Implementing the national objective to end prone/face down restraint: examining restraint positions in practice

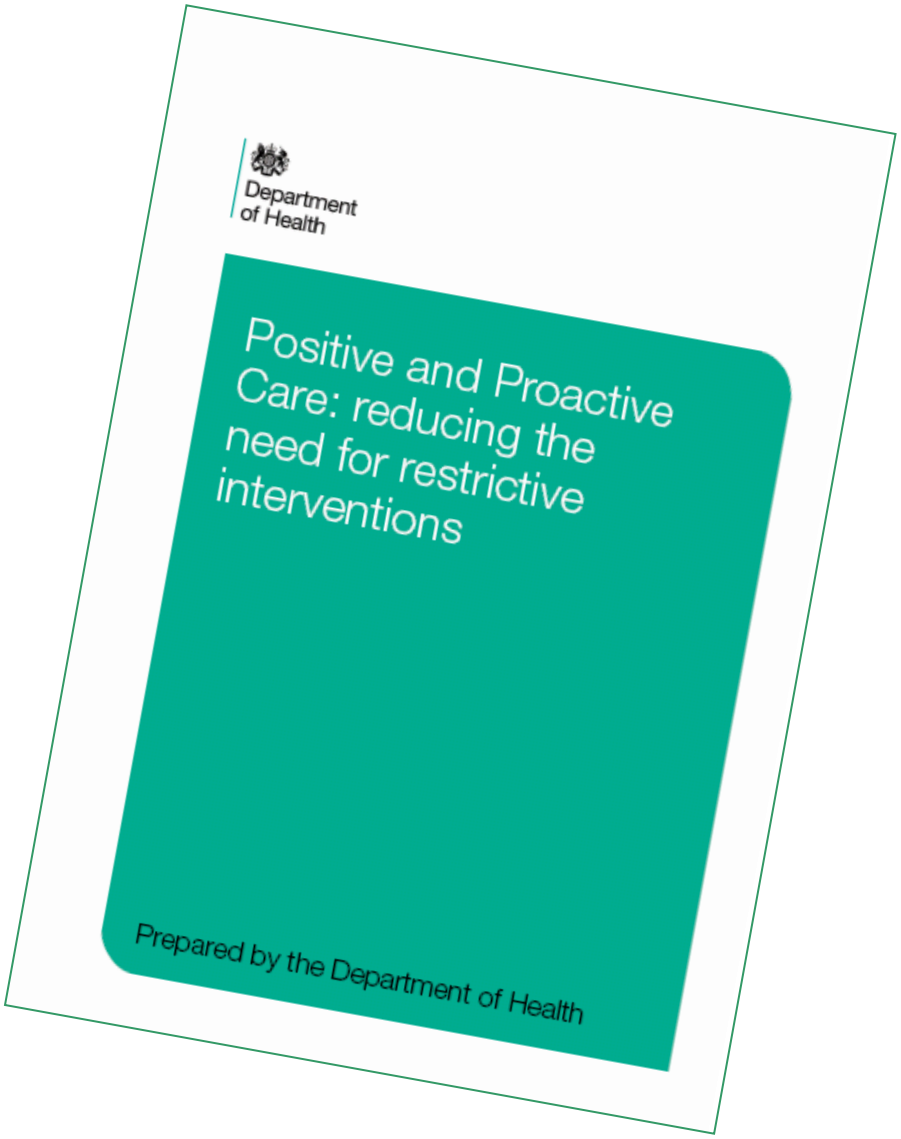
Eric Baskind

LLB (Hons), LLM, MCIArb, FRSA, FHEA, MSLS

21 April 2015

ICO Conference Centre, London

Positive & Proactive Care, DH, April 2014



[70] People must not be deliberately restrained in a way that impacts on their airway, breathing or circulation. The mouth and/or nose must never be covered and techniques should not incur pressure to the neck region, rib cage and/or abdomen. **There must be no planned or intentional restraint of a person in a prone/face down position on any surface, not just the floor.**

No restraint is 100% safe

"restraint is not itself harmless; some proportion of those who are restrained may die. We do not know what this proportion is, or how many others will come near death and be revived. As clinicians we need to accept that restraint procedures are potentially lethal and to be judicious in their use."

