



HOUSES OF PARLIAMENT

Joint Committee on Human Rights

Oral evidence: Youth detention: [Youth detention: Solitary confinement and restraint](#), HC 994

Wednesday 11 July 2018

Written evidence from witnesses:

- Dr John Chisholm, Chair, Medical Ethics Committee, [British Medical Association](#)
- Dr Laura Janes, Legal Director, Solicitor, [Howard League for Penal Reform](#)
- Dr Heidi Hales, Forensic Psychiatrist, [Royal College of Psychiatrists](#)
- Glyn Travis, Assistant General Secretary, [The Professional Trades Union for Prison, Correctional and Secure Psychiatric Workers](#)

[Watch the meeting](#)

Members present: Ms Harriet Harman (Chair); Fiona Bruce; Ms Karen Buck; Baroness Hamwee; Baroness Lawrence of Clarendon; Baroness Nicholson of Winterbourne; Jeremy Lefroy; Lord Trimble; Lord Woolf.

Questions 16–36

Witness[es]: **Dr John Chisholm**, Chair, Medical Ethics Committee, British Medical Association; **Dr Laura Janes**, Legal Director, Solicitor, Howard League for Penal Reform; **Glyn Travis**, Assistant General Secretary, The Professional Trades Union for Prison, Correctional and Secure Psychiatric Workers; **Dr Heidi Hales**, Forensic Psychiatrist, Royal College of Psychiatrists.

Q16 **Chair:** We very much thank the experts who have come to join us this afternoon. As you know, we are the Joint Committee on Human Rights, which means we are half Lords and half Commons. We have been looking at the rights of people for whom there has

been deprivation of liberty, and in particular at the question of confinement and restraint in the context of our commitment under Article 3 of the European Convention on Human Rights that no one shall be subjected to torture or to inhuman or degrading treatment or punishment. The focus of the Committee is on people's human rights in that respect.

We are very grateful indeed to you for coming along to share your expertise with us. First, what situations do staff face in children's mental health wards, in particular where restraint or confinement might be used?

Dr Heidi Hales: Is this about mental health hospitals specifically?

Chair: Children's mental health hospitals.

Dr Heidi Hales: If on our wards there is a risk of violence or self-harm that cannot be de-escalated verbally or avoided, as a last resort it might lead to restraint, but every effort is made along the way to think about not putting somebody in a secure setting. We have a care plan to work out what the triggers might be, so that we avoid things that might lead to an incident. We try verbally to de-escalate at the time and offer support, but the last resort would be restraint.

Chair: Can you say what sort of restraint? Physically, what are we talking about? What does it look like, and who does it?

Dr Heidi Hales: I am not restraint-trained. Doctors do not end up being restraint-trained; we are not part of the team. The training is very mental health-specific.

Chair: I am not talking about training. I am talking about what actually happens.

Dr Heidi Hales: If an incident happens and the staff on the ward think the young person needs to be restrained to avoid it, after all the verbal de-escalation has happened an alarm call will go out. At least three staff members are needed to form a team to do it safely. You would not do a restraint unless there were three people able to do it. I do not quite know how it happens physically, but the staff go to the young person and physically restrain them in order to calm them down. The aim for me or for anybody on the ward like me would be to move everybody else away so that it is safe, private and humane and other people are not upset or traumatised, while the team tries to make the situation safe.

Chair: I have not seen a restraint, nor would most people have seen one.

Dr Heidi Hales: It is upsetting.

Chair: You have seen a restraint.

Dr Heidi Hales: Yes.

Chair: What appears to be happening physically?

Dr Heidi Hales: A lot of people arrive on the ward and the doors are opened for them. There is a sense of urgency. Hands are put on the

young person, if it is needed, and usually they are put on the floor, or they might be put in a sitting position.

Chair: I do not know what the words are. “Wrestled” or “manhandled” are rather pejorative words.

Dr Heidi Hales: It is not manhandling or wrestling.

Chair: I do not mean that, but they are forced on to the floor or into a sitting position.

Dr Heidi Hales: It is a use of force to stop anything violent happening either to the young person or to other people.

Chair: It is to force them to lie down on the floor or to force them into a sitting position.

Dr Heidi Hales: It is to enforce calmness. The notes of patients who have been in hospital sometimes specify that hands or arms were held, or they needed to sit or they were put on to the floor. There are various stages.

Chair: It might just be grabbing hold of them, so to speak.

