Ministry of Justice

Independent review of pain-inducing techniques – Government response

Protecting and advancing the principles of justice

Designed by design102

Contents

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

We fully accept this recommendation. Where three members of staff are required to restrain a child in custody, the Managing and Minimising Physical Restraint (MMPR) syllabus sets out that the incident should be managed by two roles through to its conclusion: the Incident Manager has overall responsibility for the management of resources and logistics, but should take no active part in the restraint; and the Use of Force Supervisor is responsible for monitoring the physical restraint techniques that are being used.

The Use of Force Supervisor is a key position and the Incident Manager should ensure that someone is in the role for each restraint. As well as monitoring the restraint techniques that are being used, the person in this role is responsible for monitoring the child's behaviour, and health and welfare during the incident, as well as the condition of the other staff members who are involved. Crucially the guidance sets out that the Use of Force Supervisor should instruct that the child is released, or for the restraint techniques that are being used to be changed, if the child displays any signs of medical distress or they are advised to do so by the healthcare practitioner present at the incident.

The MMPR guidance is not specific about which grade of staff should fulfil these roles but suggests that they should be undertaken "appropriately graded" members of staff. It would generally be expected that this would be a Supervising Officer (for example, a Band 4 Officer in a public sector Young Offender Institution (YOI) or a Senior Custodial Officer in a privately managed Secure Training Centre (STC)).

In some circumstances, members of staff from the designated grades may not be available for the initial response. Unplanned use of force incidents can arise suddenly, and be dynamic and unpredictable, or there may be several children involved, and staff may be required to undertake multiple restraints at the same time.

In such instances, staff who were not "appropriately graded" would not be expected to stand and watch the incident escalate, and the guidance therefore sets out that the member of staff responsible for protecting and supporting the child's head leads the response and takes the role of Use of Force Supervisor.

The roles and responsibilities for each member of staff involved in an incident where use of force is used is part of their initial MMPR training course and should be refreshed regularly as part of their mandatory six-monthly refresher training. The National MMPR team will review the current MMPR manual to ensure that the scope of each role in any incident where use of force is used is clearly outlined, taught and used operationally so that staff taking on a leading or supervisory role are able to take decisions and issue instructions that are in the best interests of the child.

Additional incident management training is in the final stages of development by the National MMPR Team. Given the likelihood that they may need to take on the role of Incident Manager at any time, we will endeavour to make the course mandatory for all Band 5 Custodial Managers in the YCS estate, as well as Band 4s and SMT members. Before it can be rolled out, this training package will be reviewed by HMPPS Learning and Development to ensure that it meets the right standards and is consistent with other training provision.

Incidents are monitored locally in conjunction with the local authority, and establishments should act to address any findings or recommendations about their response to, and management of, incidents. Our response to other recommendations in this report, such as the establishment of the new Independent Restraint and Behaviour Panel at Recommendation 11, will enhance existing mechanisms for oversight so that practical learning and feedback about effective incident management is provided to each establishment, and help safeguard the interests of the children in their care.

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

It is YCS policy that all staff and management at YOIs and STCs, as well as those from external escort providers and other organisations who operate in the youth secure estate, must demonstrate that they have completed the rigorous and comprehensive MMPR training package before they can work with directly with children. We accept the principle of this recommendation and agree that it should be mandatory for all operational managers in the YCS and STCs to complete the full MMPR training package.

MMPR training consists of an initial course lasting eight days and at least one day of refresher training every six months. Learners are closely assessed and expected to demonstrate that they can put the techniques that they have learned into practice through written and practical scenario-based exercises.

Although the course provides learners with the necessary skills to undertake physical restraint and understand the legal and ethical framework in which those techniques may be reasonably and proportionately used, the focus is on providing the skills to monitor and respond to children's behaviour with de-escalation and diversion techniques. At all times the course trainers will emphasise that restraint should only be used as a last resort after other strategies have been exhausted.

The majority of senior managers complete the MMPR training package and attend refresher sessions, however there is a limited number who are not required to complete training in MMPR due to the terms and conditions under which they are employed.

We will continue to work with the relevant staff associations to secure agreement that any member of staff who may be called upon to be involved in a restraint incident or undertake a post-incident investigatory role can demonstrate that they have up-to-date competence in MMPR techniques.

3: That Governors and Directors, and the YCS, should consider how they can make sure that staff have a formal opportunity to debrief after a difficult day or a serious incident.

That debriefing becomes a normal and accepted part of the job of all front-line staff.