Dr. Donald Milliken, Chief of the Department of Psychiatry in Victoria BC, Canadian Medical Association, 1993, p1611

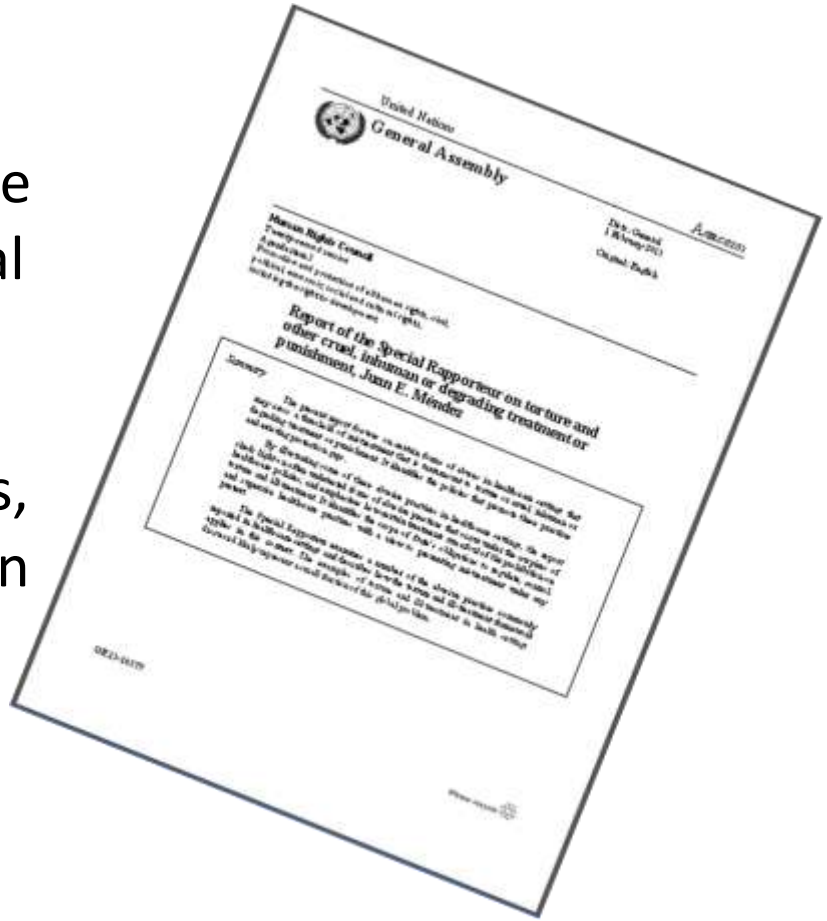
An absolute ban on physical restraint?

- Demanded by some organisations
- Best option if reasonably practicable (but not always possible)
- Early initiatives were unimpressive (eg the UK's NHS Zero Tolerance campaign in the late 1990s)
- More recent (and more impressive) initiatives include:
  - *Six Core Strategies for Reducing Seclusion & Restraint Use*
  - *REsTRAIN YOURSELF; 'Retrain don't Restrain' (National Nursing Home Restraint Removal Project);*
  - *No Force First*
  - *ImROC*
  - *Safewards*
- In certain circumstances there will be a duty to restrain
- Cannot sensibly/safely eliminate use of restraint in all cases

United Nations General Assembly, February 2013
Report of the Special Rapporteur

Absolute ban on restraints and seclusion

[63] ... It is essential that an absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities, should apply in all places of deprivation of liberty, including in psychiatric and social care institutions.


United Nations
General Assembly
Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez

These positions are unsupportable – e.g.:

- Health & Safety at Work Act 1974
- Management of Health & Safety at Work Regulations 1999
- Mental Health Act/ Mental Capacity Act
- Where there is a duty to act
- A large number of common law judgments, including:

  R (Munjaz) v Mersey Care NHS Trust [2003] EWCA Civ 1036
  Keys v Shoefayre Ltd [1978] IRLR 476
  Ingram v Worcestershire County Council, TLR, 11/1/2000
  Buck v Notts Healthcare NHS Trust (Rampton) [2006] EWCA Civ 1576
  Cook v Bradford Community Health NHS [2002] EWCA Civ 1616
  Grant v Chief Constable of Grampian Police 2001 Rep. LR 74
  Chief Constable of West Yorks Police v Hunter [2009] EWCA Civ 1576
  Brisco v Secretary of State for Scotland 1996 Rep. LR 169

So, how should violence and aggression be controlled?

- minimise occurrence and opportunities
- emphasis on violence reduction policies
- emphasis on use of force as a last resort
- minimum appropriate force to deal with situation
- organisational buy-in
- **this helps ensure that restraint use in minimised**

Some key facts about PI

- necessarily contains element of risk for staff and subject (this is just one reason why it should be use as a last resort)
- need to ensure that restraint is only used when necessary; with no more force than necessary; for no longer than necessary; and then proportionate to the circumstances and in a manner that is as safe as possible to achieve
- necessary tension between safety of subject and staff (both of whom are owed a duty of care)
- certain restraints (or restraint positions) are inherently more risky than others
- individuals with certain conditions are at higher risk of injury or death
- certain groups are also at higher risk (eg, serious mental illness/learning disabilities, high BMI, BMEs, etc.)
- Intoxicants/medications can also pose risk to safety of restraint
- need for clear ethical framework underpinning use of force
- appropriate emphasis on de-escalation and positive behaviour management
- violence reduction and restraint minimisation are central to the concept of safe subject management. Feeling safe reduces stress/anxiety and promotes positive ethical values
- prolonged periods of restraint can be very dangerous
- injury does not, of itself, imply fault