Dr Heidi Hales: It is to contain.

Chair: But ultimately they might be put on to the floor or forced into a sitting position.

Dr Heidi Hales: Yes.

Q17 **Lord Woolf:** Are jackets put on young people so that they cannot move?

Dr Heidi Hales: Mechanical restraint is a very specific form of restriction, and you need extra permission to be able to use it. There are times when people would think about using it, but it is done in very specific circumstances. The whole thing about restraint, certainly in a hospital setting, is that it is the last resort. We know that it is traumatising to the young people, and indeed to staff.

Chair: Following Harry’s point, leaving aside the training, the objective and the last resort, we are trying to get a sense of what we are actually talking about. When you say mechanical restraint, what does it mean? Presumably, it is not a machine.

Dr Heidi Hales: No. I have not seen it because I have not been on a ward that does it. Sometimes straps are needed. It is a balance to find the least traumatising situation. If a young person has been abused, it is very traumatising to have lots of people crowding over them. Sometimes they prefer—it is care-planned, or they do an advance directive—to have straps, but that is so specific and so rare that it would be very carefully thought about before permission was given.

Chair: We are not at this point inviting you to justify its use; we are just trying to get a sense of the picture. What would happen with the straps? A strap is a strap. What would they be used for?

Dr Heidi Hales: When I have heard about it, it is about stopping a female self-harming who has been abused. It is better than holding her

down because she would feel traumatised. I have not seen it personally. It is not illegal, but it is very rare.

Chair: It is putting straps round somebody. Perhaps I should not ask if you have not seen it.

Dr Heidi Hales: I have not seen it. I know it is called mechanical restraint; I know they are called straps. I know that it has to be care-planned in advance, but I do not know what it actually looks like because I have not used it, and none of my patients has had it.

Q18 **Chair:** Glyn, can I ask you about the same situation? I do not know whether anybody on the Committee has seen restraint or confinement in practice. Perhaps you could help us understand what we are talking about.

Glyn Travis: I will try to give you a pen picture of how a situation arises. Whether we are talking about a young person with mental health issues in a secure ward or a young offender in a secure training centre or a young person's establishment, the principles are very much the same for all settings. Mechanical restraints are used very sparingly in extreme circumstances.

There is a variety of mechanical restraints. There are straight rigid cuffs just like the police use. They are soft leather handcuffs with a rigid bar in the middle. They can be placed on a person who is potentially trying seriously to self-harm. There are body belts. You put somebody in a physical body restraint and secure their arms and body if they are at extreme risk—for example, if they have multiply self-harmed, are constantly pulling out stitches or sutures or are trying to infect wounds following serious harm. That type of scenario arises in extreme circumstances. It is generally done on the authority of a senior medical officer, who says, "We need to protect the health and well-being of the individual".

Q19 **Chair:** We will get on to the circumstances in a minute. You have talked about mechanical restraint. What about non-mechanical restraint?

Glyn Travis: As mechanical restraints, we also use ratchet cuffs similar to those used by the police. To minimise the impact on an extremely violent and fractious young offender, who may be tall, well-built and heavy, sometimes we restrain the individual's arms by placing them behind their back and putting them in rigid handcuffs, very similar to the police. Again, it is very rarely used, but that is the situation.

To control and restrain a young person, the first technique is to assess the individual's risk. Do they pose a risk to themselves, to others, to the good order of the establishment, and/or are they a risk to the building or property? When you have done that, as Heidi said, you always have a minimum of three people. Generally, there would be four people dealing

with the young person: three to deal with the actual restraint, if it is required, and one person to supervise and observe the control and movement of the individual from a place of normal activity to a place of seclusion or a place of their own, such as their room.

We now very rarely take individuals to the floor. We try to put them into a standing, sitting or kneeling position to restrain them. If a person is in a prone position, we bring up their knees and heads in a controlled manner. There is a person on the right arm, a person on the left arm and a person holding the head, so that there are no sudden movements by the individual, with the risk of damage to the brain or neck.

We control the person, get them into a standing position and put them in what we call a guiding hold, if the person is passive. You place the palm of your hand behind the other person and use the wrist and the elbow as a means of restricting movement and controlling the individual, because it is extremely painful if you apply a lot of pressure, especially with young people. That is why we now use minimum methods of restraining, or MMPR. You guide the person or ask them to comply and use a guiding hold, which is basically no pressure whatever, and you walk them back to their own room or to seclusion.

