europe. It involved visiting institutions in Norway, Sweden, Finland, and Germany and comparing them with YOIs in England and Wales from the perspective of a prison officer.<br>**Setting:**<br>YOIs<br>**Location of study:**<br>Cross country comparison | **Main findings and recommendations in relation to behaviour management:**<br>1. Motivational Interviewing:<br>More high quality interaction between young people and practitioners is needed immediately on the entry of the former into prison. In Norway and Sweden, one method of doing this is motivational interviewing (MI) from the moment the young people enter establishments. In Norway and Sweden, young people re-offend less (36% and 43% less) and self-harm and violence is extremely low. MI is a directive client focused method for enabling motivation to change by exploring and challenging ambivalence towards dealing with young people's behaviours. It involves working with the young people to reveal their own reasons for their behaviour and motivations to change. It aims to raise self-esteem. Style should be empathetic, collaborative, and use reflective listening and open-ended questions to discuss reasons for ambivalence about making changes. MI can be used as a mechanism for building engagement, improving relations between staff and young people, gaining responsivity, and helping young people see pathways out of offending.<br>2. Greater emphasis on pro-social modelling and learning social skills:<br>The staff of the establishments in Norway, Sweden, Finland and Germany believed that providing young people with good role models was essential to reducing recidivism. Staff should show young people how to live in a socially acceptable manner (e.g. eating together, taking young people shopping, cooking skills etc.). Pro-social modelling is a method a practitioner uses to model pro-social values and behaviours with their clients, as well as challenging clients and using positive and negative reinforcement (e.g. praising someone for coming to a member of staff with a problem rather than resorting to a physical altercation).<br>Assessments, such as risk assessments, should include more enquiries about the needs of young people and how their needs can be met in custody. In Sweden, young people are assessed within eight weeks of arrival in custody allowing time for staff to get to know them and assist them to settle in. It should help make clearer what are each young person's triggers, and the matters with which they have difficulties (e.g. peers, drugs, education). This information can then be fed into the MI. There was a strong focus on communication and everyone being aware of the young people's situations, their achievements and their set backs, so that everyone can work using the same goal. |
| Department for Education. Behaviour management and reducing offending by children placed in Children's | **Methodology and nature of study:**<br>Sets out findings from an initiative that was commissioned by DfE relating to behaviour management and | This study focused on identifying good practice and understanding why it was effective.<br>• It identified key characteristics within a residential setting that contributed to successfully managing behaviour and reducing risk of criminalisation<br>• One characteristic was behaviour management and |

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| Homes, Executive Summary. London: Department for Education, 2013. | deducing offending by children who are placed in children's homes.<br>**Sample details:**<br>A research planning workshop was held to seek the views of practitioners who work in children's homes and of the wider agencies to design the criteria for the initiative. It used an online questionnaire for children's home managers and partner agencies (n=21).<br>The researchers conducted four in-depth site visits to children's homes that involved detailed discussions with staff, young people and children.<br>**Setting:**<br>Children's Homes<br>**Location of study:**<br>UK | another was conflict resolution, which involved constructive engagement with children to encourage an open and respectful culture within children's homes, in which it was safe and acceptable to challenge inappropriate behaviour.<br>• It found that good practice often relied on consistency of expectation, and addressed the negative consequences of: inappropriate behaviour; and constant positive reinforcement of unwanted behaviours<br>• Sanctions employed by homes were understood by the children concerned and were proportionate to their misbehaviours. |
| Gyateng T, Moretti, A, May TM, Turnbull J. Young people and the secure estate: needs and interventions, London: Youth Justice Board, 2013. | **Methodology and nature of study:** Examines the experiences and needs of young people under the age of 18 resident in secure children's homes (SCHs), secure training centres (STCs) and young offender institutions (YOIs) and assesses the interventions they received while in custody. The research was conducted during 2010 and early 2011.<br>**Sample details:** The study involved a survey of 1,245 young people nearing the end of custodial sentences. An analysis of the administrative | **General findings on interventions, support and resettlement:**<br>• 21% of all of the young people who were surveyed reported having learning difficulties. Around a quarter of them wanted additional help with reading and writing.<br>• 90% of all young people surveyed were participating in education, but just under half of them reported educational needs that were not being met.<br>• Of the young people who were considered to be at high risk of re-offending because of their attitudes, 25% in YOIs, 42% in SCHs and 67% in STCs had participated in an offending behaviour programme.<br>• Over one third of all staff interviewed felt that targeted interventions worked better than generic offending behaviour sessions.<br>• One-third of staff interviewed believed that short sentences of six months or less resulted in considerably less effective interventions for young people. This was because they felt they were unable to build good relationships and it was difficult for interventions to achieve positive outcomes in such a short period of time.<br>**Findings on behaviour management** |

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| | records, where available, for the young people who were surveyed; and 42 in-depth interviews with staff of the secure estate. The majority of the survey sample was aged between 14 and 17 years old. 94% of the young people were serving a Detention and Training Order sentence, with two-fifths of the sample serving a sentence of six months or less. Young people on longer sentences, such as young people who were detained for public protection, were not included in the study.<br><br>**Setting:**<br>Secure children's homes (SCHs), secure training centres (STCs) and young offender institutions (YOIs)<br><br>**Location of study:**<br>UK | • Rules and consequences of breaking them were communicated in different ways across the secure estate. In STCs and one YOI, young people were given a booklet containing all of the rules and regulations. These young people were then expected to sign a contract stating that they would adhere to these rules. In the SCHs and one YOI, members of staff ran a group exercise in which young people were asked to create a set of guidelines themselves.<br><br>• Reward schemes:<br>Young people were asked about their experience of reward schemes and whether they had an impact on their behaviour. 90% reported being on a reward scheme.<br><br>• Most schemes involved a tiered approach: young people normally start on the middle tier (standard scheme) before advancing to the enhanced scheme, or dropping a level (basic scheme), based on their conduct or achievements.<br><br>• The enhanced scheme offered more rewards such as increased time on electronic games, telephone time.<br><br>• Of the young people who reported being on a reward scheme, those in STCs were more likely to be on an enhanced scheme (53%) than those in other types of establishment. Young people in YOIs and SCHs were more likely to be on a standard scheme (60% and 42%). In SCHs, 18% were on the basic scheme compared to 10% in both YOIs and STCs.<br><br>• Across all establishment types, there was a significant association between a young person's relationship with staff and the level of reward scheme they were on. The better their relationship, the more likely they were to be on highest level of reward.<br><br>• For YOIs and STCs, there was also a significant association between a young person's rating of their relationship with staff and the impact of the reward scheme on their behaviour. Those who reported a good relationship with staff also reported that the reward scheme had a positive impact on their behaviour. However there was no significant relationship found for children at SCHs.<br><br>• Staff generally saw incentive schemes as fair, although some in STCs and YOIs mentioned that there was a potential for positive and negative bias as the nature of the scheme meant that individual staff were given too much discretion.<br><br>• A third of staff from the five establishments who were interviewed agreed that there probably needed to be more consistency between staff to ensure that the system operates as fairly as possible. They felt that the current system may send ambiguous messages rather than providing clear, consistent guidance on what was required of the young people.<br><br>• Some staff commented on the cautious use of |

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| | | sanctions and that the scheme was heavily weighted towards bonuses.<br>• There was some concern raised by staff about the ineffectiveness of incentive schemes for young people on short sentences. It was difficult to incentivise these young people who were 'there for such a short time they do not care'. The staff were unable to offer solutions on how to best incentivise young people serving short sentences. |
| McDaniel SC, Jolivette K, Ennis, RP. Barriers and facilitators to integrating SWPBIS in Alternative Education Settings with existing behaviour management systems, Journal of Disability Policy Studies 2014: 24:4:247-256. | **Methodology and nature of study:** Research on the school-wide positive behavioural interventions and support (SWPBIS) model and a school's integration of SWPBIS with an existing behaviour management system.<br>**Sample details:** Two focus groups<br>**Setting:** Two alternative education (AE) settings<br>**Location of study:** USA | Alternative Education (AE) is defined as that provided in settings such as residential and juvenile justice facilities, and self-contained schools. Research has demonstrated that discipline practices can be improved in AE settings using a proactive, positive approach to reduce problem behaviours.<br>This paper discusses PBIS framework that can be applied within SWPBIS based on four components: a. systems; b. data; c. practices; and d. outcomes. The same four components are integral to SWPBIS in alternative education settings but are required to be delivered more intensely than in traditional settings. Alternative education settings require more opportunities for team-based problem-solving and professional development.<br>This study explored qualitatively the perceptions and outcomes of staff (n=9) who work in AE settings and who were trained in SWPBIS. They included school psychologists, social workers, program coordinator, and teachers.<br>**Main findings:**<br>Integrating PBIS with existing behaviour management systems such as the general token economy (points based system) is a difficult task. Staff valued both systems. Staff at one site found it too difficult to have both models in use together and opted to continue with their existing behaviour management system. An important lesson is that it is imperative that leadership teams work to find ways in which the two systems can compliment each other. |
| Sprague J, Scheuermann B, Wang E, Nelson CM, Jolievette K, Vincent C. Adopting and adapting PBIS for Secure Juvenile Justice Settings: Lessons Learned. Education and Treatment of Children 2013; 36:3:121-134. | **Methodology and nature of study:** An article based on the authors' collective work in numerous states and types of juvenile settings, providing rationale and guidelines for the adoption and implementation of Positive Behaviour Interventions and Supports (PBIS) practices in secure juvenile justice settings (work is in progress but the paper is accessible online). | Extension and adaptation of PBIS into juvenile justice settings is in its early stages of development and testing, but is being adopted increasingly as a promising approach to better meeting the diverse and complex needs of youth in the juvenile justice system.<br>The authors are developing material to guide facility-wide PBIS teams to define, develop and implement six essential features of PBIS. They are: a. facility-wide adoption and implementation conditions; b. universal behavioural expectations; c. systematic behaviour communication and teaching; d. positive reinforcement systems (while these systems are criticised in other studies, the authors are working towards programmes that include youth signing in with a member of staff every morning to set goals for the day and to review progress at the end of the day, solve issues that are problems and set goals for the next day); e. instructional and function based responses to mild problem behaviour; and f. strategies for defusing |