Some perspectives

- UK - 68,683 reported physical assaults against NHS staff – 1,600 prosecutions (NHS Protect, 2013-14)
- Huge variation in the use, nature and reporting of physical restraint

  For example, one health trust reported 38 incidents while another reported over 3,000 incidents (with more than 3,000 prone restraints used in total)
- in 2010, approximately 12% of patients had experienced one or more episodes of physical restraint (*Count Me In* census 2010, CQC (2011))
- in 2012, almost 1,000 incidents of injury following restraint in healthcare settings. Higher in other settings
- pain-compliance and prone restraint are currently highly controversial - banned by some; relied on by others
- UK prefers physical restraint; much of continental Europe prefers mechanical restraint
- only the bad news appears to be newsworthy
- several noteworthy cases of death/serious injury during/following PI

The death of Jimmy Mubenga

JM died in October 2010.

Brought into public focus the limitations of the restraint techniques taught to and used by Detention Custody Officers.

Post-mortem concluded that JM died from cardiorespiratory collapse, caused by restraint.

Inquest jury - death: (1) caused by restraint

(2) unlawful

Inquest heard that JM had been held in a head down restraint position, using techniques which were not part of the C&R process in which the DCOs involved had been trained.

Assistant Deputy Coroner's Rule 43 report included:

(1) C&R syllabus paid insufficient attention to the delivery of scenario-based training;

(2) Doubt about the suitability of C&R techniques to the specific circumstances in which DCOs may find themselves;

(3) An unauthorised technique had been used. Head held down for an extended period of time, while in a seated position with his hands cuffed. (Previous warnings not to use this technique - its use raised concerns about the effectiveness of that prohibition and its enforcement);

(4) Handcuffed to rear, despite well known risks inherent with this technique and advice to DCOs that it was to be avoided for extended periods;

(5) DCOs need to be regularly reminded of the dangers of positional/restraint asphyxia.

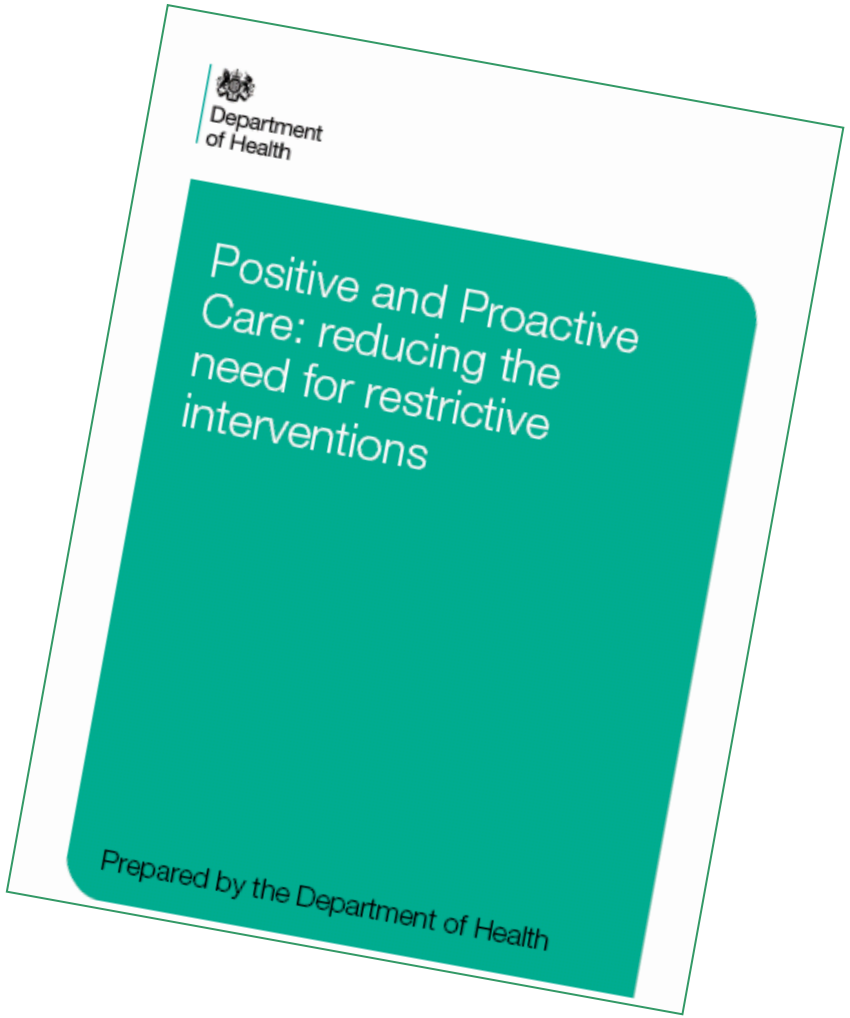
Staff face a difficult and often unenviable task