We recognise the importance of reflective practice as a key part of ongoing learning and development. It helps ensure that children are kept safe and is part of the duty of care that we owe to staff working in the youth justice system.

We accept the principle of this recommendation, and profiled briefing time at the start of shifts or in weekly Custody Support Plan (CuSP) sessions could be used to review use of force incidents, however in the operational environment there may be competing priorities which will challenge the aspiration of providing all members of staff with an opportunity for a formal debrief whenever (and wherever) they ask for it.

The importance of Incident Managers leading full and frank "hot" and "cold" debriefs after incidents where restraint has been used is already recognised in the MMPR manual as being important in ensuring that issues and concerns are raised and the risk of such incidents occurring again is reduced. This might also include establishing a care plan for members of staff who were involved.

Establishing dialogue between staff and children about what happened is an effective strategy for improving practice and encouraging more positive behaviour, and the MMPR documentation already includes a debrief form to support that process. This is particularly important in incidents where a pain-inducing or "higher level" restraint technique was used.

We know that providing opportunities for reflective practice is the right approach for supporting staff, however there may be instances where they may find it difficult to raise a concern, particularly if it relates to the actions of a colleague. Current policy is clear that it is an expectation of any role involving children for staff to identify and report any concerns, and we are creating opportunities for that to be done safely, as well as emphasising it during future MMPR refresher training.

Guided reflective practice (GRP) is already being rolled out across the YCS as part of the Framework for Integrated Care (SECURE STAIRS) and wider behaviour management strategies. The MMPR approach is consistent with this, which will ensure that we can implement a whole system approach at sites. Under this programme all Custodial Managers will receive GRP sessions from the local mental health team, as well as being trained in the approach so that they themselves can provide members of their teams with regular GRP. Encouraging staff to share their reflections with their local MMPR Coordinator or the instructor at their next MMPR refresher training session may be another strategy to help ensure that that they receive specific support, guidance or additional training in this area.

Line managers who have concerns about the impact of adverse experiences on individual members of staff should also consider directing them to the free and confidential occupational health and employee assistance programmes offered by HMPPS. Through this service they can access a range of clinical interventions, including counselling.

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

We fully agree with this recommendation. Behavioural recognition and management is an integral part of the MMPR syllabus and a cornerstone of the training provided to all YCS staff by the National MMPR Team.

The YCS is determined to bring about a cultural change across the public sector custodial estate. In January 2019 the new Building Bridges framework document was introduced. It was developed jointly by the YCS and NHS England and NHS Improvement (NHSE&I) and sets out a range of approaches to support positive behaviour from children.

Building Bridges stresses the need to develop regimes which are focused on "achieving the benefits of reward and positive reinforcement and on taking a strategic approach to reinforcing positive behaviour which informs process and practice and enables the Secure Setting to continually improve".

Establishments across all three sectors of the custodial youth estate (YOIs, STCs and SCHs) have been involved in workshops on how to implement this framework. It is part of the wider Behaviour Management Strategy (BMS) for public sector sites and delivers support at three levels:

- Mainstream services, which are provided to all children and young people
- Enhanced support services, which are responsive to children and young people with exceptionally complex needs
- Environment, which is the system in which the BMS operates and relies upon for integrity, including the Workforce Development Programme

The BMS also includes the Framework for Integrated Care (SECURE STAIRS), which we are fully committed to implementing across all YCS sites. It is an evidence-based, trauma-informed and whole systems approach, using team-case formulation to underpin the care and management of children and young people in custody. It is being supported with the introduction of specific support teams and a case management element to ensure effective throughcare at the point at which the child transitions between community and custodial settings.

In recognition of the impact of trauma on staff, both the BMS and SECURE STAIRS are underpinned by GRP sessions that are overseen and coordinated by psychologists, and provide staff with time to reflect and consider all aspects of their practice. Continuous learning and development is supported by ongoing training in adolescent development, attachment trauma theories and how to work with complex behaviours.

The BMS has various assurance processes in place, such as PRISM (Promoting Risk Intervention by Situational Management: Johnstone & Cook, 2018), Enabling Environments Awards (Royal College of Psychiatrists), Youth Custody Assurance Board and a Research Governance Board, which will combine to ensure that ongoing learning and improvement are incorporated into local strategies.

As well as this, recruitment of new staff to the YCS has been a success: as of June 2019, there were 314 more frontline officers than there were when the Taylor Review was published in December 2016, which is an increase of 36%. A new youth justice specialist role has been introduced and funding has been provided to enable every custody officer in the YCS to undertake a youth justice qualification and transition to the new role over the next four years. So far, over 400 of our frontline staff have been enrolled on this training.