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| | **Setting:** Juvenile Justice Settings<br><br>**Location of study:** USA | aggressive or escalating behaviour.<br><br>Currently, juvenile justice settings use points based reward systems located in a hierarchical system of privileges and exhibiting specified behaviours. The authors are working on a 'check in, check out' practice, which involves systematic mentorship of youth that is related to self-monitoring and managing achievement of behavioural and academic goals, and problem solving if problem behaviour occurs. This can help to improve the structure and consistency of positive feedback to youth.<br><br>The authors are conducting an evaluation study to assess the feasibility and efficacy of the PBIS staff development programme. They are providing training and technical assistance to more than 40 facilities across the United States. Their study is to be completed in 2014. |

## Primary Research: Evaluations of Specific Interventions Used with Children Resident in the Secure Estate or with Children who are Looked After

4. The reviews identified three commentary pieces by professionals that discuss three studies conducted in the UK.

5. They evaluate specific interventions containing features of positive behaviour management for looked after children.

6. Two of these studies focused on foster parents and one on a YOI.

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| Kennedy A. Exploratory research: staff perception of learner behaviour, the introduction of a 'Time Out' room and the behaviour and educational experience of young people with the Learning and Skills Department of HMPYOI Hindley. The Manchester College, 2010.<br><br>Last accessed 6 May 2014 at: http://www.excellencegateway.org.uk/node/20876 | **Methodology and nature of study:** The study explored the educational experiences at HMPYOI Hindley with a focus on behaviour management. The paper explores staff perceptions of learners' behaviour, behaviour management and the introduction of a 'reflection room', and the behaviour and educational experience of the young people.<br><br>**Sample details:** Both qualitative and quantitative research was undertaken in the form of self report questionnaires for staff (n=29) and young people (n=192) | HMPYOI Hindley is a young persons' establishment in which reside male offenders aged between 15 and 18 years. All young people are required to attend a minimum of 15 hours of activity provided by the Manchester College each week and 10 hours of purposeful activity provided by the prison.<br><br>**Main findings:**<br><br>Staff:<br>• There was a mixed response from staff in relation to introduction of a reflection room with a preference for more long-term investment in using programmes to address the underlying cause of the learners' negative behaviour.<br>• The paper recommends that strong leadership from the management team and a proactive concern from the top should permeate every aspect of the young people's educational experiences.<br>• There should be training for staff to address inconsistencies in challenging negative behaviour.<br>• Some of the staff (12%) felt that the management team were not as supportive as they could be in respect of behaviour management.<br>• There is a requirement for a more consistent approach in tackling challenging behaviour.<br>• The Incentives and Earned Privileges (IEP) policy |

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| | (quantitative), and individual interviews and focus groups with staff (n=14).<br><br>**Setting:**<br>YOI<br><br>**Location of study**:<br>Manchester, UK | was in place at HMPYOI and all staff within the learning and skills department were encouraged to make use of this merit and de-merit system to implement rewards and sanctions to learners to develop positive behaviours. Staff issued young people with red and green cards that require approval from residential managers. Of the 26 staff who responded to the questionnaire, nearly 2/3 reported an inconsistency in practice (65%) e.g. managers not always being supportive of decisions to issue red cards and responses varying from wing officers, followed by a lack of communication and information (15%) ('at the moment it's wishy washy'), and small minority (12%) felt that the current system worked well.<br><br>• Some staff felt that that current IEP system was being abused by members of staff e.g. green cards being given out when they are not necessarily deserved. Also, some staff felt that when red cards are issued, they should be followed with an immediate and more punitive response.<br><br>Young people:<br><br>• The vast majority of young people reported understanding why they received red or green cards, and also what to expect when they have been issued with a red or green card.<br><br>• They also reported that it was much easier to get a red card than receive a green card. This led to comments such as 'the system has not been thought through properly' and "you should get red cards when you are really bad and not for stupid things".<br><br>• A minority also felt that red cards were needed as well as a firmer response for bad behaviour. |
| Bywater T, Hutchings J, Linck P, Whitaker C, Daley D, Yeo ST, Edwards RT. Incredible Years parent training support for foster carers in Wales: a multi-centre feasibility study. Child: care, health and development 2010; 37:2:233-243. | **Methodology and nature of study:**<br>This paper reports a twelve-month trial platform study exploring the feasibility of the Incredible Years (IY) evidence-based parenting programme in supporting carers in managing difficult behaviour in looked after children.<br><br>**Sample details:**<br>Forty-six foster carers in three authorities. Twenty-nine foster carers received the IY intervention and 17, the control group, did not.<br><br>**Setting:**<br>Foster care<br><br>**Location of study:** | The IY parenting programme consists of 12 weekly two-hour sessions involving a facilitator led group discussion, videotape modelling and rehearsal of intervention strategies. The programme is delivered to 12 parents in a group format and two facilitators.<br><br>The programme focuses on strengthening parenting skills with the intention of preventing, reducing, and or treating conduct problems among children aged 2-17 years while increasing their social competence.<br><br>The sessions emphasise the importance of play, ways to help children learn, effective praise, use of incentives, limit setting and non-aversive ways to deal effectively with misbehaviour.<br><br>**Main findings:**<br><br>The findings include:<br><br>This feasibility study suggests that the IY parenting programme is effective in significantly reducing challenging behaviour as rated by foster carers, while also reducing foster carers' depression.<br><br>However, findings should be treated with caution due to small sample size. Also, the children were not seen as part of the study. |

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| | Wales. | Children in the control group did not show a significant improvement while the intervention children did, which suggests that there was a change in parenting style after attending the IY programme.<br><br>The findings suggest the need for children's services to ensure that foster carers are given the tools to address the emotional and behavioural needs and difficulties of their looked after children.<br><br>The IY group parenting programme could be included in foster carers' initial training rather than awaiting the diagnosis of a psychiatric disorder to provide access to evidence-based treatment and risking the chance of the placement breaking down.<br><br>There is hope that the programme will help promote long-term stability at a reasonable cost, while, possibly, reducing costs to health, social and education services in the long-term. |
| Pallet C, Scott S, Blackeby K, Yule W, Weissman R. Fostering changes: a cognitive behavioural approach to help foster carers manage children. Adoption and Fostering 2002; 26:39-48. | **Methodology and nature of study:**<br>This paper reports on an evaluation of a training course for foster carers based on cognitive behavioural theory to deliver practical advice in managing behaviour.<br><br>**Sample details:**<br>Sixty carers, qualitative narrative accounts and quantitative feed back in the form of a participant satisfaction questionnaire.<br><br>**Setting:**<br>Foster care<br><br>**Location of study:**<br>UK | Feedback from foster carers suggested that they are often given good quality emotional support from social workers, but they do not always get the same degree of practical advice on how to manage children whose behaviour is difficult.<br><br>As a result, the National Specialist Fostering and Adoption team at the Maudsley Hospital sought joint funding. This is a multidisciplinary team from the specialist child and adolescent mental health service that comes into contact with many foster carers in the course of its clinical work.<br><br>The team has two training programmes. One is for carers of children under 12 and the other for carers of looking after teenagers. The training groups meet once a week for three hours over 10 weeks, consisting of 6-12 carers. Sixty carers had completed the training to date.<br><br>The course had four essential elements:<br><br>1. Introduction to social learning theory:<br>Carers are provided with a framework for thinking about and understanding how behaviours are learned and maintained. It explores the language used by carers to describe problematic behaviour such as 'lazy, attention seeking, tantrums'. Carers are asked to observe and record clearly described behaviour. It provides an opportunity for carers to stand back and tune into the children's needs and behaviour.<br><br>2. Using positive strategies to encourage pro-social behaviour:<br>First, five sessions of the training concentrate on the positives (how carers can develop an affirming and communicative relationship with the children for whom they care). They explore strategies that focus on the children's appropriate behaviours, and provide the children with positive attention and opportunities for praise and reward.<br><br>3. Limit setting:<br>This element focuses on setting limits when the children are not compliant and strategies for disciplining them that are effective. |

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| | | 4. Additional issues, including problem solving and stress management:<br>This component explores how carers can look after themselves (e.g. by negotiating problem-solving).<br><br>The programme draws on a range of ideas from different parenting programmes that have proved to be effective that are based on cognitive behavioural and social learning theories.<br><br>Social learning theory takes the viewpoint that most behaviours are learned and, therefore, that they can be unlearned and new alternative behaviours mastered.<br><br>Cognitive behavioural theory places more emphasis on individual's beliefs and the social context in which their behaviour is learned. The individual is seen as more actively involved in judging and interpreting everyday events.<br><br>**Main findings**<br><br>• The training brought about positive responses.<br><br>• The paper recommends that other carers should attend the training.<br><br>• The programme brought about improvements in the emotions and behaviours of the children in the adults' care and better quality of relationships and interactions with them. It also had a beneficial effect on the carers' confidence and self-efficacy.<br><br>• A controlled trial is required to determine whether or not these changes took place as a result of the training or other factors.<br><br>• There is a requirement to develop further links with social services and run workshops for them on the skills that their carers are learning. |

# Annex F to: A Review of Restraint Systems Commissioned for Use with Children who are Resident In Secure Children's Homes

# Baseline Survey of Restraint Systems Used in Secure Children's Homes: Questionnaire for Managers of Secure Children's Homes

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The purpose of this questionnaire is for the Independent Restraint Advisory Panel (IRAP) to review the use and delivery of restraint systems within Secure Children's Homes. We are conducting this review to ensure we have a full picture of the restraint systems used in the under 18 secure estate in England.