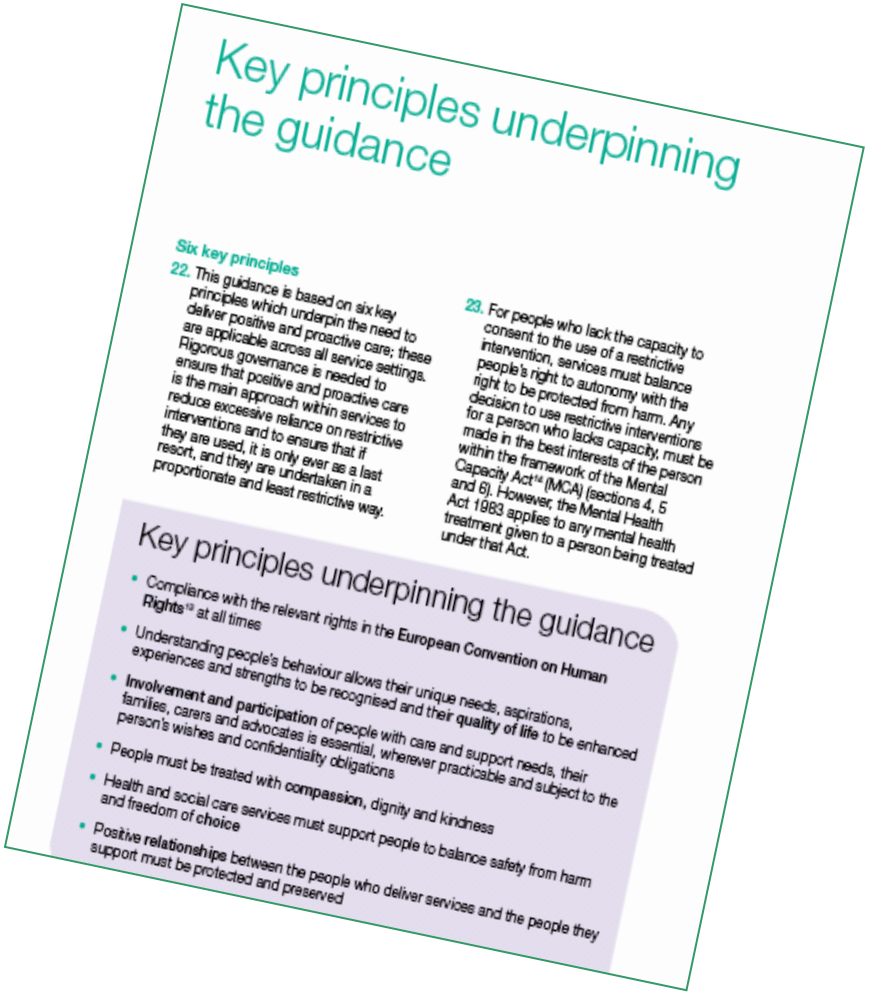
- The difficulties faced by staff are real and occur frequently
- Staff often have an unenviable task when facing violence and aggression
- Often need to make split-second decisions
- It is unfortunate that it is only the 'bad cases' that reach the press. Much good work goes unnoticed by public. This good work helps maintain a safe working environment
- Difficulties experienced when using force were noted in a 1971 case where Lord Morris acknowledged that in relation to the use of force [for the purposes of self defence] *"a person ... cannot weigh to a nicety"* the exact measure of his necessary actions (*Palmer v R [1971] AC 814*); see also section 76(7)(a) Criminal Justice and Immigration Act 2008

Reports,
Guidance
& more ....

DH Guidance “Positive & Proactive Care” (April 2014)

This Guidance has had a positive effect in reducing the use of restraint … any reported increases in use is likely to be the result of [improved] reporting





[58] The legal and ethical basis for organisations to allow their staff to use restrictive interventions as a last resort is founded **on eight overarching principles**

- Restrictive interventions should never be used to punish or for the sole intention of inflicting pain, suffering or humiliation.
- There must be a real possibility of harm to the person or to staff, the public or others if no action is undertaken.
- The nature of the techniques used to restrict must be proportionate to the risk of harm and the seriousness of that harm.
- Any action taken to restrict a person's freedom of movement must be the least restrictive option that will meet the need.
- Any restriction should be imposed for no longer than absolutely necessary.
- What is done to people, why and with what consequences must be subject to audit and monitoring and must be open and transparent.
- Restrictive interventions should only be used as a last resort.
- People who use services, carers and advocate involvement is essential when reviewing plans and restrictive interventions.