As these initiatives become embedded in practice it will be important to maintain consistency and ensure the best outcomes for the children in our care. We are considering the best way to achieve this objective.

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

We fully agree with this recommendation. The MMPR syllabus emphasises the importance of building good relationships and rapport between staff and the children in their care, however it is difficult to fully assess how many incidents have been de-escalated through good communication and trust because incidents with a positive outcome are not routinely reviewed. We will identify the most effective way to gather examples of good practice and communicate that to staff to support development of a culture of learning and support.

The YCS is introducing CuSP and a conflict resolution model. CuSP will provide each child with a named individual CuSP officer who will be trained in motivational interviewing and will have protected time each week to meet the child. This time will be used to build trust, identify their needs and help set realistic targets and goals. In doing so, CuSP will provide a consistent, prosocial, future-orientated and motivational relationship with an allocated officer. Each child's CuSP officer will aim to support a positive shift in self-identity for the young person, while also aiming to interrupt the influence of antisocial peer behaviour.

The conflict resolution model applies the principles of restorative justice to resolve conflict between children and between children and staff, thereby reducing the need for security restrictions and enabling children to access other rehabilitative services available in custody. Both CuSP and conflict resolution are being implemented across public YOI sites and within certain private YOIs and STCs.

One of the nine key features of the new Building Bridges framework, which was introduced from January 2019 after being developed by the YCS and NHSE&I, is "the development of trusting, respect-based and collaborative relationships between children, young people and staff, which form a central basis for learning about empathy and building positive relationships".

The framework puts in place a range of requirements for staff, including:

- developing and modelling positive and respectful relationships
- demonstrating that they are committed to working with children and young people on the issues that affect them
- being committed to addressing discrimination and disadvantage and promoting fair outcomes for children and young people

In addition, we are working to meet recommendations in the YCS Review of Safeguarding, which called for the YCS to develop a Code of Conduct for all adults working in the sector, and guidance to staff on demonstrating appropriate behaviour and healthy relationships. The review also called for supervision of staff to include professional conduct and challenging inappropriate behaviour and language.

As described in our response to Recommendation 4, it will be important to maintain consistency across the approaches and ensure the best outcomes for the children in our care as these initiatives become embedded in practice. We are considering the best way to achieve this objective.

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

We fully accept this recommendation, and will revisit the current guidance, training and documentation to ensure that the involvement of children is clearly understood and recorded by staff.

Information about previous health or physical injuries, or behavioural management issues should already be available to staff planning MMPR handling plans via the Comprehensive Health Assessment Tool (CHAT). This is a standardised holistic screening and assessment process for all young people throughout the youth justice system. The sensitivity of information about historic abuse means that details are not routinely available for all staff, however we are addressing this in working to meet a recommendation in the YCS Review of Safeguarding that called for it to be considered in the development of handling plans for each child.

Encouraging children to work with staff in the development of MMPR handling plans to develop and agree individualised strategies will build relationships, encourage understanding, and help staff build their professional judgement and discretion. Existing arrangements for debriefing in the MMPR manual already set out that both children and staff should be involved in reviewing incidents where force or physical restraint has been used.

The debrief should take place at a time and location which puts both the staff member and child at ease and aim to encourage dialogue and collaboration in drawing up an action plan to reduce the likelihood that the child's behaviour will deteriorate to a point where force might need to be used again.

It has been found that the debriefing process is more successful where it is mediated by staff who are not linked to the local MMPR team, such as those from the conflict resolution team, and we will consider how to reflect that in policy, guidance and practice.

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

We fully accept this recommendation and will revise the MMPR manual so that the sections on pain-inducing techniques are removed and the syllabus is comprised only of behaviour management and restraint techniques. This will need to be accompanied by training and guidance for staff to ensure that they are aware of the implications of the change and can put it into practice.

As this represents a considerable change to the existing MMPR manual, sufficient time and resources will need to be allocated to ensure that the impact is fully researched and understood before any changes are implemented.

8: The YCS, Governors or Directors should ensure that staff are trained in personal protection and breakaway techniques for use when there is a risk of serious harm to themselves or others.

This should include the response to exceptional circumstances where there may be no other recourse but to use a technique that can cause pain.

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

We fully accept this recommendation. We will review training to staff to ensure that they remain equipped with the necessary skills and interventions to manage behaviour effectively, and that when they are required to intervene with force, it is reasonable, necessary and proportionate to the threat that is posed, and can therefore be justified and defended in law.