Secure children's home managers, Local Authorities and Government Departments are being asked to complete a questionnaire, which will help establish the safety and adequacy of restraint systems. The results of this work will be the subject of a report prepared by IRAP for the Restraint Management Board and for the attention of Ministers who will make decisions about publication and dissemination.

Please read each question carefully and answer to the best of your knowledge. All responses will remain anonymous. It should take approximately one hour to complete this questionnaire.

The questionnaire is structured in five sections asking questions around;

- Commissioning arrangements
- The restraint system(s)
- Data collection
- Authorisation and "whistle blowing" procedures
- The Local Safeguarding Children's Board (LSCB)

Please email completed questionnaires by xxxx to Claire Owens.

If you have any questions about this survey then please contact Claire Owens on xxxxxx or xxxxxx.

## Section 1: Contact Details

We would be grateful if you could provide some basic contact details should we have any further questions and to let you know the outcomes from this survey.

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| **1a. Your name** | |
| **1b. Organisation** | |
| **1c. Local authority** | |
| **1d. Telephone number** | |
| **1e. Email address** | |

## Section 2: Commissioning Arrangements

This section will ask you some questions about the commissioning arrangements and the restraint systems in place within your Secure Children's Home (SCH).

| **Question 2a**<br>What are the commissioning arrangements for the restraint system(s) and the training of staff in restraint, in your SCH? |
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| **Question 2b**<br>Please describe your involvement in the commissioning processes for restraint system(s) used in your SCH. |
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| **Question 2c**<br>Who has the final say in the choice of restraint system(s) within your SCH? |
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## Section 3: The Restraint System

This section will ask you some questions about the restraint system(s) in place within your SCH, the risk assessment and management procedures in place and your quality assurance process.

| **Question 3a**<br>Are the restraint system(s) in your SCH only used in your SCH, or are they used across the Local Authority in other children's homes? |
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| ☐ Only within the SCH<br><br>☐ Used across the authority in other children's homes |

| **Question 3b**<br>Which of the following does the service you commission provide? |
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| ☐ Training in techniques for restraint only<br><br>☐ Training in techniques for restraint ,diversion, diffusion and de-escalation<br><br>☐ A whole behaviour management system<br><br>☐ Other (please specify what it provides) |

**Question 3c**
Do you know if the organisation you commission to provide restraint system training in your SCH have been subject to any independent medical risk assessment* of the restraint techniques?

** Medical risk assessment - some form of risk scoring system that seeks to measure the probability of an adverse event in relation to specific holds and positions of restraint on one axis, and the severity of the impact on another. This matrix can be sub-analysed by type of potential adverse event ranging in potential severity from bruising (minor) to interfering with airways (catastrophic).*

- ☐ Yes
- ☐ No
- ☐ Don't know

If you answered 'Yes' to question 3c go to question 3d, otherwise go to 3e.

**Question 3d**
If so, was that medical assessment conducted by you and/or specific staff in your team, the contracted provider or independently?

- ☐ By myself
- ☐ By myself and specific staff within my team
- ☐ By the contracted provider
- ☐ Independently
- ☐ Don't know

**Question 3e**
Do you hold any information about medical risk assessments and risk management procedures for your restraint system(s)?

**Question 3f**
How often are your restraint systems and training techniques reviewed?

**Question 3g**
Who reviews your restraint systems and training techniques?

| |
|---|
| |

| **Question 3h**<br>Are any medical assessments re-applied after a review process? |
|---|
| |

| **Question 3i**<br>Who gives authority to revise any systems of restraint as a result of a review? |
|---|
| |

| **Question 3j**<br>Do the risk assessment systems in your SCH include expert medical advice on the nature and severity of the risk of harm entailed in each authorised technique and restraint position? |
|---|
| ☐ Yes<br>☐ No<br>☐ Don't know |

| **Question 3k**<br>What steps do you take to ensure you quality assure the process of commissioning risk assessments and risk management procedures? |
|---|
| |

| **Question 3l**<br>If you were to bring in a new restraint system or modify your existing one, who would take responsibility for this and who would approve it? |
|---|
| |

## Section 4: Data Collection

This section will ask you some questions about data collection processes within your SCH.

| **Question 4a**<br><br>Please describe what data you collect concerning the welfare of children in your SCH and the use of restraint? (please give as much information as possible) |
|---|
| |

| **Question 4b**<br>How does your SCH define 'incidents of restraint' for the purposes of recording? |
|---|
| |

| **Question 4c**<br>What data on restraint incidents do you i) report on, and ii) to whom; |
|---|
| i) **Data on incidents reported include**:<br><br>ii) **Incidents are reported to:** |

| **Question 4d**<br>Does the data outlined in question 4c include more detailed reports on adverse incidents involving use of restraint ('exception reporting')? If so is this sent to any other parties? |
|---|
| |

| **Question 4e**<br>Is CCTV used in your SCH to support the monitoring and review of restraint incidents? |
|---|
| |

## Section 5: Authorisation and "Whistle Blowing" Procedures

This section will ask you some questions about the process for authorising staff in the use of restraint, the mechanisms in place should staff wish to raise concerns and a question about training.

| **Question 5a**<br>Is there a formal procedure in your SCH whereby staff have to be authorised (following training and assessment) to undertake restraint? |
|---|
| ☐ Yes<br><br>☐ No |
| **Question 5b**<br>How many days training (per year) are completed by the individuals authorised to undertake restraint?<br><br>*If you cannot give a figure for the year, please give other information you have, but state whether it is days per month / per quarter etc.* |
| |

**Question 5c**
Are there mechanisms in place to share with the restraint training provider any concerns you and your staff may have about the techniques in use?

*For example, any technique that shows a pattern of unintended injury, exception reporting or complaints by children.*

- ☐ Yes
- ☐ No
- ☐ Don't Know

**Question 5d**
If 'Yes' can you describe what mechanisms are in place and what happens once concerns are raised?

**Question 5e**
Are all staff members (who are authorised to use restraint) trained in basic life saving techniques?

- ☐ Yes
- ☐ No
- ☐ Don't Know

## Section 6: Local Safeguarding Children's Board (LSCB)

This section will ask you some questions about your SCHs involvement with the LSCB.

**Question 6a**
Please describe the nature and extent of the involvement of your LSCB in your SCH.

| **Question 6b**<br>Is there direct involvement from the LSCB when there are complaints by children arising out of an incident of restraint and/or an adverse incident report by management? |
|---|
| ☐ Yes<br><br>☐ No |

## Section 7: Any other comments?

| **Question 7a**<br>Do you have any comments or anything else you would like to share with us relating to the use of physical restraint and safeguarding children in SCHs? |
|---|
| |

**Thank you for taking the time to complete this questionnaire. Please email your completed questionnaire by xxxxxx to Claire Owens**

**If you have any questions please contact:** CLAIRE OWENS

# Annex G to: A Review of Restraint Systems Commissioned for Use with Children who are Resident In Secure Children's Homes

## Supplementary Questions for Managers of SCHs

| | |
|---|---|
| Does your SCH have a formal protocol or agreement for calling the police? Is this protocol a generic Local Authority one or specific to the SCH? | |
| | |
| Does your protocol include under what circumstances or for what events will the police be involved? | |
| Are the police given information about any individual health issues and if so how is this communicated to them? | |
| | |
| Who has overall responsibility for safeguarding and well -being of children during any police activity? | |
| | |
| How do you categorise single separations? | |
| | |
| Are all single separations, including voluntary recorded in the data you collect? | |
| | |
| Does your restraint training include specific breakaway techniques for 'life and limb' situations? If not please tell us what advice you give to staff about such situations. | |
| | |
| Do any taught breakaway techniques include deliberate induction of pain? If so please specify what they are? | |
| | |
| How many days initial training and subsequent refresher training do any 'in house trainers' receive? | |
| | |

| | |
|---|---|
| How long has your restraint system been in place? | |
| | |
| Does your local authority have any set criteria for how often commissioned services have to be re – tendered for? Does this include your restraint system? | |
| | |
| Do staff become operational in your unit before they have undertaken restraint training? | |
| | |
| What sort of 'breakaway' training is given to ancillary staff (those not trained or authorized to use restraint), what specific techniques are taught? | |
| | |
| How much of your data reporting is duplicated? | |
| | |

# Annex H to: A Review of Restraint Systems Commissioned for Use with Children who are Resident In Secure Children's Homes

# Baseline Survey of Restraint Systems Used in Secure Children's Homes: Questionnaires for Government Departments and Arms Length Bodies

## Questionnaire for Department for Education (DfE)

---

The purpose of this questionnaire is for the Independent Restraint Advisory Panel (IRAP) to review the use and delivery of restraint systems within Secure Children's Homes. We are conducting this review to ensure we have a full picture of the restraint systems used in the under 18 secure estate in England.