If the person refuses to comply, you apply the minimum amount of force to the area of the wrist. Nowhere else. The pain is only ever inflicted through the back of the hand. You press down. If you would like to demonstrate it yourselves, you put your wrist in this position, as I am indicating, and apply pressure. You will feel pain here, but when you lock the thumb in at the same time, you twist the wrist, so the pain increases. That is what we call restraint of a person's hand. That is how you would restrain an individual and move them from position A to position B in a safe and controlled manner, minimising the risk of pain.

There would be a person on the left arm, a person on the right arm and a person holding the head, guiding the individual all the time, making sure that they can breathe and do not need rest or recuperation at any time, because sometimes it can go on for a considerable time. Then the individual will say, "Stop". The staff say, "Are you going to comply?" If they are using pain as a means of control, they will immediately release the pain and give the individual the opportunity to walk, with guiding holds to prevent them having an outburst of anger or frustration.

Dr Heidi Hales: In hospitals, there is a different process from MMPR, and they do not do the pain bit. There is no pain unless the police come in, in which case they do their type of restraint. Maybe they have more people, but I am not trained to do it.

Q20 **Baroness Hamwee:** Mr Travis, in your written evidence—it may have been you or the association—you said: "When circumstances require restraint to be used, it will fall into one of two categories, either planned or unplanned". Could you explain planned?

Glyn Travis: A planned restraint is when you manage to secure an individual, and locate them in their room or an association room, and there are no other offenders or young people in that area. In a planned intervention, a director or a governor, or the orderly officer—someone in charge of the incident—will select specialist trained staff. They may have to use specific equipment, such as C&R equipment or riot gear, which was used when we experienced the Manchester riot. It is very, very unusual in the case of children, but it is possible if the person is armed. A specific team goes in and uses the force required to maintain and control the individual, restrain the individual and relocate them in a segregation unit, or an exclusion unit in a secure training centre. That is a planned move. An unplanned move is one when a young person who, for no reason whatsoever, decides they will just lie on the floor, disrupt everything and say, “I’m not doing that”. The individuals dealing with that have to respond to the circumstances; they cannot plan because they are in an open environment.

Q21 **Lord Woolf:** Obviously, you take into account the age of the person involved, but in general is there any distinction in the methods used when dealing with an adult and the methods used in dealing with a young person, other than the fact that you do not use more force than necessary in either case?

Glyn Travis: We do not use MMRP with the adult population in the penal system, in the prison system.

Chair: I know you said what MMRP was, but perhaps you would repeat it.

Glyn Travis: It is the minimum management of pain control and restraint. For young children, the Prison Service, the STCs and the YJB—the Youth Justice Board—have developed a new method. It has been in development and used for about eight years for juveniles and young people. We do not put on what we call a full lock restraint. When we are dealing with an adult, the training manual would require you immediately to use force and pain as a means of control. For children and young people, we use restraint without pain as a means of control. Pain is always the last option.

Q22 **Chair:** Is there a lower age limit for these processes? Is there an age limit below which you cannot use it for a child?

Glyn Travis: Generally, we would not use restraint on people under the age of 13.

Chair: Is that just custom and practice, or is it in the rules somewhere?

Glyn Travis: It is not in the rules, but generally for children under the age of 13 restraint is very unusual. It is more a matter of de-escalation, observation, supervision and management. The difficulty you face is that

a 13 year-old may look like an 18 year-old, and an 18 year-old may look like a 10 year-old. We are bound by the parameters of the individuals we deal with in the secure training centres.

Chair: What about in mental health?

Dr Heidi Hales: In hospitals, what is needed depends on the situation and the size of the person. If there is a risk of violence or self-harm, you have to do what is needed in the end to keep everybody safe. If nurses are around when somebody is on a children's ward, it might be needed, but it might be needed less, or fewer people might be around to do it, with a smaller child. In a school, if somebody is doing something, a teacher might just bear with it. It is about what you need to do to de-escalate the situation.

Q23 **Baroness Nicholson of Winterbourne:** Mr Travis, in your experience how long is the inevitable isolation, or lack of association, arising from physical restraint? Is it a shortish period in your experience?

Glyn Travis: The general exclusion period for a person who has been restrained on a one-off occasion would normally be less than six to eight hours. They would normally be restrained and taken to a unit; they would then be seen by a manager. Once the manager is content that the individual will comply, and they have got over the particular grievance, they are returned to their normal room. In the adult estate, it would always be a minimum of 24 hours, but in secure training centres it is always a lot less.