We agree with the principle of redefining pain-inducing techniques as a separate set of threat prevention interventions outside the standard MMPR syllabus, which should only be used in scenarios of imminent serious harm, such as enabling the release, rescue or escape of a child or other member of staff where there is a threat of serious harm.

The Broadmoor Model, which is cited in the report, provides a helpful starting point, but any review would need to consider a wide range of alternative models and options to ensure that we build the right one for our operational environment. If use of pain is to require a higher threshold then it will need to be defined in policy. While it could be envisaged that interventions for use in circumstances where there was imminent risk of serious harm would form the apex of a redefined module, we will need to retain safeguards, so staff would have access to the interventions they needed for responding to risks they could reasonably expect to face.

Alongside publication of this report we will write to staff to reiterate the message that all use of force is a last resort and when it is used it must meet the legal test of being a reasonable, necessary and proportionate response. When the new model has been developed, training and guidance will be provided to all staff to support the transition to this change and ensure that all can put it effectively into practice.

9: That staff in YOI and STC may use a pain-inducing technique to prevent serious physical harm to child or adult.

This might be for the:

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

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

It would be highly unlikely that the use of pain would be justified in the following situation that were observed in the review:

- **failing to give up hands for handcuffs to be fitted or refusing to submit to a restraint**
- **not complying when being moved**
- **non-dangerous though unpleasant hurting of a staff member – such as pulling hair or wrapping legs round body or legs**
- **when there is a weapon, but the risk of its use is minimal or neutralised**
- **when children are fighting, but not putting themselves at risk of serious harm**

We partially accept this recommendation, as designating which intervention may (or may not) be the appropriate response in different situations may influence the reaction of staff to dynamic or emerging events.

Scenario-based practice is already assessed and tested in the existing MMPR training syllabus. Although staff should be aware of the need that their response to any incident should be necessary, reasonable and proportionate, their response in the live operational environment will be based on factors such as their experience, physical stature or other hazards in the immediate area around the incident.

The existing MMPR syllabus and training states that a pain-inducing technique should never be used where a non-painful alternative could achieve the same objective, although it is recognised that there may be circumstances where there may be no alternative if there is an immediate risk of serious physical harm to the child, other children or staff.

Before they use a pain-inducing technique, staff are trained to state the appropriate guidelines and to check that the child has understood, and when completing their report after the incident has finished they must also be able to justify using this response.

We will consider the examples that were given in the report to develop further training scenarios that will assess the response of staff to these situations and assist them in fair and proportionate decision-making when they apply them in the custodial environment.

10: That pain is not permitted to be used to end long restraints – staff must always try letting go or changing the hold if a restraint is going on too long.

However, the same emergency criteria could apply in exceptional circumstances as in Recommendation 8.

We have already committed to reviewing our guidance and training to ensure that all staff:

- are clear about their roles in any incident where force is used
- are able to dynamically assess risk and take decisions
- when in a supervisory role, issue instructions that are in the best interests of the child

Although this may include an option to release all holds, there may be occasions when that may not be a viable option and it may place staff or others at risk of harm or injury, and we therefore partially accept this recommendation.

We are committed to ensuring that use of restraint is proportionate and reasonable and that pain-inducing techniques are only used where it is a necessary response to a situation where there is a clear and imminent risk of serious harm to a child or member of staff.

Advice from the MMPR Medical Panel is quite clear that the risk to the person being restrained increases the longer the restraint goes on, and this was a significant part of the reason why the Serious Injury and Warning Sign (SIWS) process was put in place when MMPR was introduced.

All staff trained in the MMPR package should be able to recognise and know how to respond if the child under restraint exhibits signs or symptoms of medical distress. Responses which might be considered include checks, adjustment of the holds being used, medical monitoring, placing the child in the restraint recovery position or, if instructed by a registered healthcare professional, putting a stop to the restraint and releasing all holds.

As we have said in our response to Recommendation 1, the person acting as Use of Force Supervisor in any restraint fulfils a crucial role in monitoring the impact of the restraint techniques on the behaviour, health and welfare of the child, and the members of staff who are involved in that response. The holds that are being used should be continually monitored, and adjusted if it is necessary to do so. If there were serious risk to the child from continuing the restraint, the Use of Force Supervisor would have to assess whether a threshold for using a pain-inducing technique had been met.