Secure children's home managers, Local Authorities and Government Departments are being asked to complete a questionnaire, which will help establish the safety and adequacy of restraint systems. The results of this work will be the subject of a report prepared by IRAP for the Restraint Management Board and for the attention of Ministers who will make decisions about publication and dissemination.

The questionnaire is structured in three sections asking questions around;

- Your organisations role
- Knowledge and data
- Meeting regulations and the NMS

Please read each question carefully and answer to the best of your knowledge. All responses will remain anonymous. It should take approximately one hour to complete this questionnaire.

Please email completed questionnaires by xxxx to Claire Owens.

If you have any questions about this survey then please contact Claire Owens on xxxxxx or xxxxxx.

### Section 1: Contact Details

We would be grateful if you could provide some basic contact details should we have any further questions and to let you know the outcomes from this survey.

| | |
|---|---|
| **1a. Your name** | |
| **1b. Your role and organisation** | |
| **1c. Telephone number** | |
| **1d. Email address** | |

## Section 2: DfE's role

This section will ask you some questions about the role of your organisation in relation to the restraint systems in place within Secure Children's Homes (SCHs).

| **Question 2a**<br>What is DfE's role regarding SCH's **?** |
| --- |
| |

| **Question 2b**<br>How does the DfE's role fit into and is co-ordinated with the wider landscape of secure care accommodation for children and young people (for example YOIs and STCs)? |
| --- |
| |

| **Question 2c**<br>Please describe any national policy functions DfE has in relation to SCHs. |
| --- |
| |

| **Question 2d**<br>How does the DfE contribute to strategic planning for the size and configuration of the SCH sector in relation to its 'fit' with the wider landscape of secure care accommodation (YOI and STC)? |
| --- |
| |

| **Question 2e**<br>Where does DfE understand responsibility for commissioning of restraint systems to rest? |
| --- |
| |

| **Question 2f**<br>Where does DfE understand responsibility for safe implementation of restraint systems to rest? |
| --- |
| |

| **Question 2g**<br>How would DfE characterise its formal accountability (if any) for safeguarding the welfare of children who are subject to restraint in SCHs? |
| --- |
| |

## Section 3: Knowledge and data

This section will ask you some questions about how your organisation receives and collects knowledge and data about SCHs.

| **Question 3a**<br>What information, data and intelligence for SCHs does DfE either maintain itself or receive, following collation by other parties? |
|---|
| **Behaviour management**<br><br>☐ Maintain ☒ Receive from other parties ☐ Neither maintain or receive<br><br>Please expand; |
| **Use of physical restraint**<br><br>☐ Maintain ☒ Receive from other parties ☐ Neither maintain or receive<br><br>Please expand; |
| **Single separation**<br><br>☐ Maintain ☒ Receive from other parties ☐ Neither maintain or receive<br><br>Please expand; |
| **Complaints**<br><br>☐ Maintain ☒ Receive from other parties ☐ Neither maintain or receive<br><br>Please expand; |
| **Reported Child Protection Incidents**<br><br>☐ Maintain ☒ Receive from other parties ☐ Neither maintain or receive<br><br>Please expand; |
| **Medication**<br><br>☐ Maintain ☐ Receive from other parties ☐ Neither maintain or receive<br><br>Please expand; |
| **Other** |

| |
|---|
| ☐ Maintain ☒ Receive from other parties<br><br>Please expand; |

| **Question 3b**<br>What use is made of the data collected or received? |
|---|
| |

| **Question 3c**<br>What knowledge and data does DfE collect and maintain about the restraint systems in use by the SCHs? |
|---|
| |

| **Question 3e**<br>Does DfE's role in data collection extend to monitoring of; |
|---|
| The quality and appropriateness of specific restraint systems for use on children?<br><br>☐ Yes ☒ No |
| The extent and adequacy of staff training in use?<br><br>☐ Yes ☒ No |
| The safety of the restraint systems in use?<br><br>☐ Yes ☒ No |
| The extent of use of restraint systems in individual SCHs??<br><br>☐ Yes ☒ No<br><br>See above about DfE analytical capacity |
| Secular trends in use of restraint systems in individual SCHs?<br><br>☐ Yes ☒ No<br><br>See above |

| |
|---|
| Exception reporting about adverse incidents of restraint?<br><br>☐ Yes ☒ No<br><br>Notifications by Ofsted would identify restraint related incidents in which children were harmed. However, reports of such incidents are extremely rare. |

| **Question 3f**<br>To what extent are definitions standardised (e.g. 'type of hold','restraint' 'exception requirements')…. |
|---|
| … across the SCH sector? |
| … across the different restraint systems in use? |

| **Question 3g**<br>To what extent are the reporting mechanisms on restraint in SCHs standardised …. |
|---|
| … across the SCH sector? |
| … across the different restraint systems in use? |

## SECTION 4: Meeting the National Minimum Standards

This section will ask you some questions about the DfE and its policy role with the NMS.

| **Question 4a**<br>Does DfE need to ensure that restraint systems and the training commissioned for them meet the requirements of relevant regulations and National Minimum Standards for Children's Homes? |
|---|
| ☐ Yes ☒ No |

| **Question 4b**<br>If so, how is this undertaken? |
|---|
| |

## Section 5: Any other comments?

| **Question 5a**<br>Do you have any comments or anything else you would like to share with us relating to the use of physical restraint and safeguarding children in SCHs? |
|---|
| |

**Thank you for taking the time to complete this questionnaire. Please email your completed questionnaire by xxxxxx to: Claire Owens.**

**If you have any questions please contact:** CLAIRE OWENS

# Questionnaire for Ministry of Justice (MoJ)

---

The purpose of this questionnaire is for the Independent Restraint Advisory Panel (IRAP) to review the use and delivery of restraint systems within Secure Children's Homes. We are conducting this review to ensure we have a full picture of the restraint systems used in the under 18 secure estate in England.

Secure children's home managers, Local Authorities and Government Departments are being asked to complete a questionnaire, which will help establish the safety and adequacy of restraint systems. The results of this work will be the subject of a report prepared by IRAP for the Restraint Management Board and for the attention of Ministers who will make decisions about publication and dissemination.

Please read each question carefully and answer to the best of your knowledge.

Please email completed questionnaires by xxxx to Claire Owens

If you have any questions about this survey then please contact Claire Owens on xxxxxx or xxxxxx.

## SECTION 1: Contact details

We would be grateful if you could provide some basic contact details should we have any further questions and to let you know the outcomes from this survey.

| | |
|---|---|
| **1a. Your name** | |
| **1b. Your role and organisation** | |
| **1c. Telephone number** | |
| **1d. Email address** | |

## SECTION 2: Survey Questions

| **Question 2a**<br>Does the Ministry of Justice have input into policy formulation for the parts of the SCH sector that provide placements for the criminal justice system? |
|---|
| Yes ☐<br><br>No ☐ |

If you answered 'Yes' to question 2a go to question 2b, otherwise go to 2c

| **Question 2b**<br>What are the Ministry of Justice current priorities for the parts of the SCH sector providing placements for the criminal justice system? |
|---|
| |

| **Question 2c**<br>Does the Ministry of Justice contribute to strategic planning for the size and configuration of the SCH sector in relation to its 'fit' with the wider landscape of secure care accommodation (YOI and STC) |
|---|
| |

| **Question 2d**<br>Since the move away from a formal joint policy unit with DfE, how would the Ministry of Justice characterise its formal accountability (if any) for safeguarding the welfare of children who are subject to restraint in SCHs? |
|---|
| |

## Section 3: Any other comments?

| **Question 3a**<br>Do you have any comments or anything else you would like to share with us relating to the use of physical restraint and safeguarding children in SCHs? |
|---|
| |

**Thank you for taking the time to complete this questionnaire. Please email your completed questionnaire by xxxxxx to: Claire Owens.**

**If you have any questions please contact:** CLAIRE OWENS

# Questionnaire for Ofsted

The purpose of this questionnaire is for the Independent Restraint Advisory Panel (IRAP) to review the use and delivery of restraint systems within Secure Children's Homes. We are conducting this review to ensure we have a full picture of the restraint systems used in the under 18 secure estate in England.

Secure children's home managers, Local Authorities and Government Departments are being asked to complete a questionnaire, which will help establish the safety and adequacy of restraint systems. The results of this work will be the subject of a report prepared by IRAP for the Restraint Management Board and for the attention of Ministers who will make decisions about publication and dissemination.

Please read each question carefully and answer to the best of your knowledge.

Please email completed questionnaires by xxxx to Claire Owens.

If you have any questions about this survey then please contact Claire Owens on xxxxxx or xxxxxx.