Wide choice of interventions (physical/mechanical)

- many different techniques/equipment to choose from
- choice often driven by organisational (trainer) and/or policy considerations
- training needs analysis/assessment of risks
- training time/resources key consideration
- **current focus on safety, simplicity and efficacy**

HOMES - 12 core techniques

(Home Office Manual for Escorting Safely)

1. Guiding hold
2. Figure of four arm hold
3. Isolating the arm
4. Head hold
5. Arm hold
6. Inverted wrist
7. Mandibular angle technique
8. Wrist flexion
9. Thumb flexion
10. Subject on the ground – supine
11. Subject on the ground – prone
12. Restraint recovery position

HSS - core personal breakaway techniques

4 fundamental skills that can be used either individually or combined to assist in the breakaway from attacker's grip:

- fix and move
- bowling
- close proximity techniques (CPTs)
- lever principles

Practised against 28 common attack scenarios

Mechanical restraints

Many countries use mechanical restraints as a primary means of control

But does this create a more controlled or safer environment?

In these situations physical restraint training typically focuses on breakaway techniques and distraction/subduing techniques to enable application of mechanical restraints

Use of physical restraint in these other jurisdictions might therefore appear to be lower but this can be very misleading

Important to consider the effect on physical restraint – including prone positions – if mechanical restraints are used

Prone restraint positions

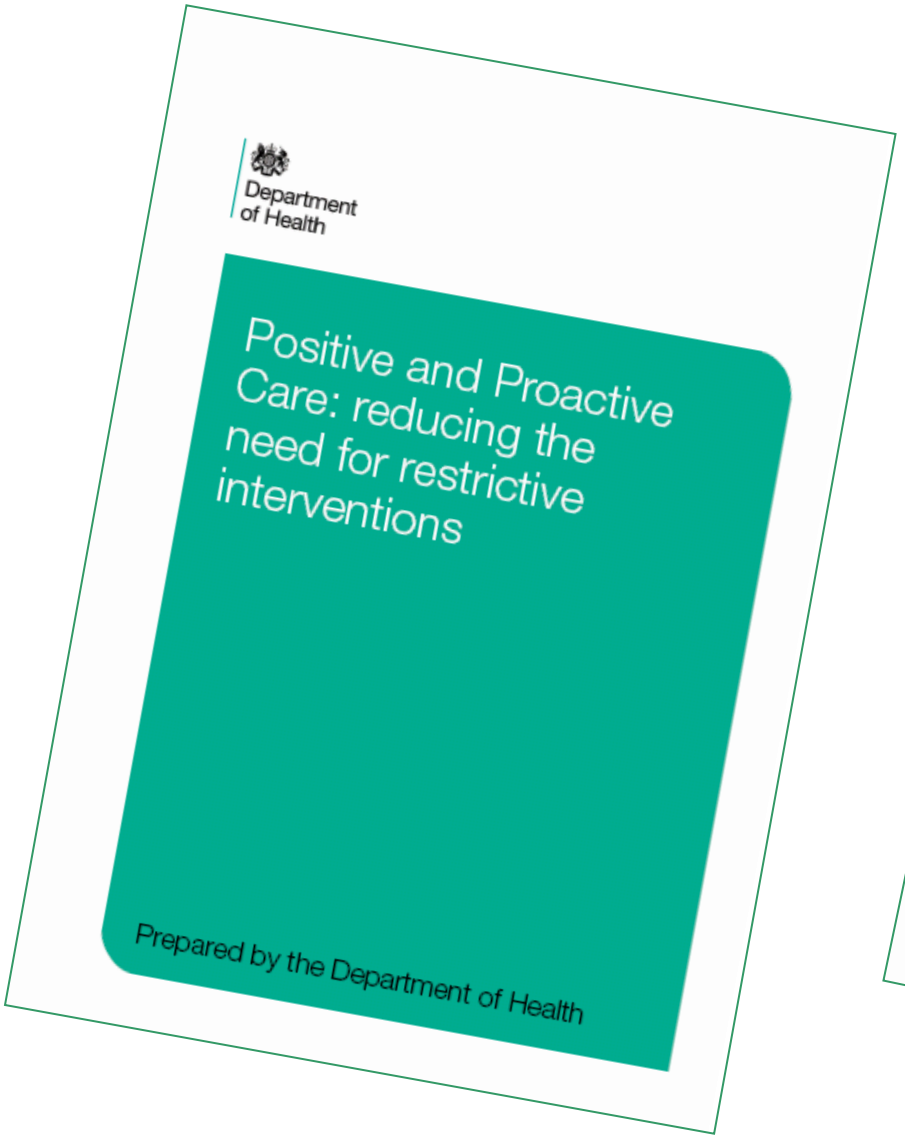
Highly controversial; banned by some agencies/organisations (although in some countries/organisations supine has been the subject of a ban)