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

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

It is essential that this panel contains people who are both independent and who have expertise in this field. (As a minimum) it should include the following: a member of the MMPR national team, a paediatrician, the Governor (or Director) and the MMPR lead of the establishment being considered, a representative of the YJB, the Local Authority LADO, a serving or former head teacher with expertise in behaviour, an expert in restraint and a representative of HMIP.

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

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

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

We accept the principle of this recommendation and agree that if staff are going to retain an ability to use a pain-inducing technique as a response to incidents which involve imminent risk of serious harm to themselves or to others there should be processes in place to ensure that those incidents are subject to full and independent scrutiny.

At this stage, we cannot commit to representation on the panel from specific agencies but we will undertake a programme of work that will establish clear terms of reference and membership for a new process that will review, and gather and disseminate learning from all incidents where a pain-inducing technique was used. As the process outlined in the recommendation envisages that practice at each establishment is likely to be reviewed on an annual basis, we must retain the ability for the National MMPR Team to undertake immediate reviews and provide targeted support to address any urgent needs that may be identified.

The arrangements for reviewing incidents where pain-inducing techniques have been used will be new, as simply expanding the existing process for incidents where a SIWS has been recorded will place additional burden on a process which has been working well and has had a positive impact on driving down the numbers of incidents that trigger the SIWS threshold.

To be effective and consider how the incident was managed, the new review process should not focus solely on the way in which staff behaved and how they used restraint techniques. We agree that the panel should also have access to a full picture of the context in which the incident took place, which will include consideration of factors such as the child's handling plan, a record of their behaviour and the outcome of any previous post-restraint debriefs.

12: The inverted wrist should only be used to gain control of strong and/or fully-grown children when there is no alternative and there is a risk of serious harm.

Staff must move to a safer hold as soon as possible.

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

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

We accept the finding about the considerable pain and discomfort experienced by many children who are restrained using the inverted wrist hold.

Although the hold provides members of staff with a greater degree of control in situations that are more challenging, we accept the evidence presented by experts in this field, including the paper which has been cited in the report, which show how difficult it is for a pain-free position to be established and maintained when this hold is being applied, especially in the highly charged atmosphere when an active restraint is underway.

As this technique can clearly cause a great deal of pain, we agree it should be subject to the same level of scrutiny as those techniques which are explicitly designated as being "pain-inducing". The National MMPR Team are already working with the YCS to understand the implications of changing the designation of this technique as it provides a transition to other restraint holds in MMPR. This change will need to be undertaken extremely carefully to ensure that staff are still able to respond safely to all scenarios, and we will work with experts in restraint techniques to ensure that staff do not lose the ability to control incidents where force has been judged to be a necessary response.

We expect that once this work is completed the inverted wrist will be placed alongside the set of interventions reserved for use in response to emergency scenarios. In doing so, any use of the inverted wrist hold should be subject to the same levels of scrutiny and oversight envisaged by Recommendation 11.

We do not agree with the suggestion that the inverted wrist hold should be reserved for use in restraints involving children who are "strong" or "fully-grown", as making that judgement is subjective and fraught with huge difficulties as each child has a unique set of physical and musculoskeletal characteristics or past injuries. Creating different sets of holds for use when restraining children with different physical characteristics opens the potential for staff responding to those incidents to apply them incorrectly, particularly when factoring in differences in the size and strength of each individual member of staff and their dynamic assessment of risk. The safety of staff members and the children in our care should be our overriding consideration and they should not be placed in that position.

13: The role of the nurse must be explicit during restraint.

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

We accept this recommendation in full. The MMPR guidance and training is very clear in setting out the expectation that a member of the establishment's healthcare team should be present at every incident where staff are deployed to restrain young people. This is an important area which requires a close working relationship between all parties to ensure that the child is properly protected.

While it is widely recognised that the response to spontaneous incidents in an operational environment cannot always be immediate, the expectation is that a member of healthcare staff should arrive at the scene of an incident whenever, and as soon as, it is practicable to do so.

The guidance is also clear that once healthcare practitioners are present at an incident they must have the confidence that any clinical advice that they offer will be listened to and adhered to by all involved: it is a key role in ensuring the safety of the restraint for all involved. Healthcare practitioners should also take an active role in the formulation of restraint handling plans and in undertaking post-incident debriefs. We will review whether this message needs to be reiterated to all members of staff.

The MMPR syllabus is equally clear that if the child who is being restrained exhibits symptoms or signs which suggest that they are experiencing medical difficulties or distress, the Use of Force Supervisor for the incident should order any holds that are being used to be adjusted, or the restraint should be stopped. We believe that this is widely understood by staff but as we say in our response to Recommendation 1 we will review the current MMPR manual.