## Section 1: Contact Details

We would be grateful if you could provide some basic contact details should we have any further questions and to let you know the outcomes from this survey.

| | |
|---|---|
| **1a. Your name** | |
| **1b. Your role and Organisation** | |
| **1c. Telephone number** | |
| **1d. Email address** | |

## Section 2: Survey Questions

| **Question 2a**<br>What is Ofsted's role regarding SCHs? |
|---|
| |

| **Question 2b**<br>How does Ofsted's role fit with the wider landscape of secure care accommodation for children (including secure training centres and Young Offender institutions?) |
|---|
| |

| **Question 2c**<br>Does Ofsted, under its licensing role, need to ensure that restraint systems and the training commissioned for them, meet the requirements of relevant regulations and National Minimum Standards for Children's Homes? |
|---|
| Yes ☐ |

| |
|---|
| No ☐ |

If the answer to question 2c was 'Yes' please answer question 2d, otherwise go to 2e.

| **Question 2d**<br>If so, how is this undertaken? |
|---|
| |

| **Question 2e**<br>What data does Ofsted review in preparation for inspection in relation to; |
|---|
| |
| The use of single separation? |
| Any complaints? |
| Any safeguarding concerns? |

| **Question 2f**<br>How is such data analysed? Does it extend to comparative analysis across the sector? |
|---|
| |

| **Question 2g**<br>To what extent are definitions (e.g. 'type of hold', 'restraint', 'exception requirements') standardised across the sector? |
|---|
| |

| **Question 2h**<br>To what extent are definitions (e.g. 'type of hold', 'restraint', 'exception requirements') standardised across the different restraint systems in use? |
|---|
| |

| **Question 2i**<br>To what extent are the reporting mechanisms on restraint in SCHs standardised across the sector? |
|---|
| |

| **Question 2j**<br>To what extent are reporting mechanisms on restraint in SCHs standardised across the different restraint systems in use? |
|---|
| |

| **Question 2k**<br>Does Ofsted have a clear system for identifying the actions to be taken when the inspection of a specific SCH and its restraint system shows a risk to the safety or well-being of children and/or others? |
|---|
| |

| **Question 2i**<br>To what extent do concerns raised via an inspection lead to changes in practice at local authority and/or SCH level? |
|---|
| |

| **Question 2j**<br>Are you aware of the extent to which any concerns raised by inspections are fed back to the relevant restraint training provider? |
|---|
| |

| **Question 2k**<br>Who is responsible for feeding back any concerns raised by inspections to the relevant restraint training provider? |
|---|
| |

## Section 3: Any other comments?

| **Question 3a**<br>Do you have any comments or anything else you would like to share with us relating to the use of physical restraint and safeguarding children in SCHs. |
|---|
| |

**Thank you for taking the time to complete this questionnaire. Please email your completed questionnaire by xxxxxx to: Claire Owens.**

**If you have any questions please contact:** CLAIRE OWENS

# Questionnaire for the Youth Justice Board (YJB)

The purpose of this questionnaire is for the Independent Restraint Advisory Panel (IRAP) to review the use and delivery of restraint systems within Secure Children's Homes. We are conducting this review to ensure we have a full picture of the restraint systems used in the under 18 secure estate in England.

Secure children's home managers, Local Authorities and Government Departments are being asked to complete a questionnaire, which will help establish the safety and adequacy of restraint systems. The results of this work will be the subject of a report prepared by IRAP for the Restraint Management Board and for the attention of Ministers who will make decisions about publication and dissemination.

This questionnaire is structured in three sections asking questions around;

- Your organisations role
- Knowledge and data
- Your organisations perspective on restraint

Please read each question carefully and answer to the best of your knowledge.

Please email completed questionnaires by xxxx to Claire Owens.

If you have any questions about this survey then please contact Claire Owens on xxxxxx or xxxxxx.

## Section 1: Contact details

We would be grateful if you could provide some basic contact details should we have any further questions and to let you know the outcomes from this survey.

| | |
|---|---|
| **1a. Your name** | |
| **1b. Your role and organisation** | |
| **1c. Telephone number** | |
| **1d. Email address** | |

## Section 2: The YJB's role

This section will ask you some questions about the role of your organisation in relation to the restraint systems in place within Secure Children's Homes (SCHs).

| **Question 2a**<br>Please explain what the role of the Youth Justice Board (YJB) is in relation to the use of physical restraint and safeguarding of young people in Secure Children's Homes (SCHs). |
|---|
| |

| **Question 2b**<br>Please describe the YJB's role regarding any SCH national policy functions. |
| --- |
| |

| **Question 2c**<br>How does the YJB contribute to strategic planning for the size and configuration of the SCH sector in relation to its 'fit' with the wider landscape of secure care accommodation (YOI and STC)? |
| --- |
| |

| **Question 2d**<br>How would YJB characterise its formal accountability (if any) regarding behaviour management so far as the welfare and the well-being of the children in concerned? |
| --- |
| |

| **Question 2e**<br>How would YJB characterise its formal accountability (if any) regarding the use of physical restraint so far as the welfare and the well-being of the children in concerned? |
| --- |
| |

| **Question 2f**<br>How would YJB characterise its formal accountability (if any) regarding single separation so far as the welfare and the well-being of the children in concerned? |
| --- |
| |

| **Question 2g**<br>How would YJB characterise its formal accountability (if any) regarding complaints so far as the welfare and the well-being of the children in concerned? |
| --- |
| |

| **Question 2h**<br>How would YJB characterise its formal accountability (if any) for safeguarding the welfare of children who are subject to restraint in SCHs? |
| --- |
| |

| **Question 2i**<br>What do you understanding about the lines of accountability of SCHs beyond the role of the YJB? |
| --- |
| |

## Section 3: Knowledge and data

This section will ask you some questions about how your organisation receives and collects knowledge and data about SCHs.

| **Question 3a**<br>What information, data and intelligence for SCHs does YJB either maintain itself or receive, following collation by other parties? |
|---|
| **Behaviour management**<br><br>☐ Maintain ☒ Receive from other parties ☐ Neither maintain or receive<br><br>Please expand; |
| **Use of physical restraint**<br><br>☐ Maintain ☒ Receive from other parties ☐ Neither maintain or receive<br><br>Please expand; |
| **Single separation**<br><br>☐ Maintain ☒ Receive from other parties ☐ Neither maintain or receive<br><br>Please expand; |
| **Complaints**<br><br>☐ Maintain ☒ Receive from other parties ☐ Neither maintain or receive<br><br>Please expand; |
| **Reported Child Protection Incidents**<br><br>☐ Maintain ☒ Receive from other parties ☐ Neither maintain or receive<br><br>Please expand; |
| **Medication**<br><br>☐ Maintain ☐ Receive from other parties ☒ Neither maintain or receive<br><br>Please expand; |

**Other** (please add)

☐ Maintain ☐ Receive from other parties

Please expand;

**Question 3b**
Are there any exclusions to the data you collect?

**Question 3c**
What use is made of the data collected or received?

**Question 3d**
What knowledge and data does YJB collect and maintain about the restraint systems in use by the SCHs?

**Question 3e**
Does the YJBs role in data collection extend to monitoring of;

The quality and appropriateness of specific restraint systems for use on children?

☐ Yes ☒ No

The extent and adequacy of staff training in use?

☐ Yes ☒ No

The safety of the restraint systems in use?

☐ Yes ☒ No

The extent of use of restraint systems in individual SCHs??

☒ Yes ☐ No

Secular trends in use of restraint systems in individual SCHs?

☒ Yes ☐ No

| |
|---|
| Exception reporting about adverse incidents of restraint?<br><br>☐ Yes ☒ No |

| **Question 3f**<br>When data analysis on a SCH and/ or restraint system used in one or more homes shows a risk to the safety of children and / or others does the YJB have a system for identifying actions to be taken? |
|---|
| ☒ Yes ☐ No |

If you answered yes to question 3f, please answer question 3g and 3h otherwise go to 3i.

| **Question 3g**<br>How far does the system include clear mechanisms to promote change in practice at Local Authority / SCH level, based on the trends and any adverse outcomes identified? |
|---|
| |

| **Question 3h**<br>When data analysis shows a risk to the safety of children and / or others, is there a mechanism for feeding back actions to be taken? |
|---|
| |

| **Question 3i**<br>To what extent are the reporting mechanisms on restraint in SCHs standardised …. |
|---|
| … across the SCH sector? |
| … across the different restraint systems in use? |

## Section 4: The YJBs perspective on restraint

This section will ask you some questions about your organisations perspective on restraint.

| **Question 4a**<br>Is there a central collection and analysis of data through a single route/agency? |
|---|
| ☒ Yes ☐ No |

If you answered "Yes" go to question 4b otherwise go to 4c.

| **Question 4b**<br>How effective do you think the central collection and analysis of data through a single route/agency is? |
|---|
| |

| **Question 4c**<br>Is data and monitoring integrated at SCH level (i.e. include all placements, whether Criminal Justice System or Welfare) |
|---|
| |

| **Question 4d**<br>To what extent are definitions standardised (e.g. 'type of hold' ,'restraint' 'exception requirements')…. |
|---|
| … across the SCH sector? |
| … across the different restraint systems in use? |

## Section 5: Any other comments?

| **Question 5a**<br>Do you have any comments or anything else you would like to share with us relating to the use of physical restraint and safeguarding children in SCHs? |
|---|
| |

**Thank you for taking the time to complete this questionnaire. Please email your completed questionnaire by xxxxxx to: Claire Owens.**

**If you have any questions please contact:** CLAIRE OWENS

# Annex I to: A Review of Restraint Systems Commissioned for Use with Children who are Resident In Secure Children's Homes

# Baseline Survey of Restraint Systems Used in Secure Children's Homes: Questionnaire for Local Authorities

## Questionnaire for Local Authorities

---

The purpose of this questionnaire is to gather information about your LA's governance and management of the Secure Children's Home in your area. This information will contribute towards the Independent Restraint Advisory Panel's (IRAP) review of restraint systems within Secure Children's Homes.

Secure children's home managers, Local Authorities and Government Departments are being asked to complete a questionnaire, which will help establish the safety and adequacy of restraint systems. The results of this work will be the subject of a report prepared by IRAP for the Restraint Management Board and for the attention of Ministers who will make decisions about publication and dissemination.

Please read each question carefully and answer to the best of your knowledge. Please spell out any acronyms, at least in their first instance. All responses will remain anonymous. It should take approximately 30 minutes to complete this questionnaire.

Would be grateful if you could email completed questionnaires back to Claire Owens as soon as possible. The deadline for the return of questionnaires is10am on xxxxxx.