Baroness Nicholson of Winterbourne: For children and young people, would the timing of that lack of association go down on the record?

Glyn Travis: Yes. When a person is removed from their normal living area or their room and they are excluded, whether in a specific exclusion unit, of which currently we have two in the system, or just in a care and resettlement unit, which is a smaller area with one or two rooms where the person is isolated, it will be discussed and there will be interaction with the individual to try to establish what the problem was and then bring them back.

Baroness Nicholson of Winterbourne: Dr Hales, would your colleagues take into account the amount of time away from association when assessing the mental health impact?

Dr Heidi Hales: In the custodial system?

Baroness Nicholson of Winterbourne: Yes, in terms of their mental health.

Dr Heidi Hales: My difficulty is that the hospital and custodial systems are quite different, as are the checks and balances. In the custodial system, we would be concerned about how long somebody was excluded from general interaction because of what it means to that young person.

It is not necessarily when it is acute, but there might be chronic things that lead to longer periods of exclusion, which are more troubling.

Q24 Fiona Bruce: We have had some helpful evidence on the physical arrangements. I want to ask about the impact on young people themselves of restraint and confinement or exclusion. I am addressing the question particularly to Dr Janes and Dr Chisholm. We are interested in the negative impacts but also the positive ones. If you have any medical evidence of those impacts, we are interested in those too. That is quite a comprehensive question.

Dr Laura Janes: I am a lawyer by training. I work at the Howard League for Penal Reform. I am not able to talk about the medical impacts, but I am certainly able to talk about what children tell us, because they contact us directly, quite often in the immediate aftermath of experiencing the use of force. From the records I see and the evidence more widely available, I would struggle to provide you with any positive impacts of the use of force or isolation because I am not aware of any, other than a short period of time-out in the way one might have in a parental context. Perhaps I can give you some examples of things that children have said to us on our advice line. I will give a small selection in relation to the use of force. A 14 year-old from a secure training centre called our advice line in May last year. He reported two incidents of force being used on him. He felt that the officers had switched on their body cameras only at points when it suited them. He said that he had been restrained following a fight with another young person, and he described a member of staff bear-hugging him and putting his hands in a hold.

He went on to describe the use of the wrist movement that Mr Travis was talking about. He said that a member of staff bent his wrist all the way back. He said, "What are you doing to my wrist? It's hurting. Stop that". He said that the staff member then pushed back his wrist even harder. He was taken to his cell and pushed forward on to the floor. The young person told us he suffers from asthma and was having trouble breathing, and he was unable to speak because he was having such trouble with his breathing. That is one fairly typical example of the types of call we get.

In the last year we have had about 20 calls, not all from young people; sometimes they come from concerned parents. For example, in April this year, a mother called on behalf of a 16 year-old white boy in a YOI. She said that her son had asked for a paracetamol and it was refused. The child became frustrated and sprayed some water at the officer and was then restrained. He said it hurt. When she went to see him, she found her son's arm covered in bruises. That is the kind of experience that children describe to us on our advice line.

Dr John Chisholm: I speak as a doctor and I lead for the British Medical Association on matters relating to medical ethics and human rights, but I emphasise that I have no experience personally of working in secure

environments. The BMA's view is that the use of both solitary confinement and restraint can have serious health consequences, both physical and mental. Because of the adverse effect on people's health, the place of solitary confinement and restraint should be minimised in a system that seeks to rehabilitate and to address the problems that led to offending behaviour. As Laura has already said, there is a place for brief periods of segregation in certain circumstances, but not circumstances that would amount to solitary confinement.

As background, you have to realise that people in the youth justice system are usually some of the most disadvantaged and vulnerable in society. They come from a position where they are perhaps more at risk than other people would be. Children and young people are still in the throes of developing, not just physically but socially, psychologically and neurologically. If you isolate them and if you restrain them, it can have negative health effects. The health effects of solitary confinement can include anxiety, depression, aggression, cognitive disturbances and, in the extreme, even paranoia, hallucinations and psychosis. As Laura said, I see lots of negatives but nothing positive.