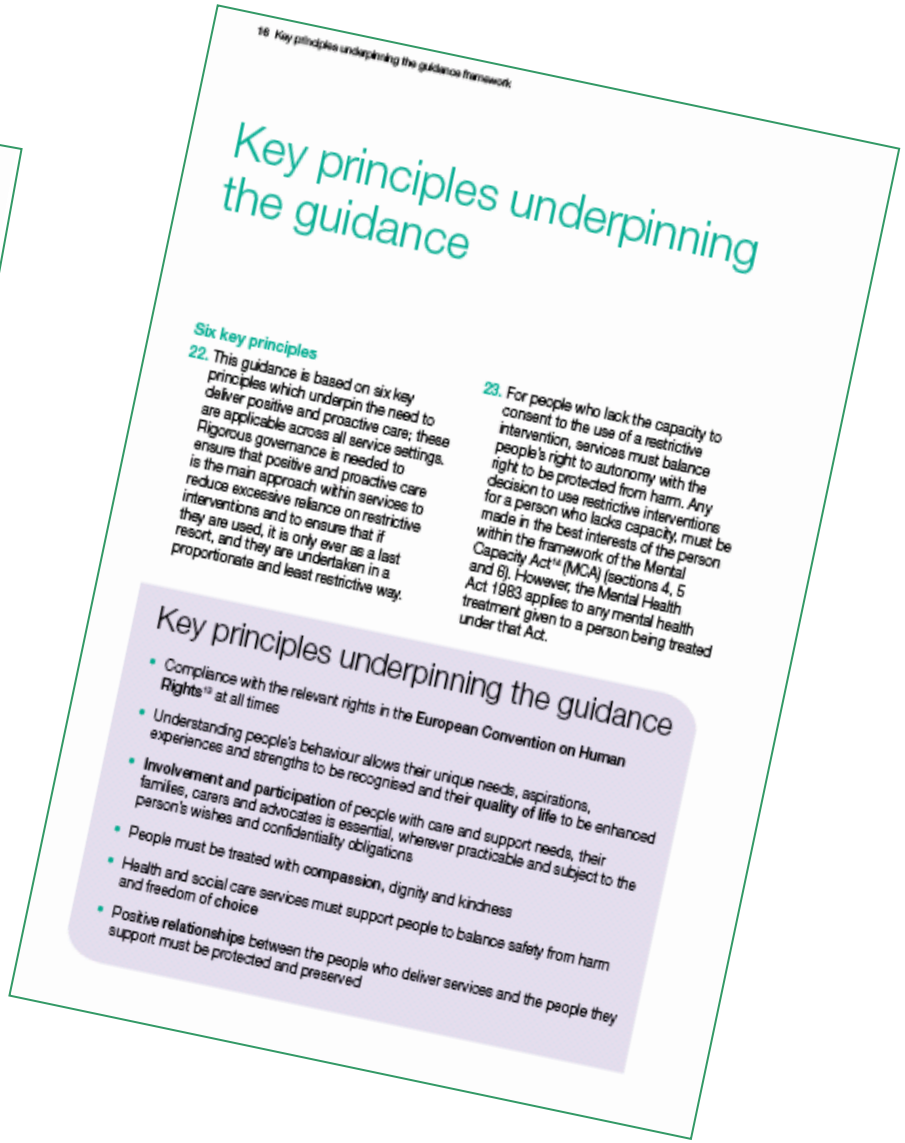
But why? See, for example:

- *Mid Staffs NHS Foundation Trust Public Inquiry (Francis QC, 2013)*
- *Winterbourne View*
- *CQC's Mental Health Act Monitoring Report (2010/11)*
- *MIND 2013: "failing to put an end to the use of face down physical restraint is unacceptable."*
- Dr Cary, Consultant HO Forensic Pathologist, expert evidence to Bennett inquiry (2004) *"Prone restraint is an area that we know from cases around the world is a position in which people appear to die suddenly when they are restrained for long periods."*

Putting PI into (the wrong) context
Winterbourne View

DH Guidance “Positive & Proactive Care” (April 2014)





Positive & Proactive Care, DH, April 2014

(para 70)

People must not be deliberately restrained in a way that impacts on their airway, breathing or circulation. The mouth and/or nose must never be covered and techniques should not incur pressure to the neck region, rib cage and/or abdomen. **There must be no planned or intentional restraint of a person in a prone/face down position on any surface, not just the floor.**

What is the status of this “prohibition”? Widely criticised by practitioners and experts alike. Not followed by other agencies.

Subsequent important clarification.

Protect

NHS Protect consulted DH and HSE; DH provided following clarification (*NHS Protect, March 2015*)

- Guidance provides information and good practice but is not statutory guidance or legally binding. Providers can choose to depart from the Guidance but may be asked (e.g. by court or CQC) to justify their reasons for doing so
- Not acceptable in modern health and care service that restrictive interventions, such as face down restraint, have become normalised
- Service providers should be exploring alternative techniques and approaches which pose less risk to staff and service users, and ensuring staff are adequately trained and supported in these
- it is accepted that there may be exceptional circumstances where the use of prone restraint will happen ...On rare occasions, face down restraint may be the safest option for staff and service users, with few, if any, viable alternatives

Protect

NHS Protect's Q&As on Positive and Proactive Care Guidance

- ***Should staff still be trained in the use of prone restraint?***

  Individual employers are best placed to decide what training their staff should undertake