If you have any further questions, or if you anticipate any difficulty in meeting the deadline for submission, please contact Claire Owens on xxxxxx or xxxxxx.

**Please note -** Your SCH manager has received a separate, more detailed questionnaire to complete. This questionnaire is for completion by the DCS, or by an appropriate LA manager (other than the SCH manager).

### Section 1: Contact Details

We would be grateful if you could provide some basic contact details should we have any further questions and to let you know the outcomes from this survey.

| | |
|---|---|
| **1a. Your name** | |
| **1b. Your role** | |
| **1c. Organisation** | |
| **1d. Telephone number** | |
| **1e. Email address** | |

## Section 2: Governance and commissioning

| **Question 2a**<br>What involvement does the Local Authority manager with responsibility for your SCH have in the commissioning of the restraint system(s) used in the SCH? |
|---|
| |

| **Question 2b**<br>Who has the final say in the choice of restraint system(s) within your SCH? |
|---|
| |

| **Question 2c**<br>How is your SCH Managed? (Please tick those which apply and add information as necessary) |
|---|
| ☐ Managed within overall LAC service<br>☐ Managed within residential / family placement service<br>☐ Other (Please specify) |

| **Question 2d**<br>Please describe how the system of accountability for the care and support of children in the SCH run by your Local Authority works? |
|---|
| |

| **Question 2e**<br>What role and input do councillors and committees have in the oversight of the SCH run by your Local Authority? |
|---|
| |

## Section 3: The Restraint System

| **Question 3a**<br>Are the restraint system(s) in your SCH only used in your SCH, or are they used across the Local Authority in other children's homes? |
|---|
| ☐ Only within the SCH<br>☐ Used across the authority in other children's homes<br>☐ Don't know / unsure |

**Question 3b**
Has the restraint system and training in your SCH has been subject to any independent medical risk assessment* of the restraint techniques?

** Medical risk assessment - some form of risk scoring system that seeks to measure the probability of an adverse event in relation to specific holds and positions of restraint on one axis, and the severity of the impact on another.*

- ☐ Yes. If Yes, by who?
- ☐ No
- ☐ Don't know / unsure

**Question 3c**
How, and to whom in the LA, would your SCH report any serious incidents resulting from the use of restraint?

**Question 3d**
If your SCH was to bring in a new restraint system or modify their existing one, who would take responsibility for this and who would approve it?

## Section 4: Data Collection

**Question 4a**
What data on the use of restraint do you require from your SCH and how often is it reported to you?

The data required by our LA on use of restraint is;

Frequency:

- ☐ Weekly
- ☐ Monthly
- ☐ Annually
- ☐ When a restraint occurs
- ☐ Other (please specify)

## Section 5: 'Whistle Blowing' Procedures

| **Question 5a**<br>Are there mechanisms in place for staff to express any concerns about the restraint system/ techniques other than the through the SCH internal management processes? |
|---|
| ☐ Yes,<br><br>If yes, please state what these mechanisms are<br><br>☐ No<br><br>☐ Don't know / unsure |

## Section 6: Local Safeguarding Children's Board (LSCB)

| **Question 6a**<br>Please describe the nature and extent of involvement of the LSCB with the SCH within your Local Authority. |
|---|
| |

| **Question 6b**<br>Is there involvement from the LSCB when there are complaints by children arising out of an incident of restraint and/or an adverse incident report by management? |
|---|
| ☐ Yes- Direct involvement (e.g. from a member of the LSCB- please specify)<br><br>☐ Yes- Indirect involvement (e.g. from LADO- please specify)<br><br>☐ No |

## Section 7: Any other comments?

| **Question 7a**<br>Do you have any comments or anything else you would like to share with us relating to the use of physical restraint and safeguarding children in SCHs. |
|---|
| |

**Thank you for taking the time to complete this questionnaire. Please email your completed questionnaire by xxxxxx to Claire Owens.**

**If you have any questions please contact:** CLAIRE OWENS

# Annex J to: A Review of Restraint Systems Commissioned for Use with Children who are Resident In Secure Children's Homes

# Baseline Survey of Restraint Systems Used in Secure Children's Homes: Questionnaire for Local Safeguarding Children's Boards

## Questionnaire for Chairs of Local Safeguarding Children's Boards

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The purpose of this questionnaire is for the Independent Restraint Advisory Panel (IRAP) to review the use and delivery of restraint systems within Secure Children's Homes. We are conducting this review to ensure we have a full picture of the restraint systems used in the under 18 secure estate in England.

Secure children's home managers, Local Authorities and Government Departments are being asked to complete a questionnaire, which will help establish the safety and adequacy of restraint systems. The results of this work will be the subject of a report prepared by IRAP for the Restraint Management Board and for the attention of Ministers who will make decisions about publication and dissemination.

Please read each question carefully and answer to the best of your knowledge. All responses will remain anonymous. It should take approximately 15 minutes to complete this questionnaire.

Please email completed questionnaires by xxxx to Claire Owens.

If you have any questions about this survey then please contact Claire Owens on xxxxxx or xxxxxx.

### Section 1: Contact Details

We would be grateful if you could provide some basic contact details should we have any further questions and to let you know the outcomes from this survey.

| | |
|---|---|
| **1a. Your name** | |
| **1b. Role and Organisation** | |
| **1c. Telephone number** | |
| **1d. Email address** | |

### Section 2: Survey Questions

| **Question 2a**<br>Please describe the nature of any contact between officers of the LSCB and the Secure Children's Home (SCH) in your area? |
|---|
| |

| **Question 2b**<br>Please outline the frequency of contact between officers of the LSCB and the Secure Children's Home (SCH) in your area? |
|---|
| |

| **Question 2c**<br>Which of the following data about the use of restraint does the LSCB receive and/ or monitor regarding the welfare of children in the SCH? | | |
|---|---|---|
| | Receive | Monitor |
| Statistics on the extent of use of restraint | ☐ | ☐ |
| Complaints about the use of restraint | ☐ | ☐ |
| Adverse incidents involving restraint | ☐ | ☐ |
| Other (please describe) | ☐ | ☐ |

| **Question 2d**<br>What are your LSCBs procedures for responding to areas or issues of concern about the welfare of individual children in SCHs? |
|---|
| |

## Section 3: Any other comments?

| **Question 3a**<br>Do you have any comments or anything else you would like to share with us relating to the use of physical restraint and safeguarding children in SCHs. |
|---|
| |

**Thank you for taking the time to complete this questionnaire. Please email your completed questionnaire to: Claire Owens.**

**If you have any questions please contact:** CLAIRE OWENS

# Annex K to: A Review of Restraint Systems Commissioned for Use with Children who are Resident In Secure Children's Homes

# Baseline Survey of Restraint Systems Used in Secure Children's Homes: Questionnaire for Providers of Training on Restraint

## Question 1: Background of training provider:

Please tell us the history of your company / organisation:

1.1 Who founded your company / organisation and training model and when?

1.2 Where does your training model have its roots (adult, children, law, health)?

1.3 When was your *current* model of training established / trademarked?

1.4 How has your training evolved to maintain currency and to be fit for purpose?

1.5 Is 'behaviour management' a part of your training model or is it a separate entity?

## Question 2: Your trainers:

2.1 How many trainers do you directly employ to deliver your training model?

2.2 How many contract trainers do you commission to deliver your training model?

2.3 What are the minimum entry criteria / professional profile characteristics of a trainer?

2.4 How many days in duration is the initial training of your trainers?

2.5 Is update training of your trainers mandatory?

2.6 How many days in duration is trainer update training?

2.7 Is update training undertaken annually?

2.8 Do you have different levels of trainer (e.g. level 1,2,3)?

2.9 Have you ever suspended / withdrawn a trainer from delivering your training, and if so why?

2.10 Have you ever withdrawn your training from an individual or establishment, and if so why?

## Question 3: Accreditation / Approval / Endorsement of training:

3.1 Please tell us who (if anybody) approves / accredits / endorses your training model?

3.2 If applicable please explain briefly to us what this approval / accreditation / endorsement process involves (e.g. paper submissions, interviews, demonstrations, time frames…)

3.3 Who has the authority to change what you teach?

3.4 Who has the authority to change how you teach what you teach?

3.5 Who validates your trainers training other than you?

## Question 4: Commissioning of providers to deliver training:

4.1 Please tell us who purchases your training?

4.2 How are purchasers guided as to the choice of skills they require from the "menu" of skills you offer?

4.3 Has a purchaser ever decided to cease purchasing your training and moved to another supplier and if so were you told why they moved?

4.4 Do you provide only physical skills to providers or do you also provide training packages in relation to behaviour management?

## Question 5: Training Provision:

5.1 Please tell us how many staff you have trained over the years (if known) and how many do you train on an annual basis?

5.2 How many days is the initial training for staff?

5.3 How many days is the update training relative to length of initial course?

5.4 Is update training undertaken on an annual basis?

5.5 How do you objectively assess course attendees in relation to attitude, physical skill and competence?

## Question 6: Physical Intervention Skills / Techniques:

6.1 How many separate skills / processes does your training model have?

6.2 In which of the following positions do you teach restraint techniques: standing / seated / prone / supine?

6.3 Do you teach restraint techniques for any other position(s)?

6.4 How does your training model optimise initial learning and minimise subsequent skill drift / degradation over time?

6.5 How are your skills / techniques designed to minimise misuse?

6.6 Please give examples of how your skills / techniques are linked to stated theoretical models used within your training syllabus?

6.7 Within your training model do you have restraint skills / techniques that deliberately induce pain? If yes what is the stated purpose of this pain induction?