We have seen a reduction in the number and seriousness of events which require a referral for the incident to be reviewed by the SIWS panel and anticipate that fulfilling Recommendation 11 by introducing scrutiny of incidents where a pain-inducing technique was applied will have a similar impact as the arrangements for the SIWS panel.

The approach of the MMPR manual is supported by the intercollegiate guidance Healthcare Standards for Children and Young People in Secure Settings, which was published by the Royal College of Paediatrics and Child Health in 2019. The guidance identifies that healthcare practitioners should be trained in the principles of the restraint methods used in the setting where they are working (i.e. MMPR in YOIs and STCs) so they can fully understand potential risks and injuries. The important role of healthcare practitioners is also acknowledged where the guidance refers to their advisory role in preparing for planned interventions where restraint may be expected, such as searches or relocations, and in having access to children shortly after they have been restrained so that any injuries can be identified and treated.

A bespoke MMPR training package which has been developed for healthcare staff and managers working in the custodial state is awaiting sign-off. Once implemented, the YCS and NHSE&I will continue work together to ensure that the training package for healthcare staff and managers continues to ensure that the vital role and voice of healthcare practitioners in any restraint incident is clearly understood and adhered to.

14: Escorts to STC and SCH should be trained in an MMPR syllabus that no longer allows for the use of pain.

Like staff in YOI and STC they may receive additional training in self-defence and an emergency response that can include the use of pain in the same exceptional circumstances that apply to YOI and STC staff. Staff who drive the cellular vehicles between YOI and court should be trained in MMPR. Escort staff should not be allowed to use restraint to maintain "good order and discipline".

The re-competition for the Prisoner Escort and Custody Service (PECS) Generation 4 contracts for the provision of services which will escort children remanded or sentenced to custody in England and Wales is complete, and those contracts are due to go live from August 2020.

We agree with this part of the recommendation in full. The National MMPR Team have planned how relevant training in the restraint package will be delivered to both new and existing staff from the preferred bidders, and the training programme is in place.

The new contracts require PECS suppliers to ensure that all escort staff who engage directly with children under the care of the escort providers will be trained in MMPR when the new contracts take effect. The training in MMPR will be identical to the syllabus provided to staff in YOIs and STCs, and in due course will reflect any changes that are introduced as a result of our work to meet the recommendations in this report.

Additionally, when they are commenced, the PECS Generation 4 contracts will ensure that suppliers meet a recommendation in the Safeguarding Review which called for transportation staff to receive age-appropriate safeguarding training, including child protection and use of force.

The current certification for staff who escort children is set out in the Criminal Justice and Public Order Act 1994 and differs from that for staff who work in custody. Schedule 1 of the Act permits the use of reasonable force for the purpose of good order and discipline. We consider that changing this Schedule to meet the Recommendation would create considerable hindrance in them effectively discharging their duty and fulfilling the orders of the court. We are not proposing to revisit this certification at this stage and cannot commit to implementing this part of the recommendation.

15: All operational staff in STC and YOI should be equipped with body worn cameras.

Staff should be obliged to turn them on when an incident is developing.

We recognise the considerable contribution that footage from body worn video cameras (BWVC) can have in creating a safer environment and a culture of transparency, and fully support this recommendation.

Footage is especially useful where it has captured the events which led up the point where staff made the decision to respond to a child's behaviour with force. In doing so it can support a culture of reflective practice and learning through enabling good practice to be highlighted or for additional support and training to be targeted.

Prison Service policy on the use of BWVC is set out in PSI 04/2017. The policy recognises that there may be circumstances where the start of recording may be delayed due to the spontaneity of the incident, but staff are instructed that where BWVC is available it must be activated in the following circumstances:

- when the person equipped with BWVC is required to exercise force
- when there is risk to their safety or the safety of another person
- when they are responding to an alarm bell or incident

We are working to make BWVC available to each member of operational staff across the youth justice estate, however there is currently insufficient equipment available to meet this need.

Deployment of BWVC at each establishment is therefore determined locally by the Governor and will be guided by factors such as the number of available cameras, the number of people who have been trained to use them and the local strategic and dynamic response to managing security and the safety of children and staff.

We will consider how use of BWVC can be built into the MMPR training package to encourage it to be used during incidents. However, in determining future implementation any additional rollout, we will need to take account of an evaluation of the use of BWVC, which was called for in the YCS Safeguarding Review.