  Employers must acknowledge and seek to minimise the risks associated with any restrictive interventions taught to staff. Training providers should issue care providers with specific risk profiles for each technique taught

  There must be Board level or equivalent authorisation and approval of any restrictive interventions taught to their staff and used in practice

  If Boards decide that they need staff to be trained in prone restraints -vital that that they are trained in the risks and appropriate techniques

- ***How will CQC use Positive and Proactive Care?***

  It informs CQC's monitoring and inspection as to whether provider is delivering safe/appropriate care. Departing from the guidance is not itself a basis for CQC enforcement action

- ***Could staff take action against DH if they are hurt by patient/service user and would, prior to publication of Positive and Proactive Care, have used restrictive intervention?***

  No, Positive & Proactive Care provides information and good practice guidance; it is not statutory guidance or legally binding. Employers are responsible for, assessing, managing and controlling the risks to staff and service users. They are accountable for injuries sustained by their staff who are acting in the course of their employment where they have not been appropriately instructed, trained or supervised

Mental Health Act Code of Practice, 2015 (effect from 1/4/15)

Department of Health

the "cogent reasons" qualification

Patients should not be deliberately restrained in a way that impacts on airway, breathing or circulation. The mouth and/or nose should never be covered and there should be no pressure to the neck region, rib cage and/or abdomen. Unless there are cogent reasons for doing so, there must be no planned or intentional restraint of a person in a prone position (whereby they are forcibly laid on their front) on any surface, not just the floor (para 26.70)

NATIONAL MINIMUM STANDARDS FOR THE SAFE AND THERAPEUTIC MANAGEMENT OF AGGRESSION AND VIOLENCE IN MENTAL HEALTH INPATIENT SETTINGS

Care Services Improvement Partnership/National Institute for Mental Health in England (draft)

"Restraining service users on the floor – either in the prone or supine positions – should be avoided. In exceptional situations, if the service user needs to be placed in these positions it should be for the shortest possible period of time to bring the situation under control."

INDEPENDENT REVIEW OF RESTRAINT IN JUVENILE SECURE SETTINGS

Peter Smallridge and Andrew Williamson, 2008

"In the light of the competing evidence we feel that we cannot make any recommendation to ban prone restraint, but we consider it prudent that when prone restraint is used there should be a re-assessment of the risks after control has been obtained in the initial restraint." (para 6.35)

Prone restraint positions

Use of prone restraint is widespread across many sectors (police, prison, High Secure Services, etc.)

No restraint position can ever be 100% safe but restraining subject on ground is inherently more dangerous than standing restraint positions. But, applied correctly and in appropriate circumstances they can be an important part of the restraint mix.

Prone restraint positions - ‘applied correctly’

- subject to standing/seated as soon as reasonably practicable (but note the risks associated with seated even where torso is kept upright (*Parkes,* 2008; *Parkes et al,* 2011)
- head/neck is protected and/or not in danger
- no pressure on chest area, back, neck, etc.
- airway/breathing is not compromised
- subject’s vital signs and well-being monitored
- applied by appropriately trained staff

Prone restraint positions - ‘appropriate circumstances’

- to be avoided wherever possible (all takedowns/ground holds)
- when control cannot reasonably be established in standing
- when the team reasonably decide that it is the safest position for the subject in all of the circumstances
- avoiding prone with subjects with certain conditions or with certain groups (eg, serious mental illness/learning disabilities, high BMI, pregnant, intoxicated, BMEs, etc.)
- never for prolonged periods

Alternatives to prone – (1) supine

- Some consider supine position safer than prone but this is unsupported by the evidence (see, eg, *Morrison et al* 2001; *Mohr et al*, 2003. The risks are just different
- Supine is a much less secure position in which to hold a subject and will often require greater strength/force than other positions to hold safely (*Baskind,* 2012). Consider eg flailing arms, head, kicks, choking, vomit, protect airways
- Women have approximately 50% of upper and 70% of lower body strength of men at age 18 (*Wilmore,* 1979). May struggle to hold safely in supine and resort to unsafe holding. Also consider workforce (aging, fitness, etc)
- Individuals who have been sexually abused will often fight furiously to avoid supine position
- Winterbourne View serious case review called for ban on a supine restraint position (yet DH ban prone)

Alternatives to prone – (2) side

- Not secure or safe
- Subject can attack far too easily
- Women have approximately 50% of upper and 70% of lower body strength of men at age 18 (*Wilmore,* 1979). May struggle to hold safely in supine and resort to unsafe holding. Also consider workforce (aging, fitness, etc)

Alternatives to prone – (3) seated

The most dangerous restraint position of all (especially for obese) appears to be hyperflexion (bent forward from the waist) while seated. (*Paterson and Bradley,* 2008; *Paterson et al,* 2014).

Hugely significant following death of JM.