6.8 Within your training model do you have break-a-way / disengagement skills / techniques that deliberately induce pain? If yes what is the stated purpose of this pain induction?

6.9 Is it possible that any of your skill / technique could induce pain indirectly / accidentally… if yes how does your training minimise this possibility?

6.10 Do you employ "strikes" within your restraint and / or break-a-way skills?

6.11 Do you teach restraint and / or break-a-way skills / techniques to forcibly move people against their will?

6.12 Does your training model give any advice to staff about protecting the "head" of a young person during the application of restraint and / or during the application of break-a-way techniques?

6.13 Does your training model include holding / protecting / managing the head of a young person during the restraint process? If so please explain in what situations the head would be held, in what physical positions the head would be held and explain / demonstrate to us how your skills / techniques actively avoid interference with the airway, hearing and vision of the young person?

6.14 Does your training address armed situations / use of weapons?

6.15 Does your system use personal protective equipment?

6.16 Do you provide specific training and / or advice in relation to the restraint of children being transported in vehicles?

6.17 Please explain to us how the restraint and break-a-way techniques employed within your training model meet the requirements of all relevant legislation. As well as addressing general legal principles covering the use of reasonable force etc. please demonstrate in your answer how you comply with the regulations and guidance of the 1989 Children Act.

## Question 7: Risk Assessment:

7.1 Please tell us about your medical expert (risk assessor[s]) including a brief summary of their background, why you chose them and how they are currently engaged in relation to monitoring / updating your skills / techniques.

7.2 Are all skills either revisions or new skills assessed by your medical expert before introduction to practice?

7.3 Has your expert ever told you to amend / withdraw a skill either before or after its implementation?

7.4 Has your expert ever refused to approve a skill presented to them?

7.5 Does your expert grade your skills based on contextual variables such as age, gender, height, mental health, learning disability, offending behaviour?

7.6 Explain how your risk assessment process works e.g. 5x5 matrix?

7.7 What specific risks are assessed for within your risk assessment?

7.8 How are the risks as quantified by the risk assessment process presented / articulated to trainers, purchasers and course participants?

7.9 Does the level of restriction and / or the number of staff involved directly correlate with the risk rating of a skill?

7.10 Please show us your highest risk rated skill / technique?

7.11 Give us a few examples (if possible) of how your skills have been adapted in light of current evidence and / or best practice?

7.12 Explain how your restraint / disengagement skills / techniques are tailored to the young person being cared for.

7.13 Who has the authority to adapt / modify your skills / techniques?

7.14 Do your restraint skills / techniques and de-escalation skills have a hierarchy in regards to numbers of staff involved, degree of restriction and degree of force applied?

7.15 Do you apply any caveats to restraint techniques in relation to their duration, repetition, and numbers of staff involved as part of the risk reduction strategy?

7.16 Please explain how risk is utilised in order to direct when restraint should be initiated and when restraint should be ceased.

7.17 What injuries have there been in the history of your model? Please give details of who was injured and define those injuries?

7.18 Is it possible to identify in what contexts (environmental, physical, psychological) risk of harm increases during the use of your restraint skills / techniques, and if so how act to reduce the extent of those risks?

7.19 Do you provide Basic Life Support and / or Manual handling?

7.20 Do you require all those involved in the use of restraint / break-a-away training to be trained in Basic Life Support and or Manual Handling?

7.21 Specifically what information do you provide to trainers in relation to the warning signs of an active and / or imminent medical emergency, and how do your trainers share this information with course attendees and providers?

## Question 8: Audit and Monitoring

8.1 Would all injuries no matter how small be reported to you or only major injuries (define explain process of audit / monitoring)?

8.2 Do you actively monitor your restraint system to see if there are reports of pain and / or injury from the application of your skills / techniques application, whether that pain and or injury is intentionally for accidental?

8.3 What explicit mechanism(s) do you have in place to facilitate communication between yourselves as the provider, your trainers, the staff you train and purchasers of your training?

8.4 What explicit mechanism(s) do you have in place to facilitate communication with the young persons who are restrained?

8.5 How is success in physical restraint and / or the use of disengagement techniques quantified?

IRAP would like to offer its gratitude for you coming here to answer our questions. We would like now to offer you the opportunity to ask any questions of us and / or raise any areas of concern you may have.

# Annex L to: A Review of Restraint Systems Commissioned for Use with Children who are Resident In Secure Children's Homes

# Baseline Survey of Restraint Systems Used in Secure Children's Homes: Questionnaire for Healthcare Leads in SCHs

**For the person completing this form:**

Name of Establishment (e.g. SCH) .....

Position / Job Title .....

**Contact Details:**

(Email) .....
Tel .....
Postal address .....
.....

Are you the head of the health service in this establishment? Yes/No

If not, who is (please provide details below)?

**Contact Details:**

(Email) .....
Tel .....
Postal address .....
.....

**Please describe your own professional background:**

- General Practitioner
- Nurse (LAC/CAMHS/Other)
- Psychiatrist
- Psychologist
- Other

**Please could you describe the health professionals who provide the service in your establishment in 'whole time equivalents' and the frequency of their visits:**

- General Practitioner
- Nurse (LAC/CAMHS/Other)
- Psychiatrist
- Psychologist
- Other

**Question 1:** At what point on admission do you usually undertake your assessment e.g. within the first hour, first day, first week or later?

**Question 2:** Do you complete a structured form? If so could you please provide a blank copy?

**Question 3:** Who has access to any medical information on any individual child or young person?

**Question 4:** Who is this information shared with?

**Question 5:** How is this information shared?
a. Verbally informal
b. Verbally/formally e.g. case meeting
c. In writing
d. Access to notes

**Question 6:** Does the child or young person have access to their health records? Yes/No

**Question 7:** Are they consulted about sharing information and, if so, with whom?

**Question 8:** Is the child or young person's consent necessary before sharing information?

**Question 9:** What medical conditions do you consider important to share with the manager?

**Question 10:** What medical conditions do you consider important to share with the person in charge of writing any behaviour management/physical restraint programme for the child or young person?

**Question 11:** What medical conditions do you consider important to share with any other persons?

**Question 12:** Do you regard yourself as having a responsibility for the medical risks associated with restraint for any individual? If not who has that responsibility?

**Question 13:** Does the Manager and/or person(s) in charge of writing the behaviour/restraint programme for an individual discuss the medical suitability/risk of any particular restraint hold for that individual with you or any other health professional? Is this:

a. Always
b. Sometimes
c. Never

**Question 14:** Do you have a role post-restraint? Is this an assessment of possible injuries or what happened or learning lessons, etc?

**Question 15:** If the answer to question 13 above is no is there another member of the health care team involved? Yes/No

Thank you for taking the time to complete this questionnaire. Please return it via email to Jim Brown.

# Annex M to: A Review of Restraint Systems Commissioned for Use with Children who are Resident In Secure Children's Homes

## Baseline Survey of Restraint Systems Used in Secure Children's Homes: Questionnaire for SCH Managers Concerning Responsibilities for Healthcare

**For the person completing this form:**

Name of Secure Children's Home .....

Position / Job Title .....

**Contact Details:**

(Email) .....

Tel .....

Postal address .....

.....

**Question 1:** In your Secure Children's Home who decides on which restraint holds are suitable for any particular child/young person should they be necessary, as part of their behaviour management strategy?

**Question 2:** What information do you have about any medical condition that a child/young person might have?

**Question 3:** How do you obtain that information?

**Question 4:** When do you receive that information?
a. On admission
b. Next day
c. After several days

**Question 5:** Who do you share the information with?

**Question 6:** Do you seek permission from the child/young person?

**Question 7:** Do you discuss any risks from any restraint holds with the medical team/health care provider and, if so, with whom?

**Question 8:** Are you responsible for any risk associated with the use of restraint for an individual – either the child/young person or member of staff? If not who is?

Thank you for taking the time to complete this questionnaire. Please return it via email to Jim Brown.

# Annex N to: A Review of Restraint Systems Commissioned for Use with Children who are Resident In Secure Children's Homes

# Baseline Survey of Restraint Systems Used in Secure Children's Homes: Questionnaire for the Medical Experts of Providers of Training

## Question Headings

**Section 1 - Background of Medical Expert(s)**

**Section 2 - The Risk Assessment Process**

**Section 3 - Audit and Monitoring**

**Section 4: Responsibility**

## Definitions

Provider: An organisation which commissions / employs you to undertake the medical risk assessment of their physical restraint skills

Medical Expert: A person(s) commissioned / employed to undertake the medical risk assessment of the providers physical restraint skills

## Section 1: Background of Medical Expert(s):

1.1 For which providers do you currently offer medical expertise to in relation to physical restraint risk?

1.2 Have you provided medical expertise to in relation to physical restraint risk to any other providers / organisation / bodies?

1.3 What is your current occupation?

1.4 Please outline your educational / professional background to date.

1.5 How many years have you being acting as a medical expert in relation to physical restraint for the provider in question?

## Section 2: The Risk Assessment Process

2.1 Please outline in detail for us the robust process you go through in order to arrive at a "risk rating" for each physical restraint skill / process?
- paper submissions
- interviews
- demonstrations

2.2 Do you assess risk for the person being restrained or do you also assess risk for those applying the restraint?

2.3 What medical risks do you assess for? e.g. musculoskeletal, cardiovascular…

2.4 How is the risk rating quantified and subsequently articulated to the provider? e.g. scores, words

2.5 How often do you review the physical restraint skills for each provider you risk assess for (annually, bi-annually…) ?

2.6 For each training model that you act as a medical exert for how many times have you reviewed their physical skills?

2.7 Do you demand that all skills either revisions of existing skills or new skills be assessed by you as the medical expert before their introduction into practice by the provider?

2.8 Have you ever told your provider to amend / withdraw a skill either before or after its implementation?

2.9 Have you ever refused to offer a physical restraint a risk rating? If so why?

2.10 Do you grade skills based on variables such as age, gender, height, mental health, learning disability, and offending behaviour?

2.11 Are you able to offer us examples of how your risk assessment of skills has taken account of current evidence and / or best practice?

2.12 Do you apply any caveats to the level of risk you ascribe a skill in relation to its duration / repetition of application?

2.13 Do you apply any caveats to the level of risk you ascribe a skill in relation to the numbers of staff involved in the application of the skill(s)?

2.14 Do you apply any caveats to the level of risk of an individual skill when applied in conjunction with one or more other skills / techniques? e.g. a wrist hold may carry a rating of x risk but would that rating change with applied while another staff member was say holding the persons head or legs?

2.15 Is it possible to identify in what settings and / or in the presence certain risk factors how risk may increase or decrease from the rating it was initially given?

2.16 What specifically what information do you offer providers in relation to the warning signs of an active and / or imminent medical emergency?

2.17 Are your risk assessments purely based on physiological consequences of the restraint skills or do you also consider psychological consequences of the physical restraint skills?

## Section 3: Audit and Monitoring

3.1 Please tell us what mechanisms e.g. verbal / written you have in place for feedback from providers in relation to injuries, complaints of pain be they intentionally inflicted or accidently, or any other pertinent matters that may arise as a direct consequence of the application of the risk assessed physical restraint skills?

3.2 If a mechanism exists for feedback (see 3.1 above) please tell us the frequency of this feedback?

3.3 If a mechanism exists for feedback (see 3.1 above) please tell us how you formally respond and / or act in relation to the feedback received?

3.4 Could you give us an example of how the feedback process has worked in the past and how the feedback loop has been completed?

3.5 Do you have any explicit mechanism(s) to gain feedback from young persons who are restrained?

3.6 Has a purchaser ever decided to cease purchasing your expertise and moved to another expert, and if so were you told why they moved?

## Section 4: Responsibility

4.1 Do you approve the use of physical restraint skills for use with young persons, or do you see your role merely as offering a professional opinion of risk?

4.2 If you do not approve the use of physical restraint skills you risk assess who does… i.e. where does the responsibility lie for the selection of physical restraint skills to be applied to young persons during a physical restraint event?

IRAP would like to offer its gratitude for you coming here to answer our questions. We would like now to offer you the opportunity to ask any questions of us and / or raise any areas of concern you may have.

# Annex O to: A Review of Restraint Systems Commissioned for Use with Children who are Resident In Secure Children's Homes

## Specific Questions for Commissioners of Training on Restraint

**Set by the Gail Hopper, a member of the IRAP Working Group representing the Association of Directors of Children's Services**

1. Do we know if all our staff are trained in techniques?
2. Do we have system that tells us if trained techniques are being implemented?
3. Do we have a process if actions do not match taught techniques?
4. Do we have a risk assessment framework that references the techniques used?
5. Are individual children risk assessed against techniques?

How would we know these things?

# Annex P to: A Review of Restraint Systems Commissioned for Use with Children who are Resident In Secure Children's Homes

# Semi-structured Interviews with Children and Young People

## Activity

Semi-structured interviews with children and young people in Secure Children's Homes

## Aim

To gather the views and experiences of children and young people about the use of restraint in Secure Children's Homes.

## Outline Brief

1. IRAP seeks to conduct individual, semi-structured interviews with 40 to 50 children currently resident in a SCH.
2. The children interviewed should be aged from 13 to 16 and represent both genders and if possible, a range of ethnicity/cultural backgrounds.
3. We would like to interview children resident in both welfare only and mixed welfare and youth justice units.
4. If possible, there should be children at three stages in their stay – newly admitted, mid stage and pre -release.
5. If possible, there should be children who are in secure for the first time, and those who have previous experience in other parts of the secure estate.
6. We would like to interview both children who have been subject to restraint during their stay, and those who have not.
7. Interviews will take between 30 and 45 minutes and be conducted by an IRAP member.
8. IRAP members will always endeavor to use simple and appropriate language, and will use other tools (visual depiction etc.) where necessary. They will seek advice from SCH managers as to any specific issues for individual children.
9. Interviews will be written up, any material used in the final IRAP report will be anonymised and individual SCHs will not be named; all materials will be kept securely and destroyed on finalisation of the work.
10. IRAP members will comply with specific safeguarding procedures in place in SCHs and with Ofsted reporting requirements. Any learning points will be discussed with the SCH manager, and where appropriate fed back to staff.

## Areas to be covered in the interviews

Introduction and why these interviews are being conducted, assurance of confidentiality within safeguarding procedures.

1. What is the child's definition of restraint: how do they describe a restraint incident?
2. What information have they been given about the use of restraint in this SCH, when and how was this given to them?
3. The child's experience of restraint: in current SCH and in any previous secure placements. Do they perceive any differences?
4. Why the child thinks they were/were not subject to restraint in the current placement (and previous where applicable).
5. Why the child thinks others might be subject to restraint.
6. How the child feels before, during and after being restrained. Can they describe the process? Who do they talk to about how they feel?
7. What does the child think would happen if restraint isn't used? This can be either their personal experience or when they have witnessed restraint, or just their general views.
8. Has the child ever been hurt/seen others being hurt during a restraint incident? If so, what happened and how was it dealt with?
9. Has the child ever felt unwell during a restraint, did they tell the staff, what happened as a result?
10. Has the child ever felt upset or anxious about a restraint incident (on them or another child), what did they do about this, who did they talk to, what happened as a result?
11. How would they like to be treated when they get angry or upset about something? What do they think is the best way for staff to deal with them when this happens?
12. Who do they think is 'in charge' of a restraint incident?
13. What do they know about how staff are trained in behaviour management and restraint?
14. Has the child ever complained about a restraint related incident, if so what happened? How was it dealt with?
15. Has the child ever been subject to restraint using handcuffs (in any previous placement) how do they feel about this?
16. How is the child debriefed after a restraint incident, did they think this was helpful, what would have made it better?
17. Is the child's experience of/feeling about restraint different dependent on the sex of the staff members involved?
18. Does the child have any health (physical or psychological) issues which they feel might impact on the use of restraint on them?
19. How does the child feel about 'guiding hand' touching? Can they distinguish between a touch that is meant to be supportive/comforting and something that is meant to enforce a request (for example to move away from an incident)?

# Annex Q to: A Review of Restraint Systems Commissioned for Use with Children who are Resident In Secure Children's Homes

## Summary of IRAP's Recommendations

### Recommendation 1

As a matter of urgency, the local authorities and the NGO that run SCHs should develop a single set of principles and requirements, with an ethical and values-based governance framework to underpin commissioning of training of their staff in restraint and disengagement for use in SCHs. The requirements should include the preferred qualifications particularly in relation to adult learning models and methods. This framework should take account of, and build on, where necessary, policy and guidance already in place[51].

### Recommendation 2

Every local authority or the NGO should ensure that the person who is the nominated Responsible Individual for their SCH understands their responsibilities and accountability in relation to commissioning training in restraint and disengagement for their staff. This responsibility must include that for robust monitoring and quality assurance to ensure that the system commissioned is as safe as possible for use with children, and that it is reviewed regularly and amended when necessary. While this function may be undertaken by, or in conjunction with other managers the accountability for it cannot be delegated.

### Recommendation 3

The Department for Education should establish an expert group to oversee and assist with developing and implementing the governance framework that IRAP recommends. The group should include representation from DfE, DH, MoJ, Home Office, the Welsh Government, NHS England, Ofsted, the YJB, the Association of Directors of Children's Services and the Secure Accommodation Network. The may wish to consider incorporating into this expert group expert medical advice from the medical Royal Colleges.

### Recommendation 4

The Department for Education should develop, in consultation with local authorities, standard definitions and an agreed common language to describe restraint and its practice, and incidents that involve restraint. This task should take into consideration the work in this area that the YJB has undertaken already.

[51] http://iapdeathsincustody.independent.gov.uk/news/iap%E2%80%99s-common-principles-on-the-safer-use-of-restraint-published-today/ ; http://www.justice.gov.uk/youth-justice/custody/behaviour-management;

## Recommendation 5

Consideration should be given to establishing a single inspection body for all settings where children are deprived of their liberty. As a minimum, there should be a consistent and universal approach and framework for all agencies and their staff that have inspection functions for these settings.

## Recommendation 6

NHS England and NHS Wales should ensure that all healthcare professionals who provide services for children in SCHs are aware of the intercollegiate healthcare standards in place for children in secure settings and, in particular, that they have a clear understanding of their roles and responsibilities in identifying any medical risks (physical and / or psychosocial) associated with using restraint, both generally and for particular children.

## Recommendation 7

There should be a requirement for the Department for Education to work with local authorities (including LSCBs), YJB, and Ofsted to establish: what are the essential data that are required from SCHs; the purposes for which they are collected; how the data is analysed; and what information should be fed back to commissioners and providers to improve practice. These data requirements should be subject to periodic review.

## Recommendation 8

A cross-governmental body should be established that is charged with monitoring and reviewing restraint of children of all ages who are in receipt of regulated children's services.

# Annex R to: A Review of Restraint Systems Commissioned for Use with Children who are Resident In Secure Children's Homes

# 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.