All seated positions should be considered risky - even where torso is kept upright (*Parkes,* 2008; *Parkes et al,* 2011)

PAIN-COMPLIANCE TECHNIQUES

Note relevance to the "prone discussion" – in appropriate circumstances can obviate need for prone/lengthy restraint

Pain compliance is "the intentional use of a painful stimulus to control a violent person" (*Baskind*, 2007).

Probably the most contentious and misunderstood area in restraint practice raising important issues of ethics, law and efficacy of application.

Most general situations can be dealt with without use of these techniques.

Pain-compliance techniques

In certain circumstances pain-compliance should be considered:

- to force subject to release grip (eg bite, weapon, object, etc.)
- to prevent an otherwise prolonged restraint
- where its use is the safest and most appropriate way of controlling the subject or dealing with the incident

Where these techniques are used they must be:

- used for the shortest possible time;
- with load clear commands; and
- be capable of (physical) de-escalation

Although these techniques are often over-used they cannot safely be dispensed with.

Positive & Proactive Care, DH, April 2014

Deliberate use of pain – (*para 69)*

- Staff must not cause deliberate pain to a person in an attempt to force compliance with their instructions.
- Where there is an immediate risk to life ... recognised techniques that cause pain as a stimulus may be used as an intervention to mitigate that risk.
- These techniques must be used proportionately and only in the most exceptional circumstances and never for longer than is necessary to mitigate that immediate risk to life.

The 'immediate risk to life' qualification is too restrictive.

Mental Health Act Code of Practice (2015)

… **Unless there are cogent reasons for doing so**, staff must not cause deliberate pain to a patient in an attempt to force compliance with their instructions (for example, to mitigate an immediate risk to life). Para 26.41

THE REAL DANGERS ASSOCIATED WITH RESTRAINT

Prolonged (*Baskind & Eustace 1994; Baskind 2007*)
Seated (*Parkes et al 2008 & 2011; Leadbetter 1998*)
Kneeling (*Paterson et al 2003*)
Prone (*MIND 2013; Baskind 2013*)
Supine (*Morrison et al 2001; Winterbourne, 2012*)
Prone v Supine (*Baskind 2013*)
Mechanical restraints (*IPCC 2012*)
Pain compliance (*Baskind & Boatman,* 2010; *Baskind et al,* 2014)

POSITIONS & RESTRAINTS

	Death/ Serious injury	Position	Key points
David Bennett (1998)	D	prone	1, 2, 3, 4, 5(a)
Kurt Howard (2002)	D	prone	1, 2, 3, 4
Victor Massey (2006)	D	prone	1, 2, 3, 4, 5(a),(b),(c)
Kushan Hapuarachchi (2008)	S	prone	1, 2, 3, 4, 5(b)
Sean Rigg (2008)	D	prone	1, 2, 3, 4, 5(a)
Jimmy Mubenga (2010)	D	seated	1, 2, 3, 4
Jacob Michael (2011)	D	prone	1, 2, 3, 4, 5(a)
Marjorie Maltby (2012)	D	semi-prone/leaning	1, 2, 3, 4 5(b),(d)
David Ivin (2014)	D	prone	1, 2, 3, 4, 5(d),(e)

Key: ***1. Prolonged restraint. 2. Lack of appropriate training. 3. Poorly applied technique. 4. No effective monitoring.*** *5. Significant other factors (a) mental health (b) incapacitant spray (c) rapid tranquilisation (d) obesity (e) intoxication*

Let’s keep to our own disciplines

Some issues for debate

- Does conflict often/ever depend on staff rotas/shifts?
- Could/should organisations look at the use of force as a (rebuttable) failure?
- Increased staff and organisational accountability
- Many organisations believe physical restraint is over-used. It is. But they train staff to restrain and then complain when they use it.

  "I suppose it is tempting, if the only tool you have is a hammer, to treat everything as if it were a nail"

  Abraham Maslow, The Psychology of Science, 1966, p15
- Recent approaches are much better – greater emphasis on violence reduction, behaviour management, de-escalation, environmental and other factors, etc.
- Training titles are important. Note shift from C&R – MVA – PMVA - PSVR

SUMMARY

- Greater awareness of factors causing violence & aggression
- Greater emphasis on violence/restraint reduction strategies
- Better/more accurate reporting (but this could lead to misleading/perceived increase in number of incidents)
- Move to fewer techniques but more adaptable to different situations
- More (effective) use of “near miss” and good outcome data
- Future increase in use of certain mechanical restraints?
- Better joined-up approach between agencies
- NICE CG25 (2005) - due to be replaced in 2015 and include views of people who have experienced restraint/seclusion
- **Much lower use of ALL restraint**
- **A Safer Future**

QUESTIONS?

Thank you for listening to this presentation and I hope you have benefited from it.

With best wishes,

Eric Baskind
LLB (Hons), LLM, MCIArb, FRSA, FHEA, MSLS

21 April 2015
ICO Conference Centre, London