Restraint can sometimes cause serious physical injury. It can often cause profound psychological distress, which is particularly damaging, as Heidi has already said, if people have pre-existing mental health problems or past histories of physical or sexual abuse. In 2016-17, there were 70 occasions when a young person required medical treatment for an injury resulting from restraint. There were 92 cases where medical warning signs were observed, such as loss of consciousness, a reduction in consciousness, an abrupt cessation of struggling, cyanosis, which means going blue, difficulty breathing, and complaints of nausea or vomiting.

Worryingly—we may come on to this in later questions—the use of restraint seems to be significantly increasing. There is the suggestion, or perhaps implication, that it is being used more on a routine than an exceptional basis, but the use of both solitary confinement and restraint has potentially serious adverse consequences for the health of children and young people.

Q25 Fiona Bruce: Mr Travis, in a sense, of all the members of the panel you are the individual who is there at the moment; you have had practical personal experience of this many times. What do you think are the benefits? We have not heard any.

Glyn Travis: As both doctors have said, there is absolutely no benefit to an individual who is subject to restraint or exclusion. There is none. The benefits are to the other individuals in the area. If a person is excluded, secluded or put into segregation, or restrained, the rationale is to try to ensure that the service provider delivers other specific areas of work. When an individual does not conform, whether because they are being extremely violent at one extreme—self-harming, mutilating, even

attempting suicide in the most tragic circumstances—or simply being disruptive, the whole regime for a group of people can quickly come to a halt because of the staffing levels in the small areas we deal with. That leads to those individuals becoming disruptive.

What Dr Janes has just described is totally unacceptable. As a responsible trade unionist, and a professional person as all those dealing with young people should be, I think those cases should be referred to the police, because it is simply unacceptable. We never condone that. We always say that the methods we are trained in are to do two things: to control, and to minimise injury to the individuals concerned at all times. That is the ultimate aim of every restraint and seclusion.

Dr Heidi Hales: I am a psychiatrist working in both prisons for young people and hospitals for young people. Sometimes I see them at the time of restraint, but I am not involved in that. I see them afterwards and have to do the reviews for seclusion, and I see them in segregation. I have had to think about the effects on them. Conflating hospitals and custodial settings worries me. They have different resourcing and different people on the ground doing the caring. In a hospital, the nursing staff use restraint as the last resort. We hope they are more psychologically trained. It would be good to have more psychological training across the piece.

On very rare occasions, people feel contained if they are stopped from doing something that they know is very bad. A young female who is hurting herself because she is completely emotionally dysregulated will sometimes find it supportive, but you have to be very careful how you do that restraint. In the same way, on occasion, I have seen people in segregation in the custodial system who need a tiny bit of time out and they seem to appreciate that.

That is very different from people being put into solitary confinement for weeks on end. They do not come out and that makes it worse; they are like a caged animal. When they come out, things happen; they get in a worse situation and end up inside for longer. All those things can happen. One has to think about the acute situation. Sometimes, for a few hours, people can find it containing and reassuring to keep themselves safe, and maybe that is what we can do to support them. It is done differently in hospitals from the way it is done in custodial settings. It is a bit more challenging to think about in a longer-term setting.

Dr Laura Janes: Can I come back on the issue of harm and say a little about the impact of isolation, because earlier I only covered restraint?

In relation to harm, the point Mr Travis makes is very important, but something that is not particularly well recognised is the distress caused to other children from witnessing those levels of violence, and being out on the landing knowing that there are other children who cannot come out. I am sure it is also an extremely stressful and harrowing process for the staff involved.

I draw the Committee's attention to the report issued by the Committee for the Prevention of Torture in April 2017, particularly paragraphs 92 to 93. The committee talked to a child at Cookham Wood who had been kept languishing in his cell for a very long time. They talked to a young child about being frustrated. The report noted that staff acknowledged that long lock-up times contributed to the children's sense of frustration, and noticed a negative spiral effect.

In the year to March 2018, we received approximately 40 calls on our advice line from or on behalf of children about being kept in isolation. I will give you two examples to give you a feel for what children are telling us. In November 2017, a 17 year-old black British Caribbean boy detained in a YOI called us to say he had been in a segregation unit for 18 days. He had just been told he would be there another seven days. When we asked him what his regime was like, he described it as "23 hours bang-up, come out for half an hour outside, 15-minute shower, 15-minute phone call, no education even in cell, 30 minutes' exercise, no gym time". We asked whether he had put in a complaint. He said, "I haven't put a complaint in. There's no point. Nothing happens. I know how to do it. I've done it before, and nothing happens".

Dr John Chisholm: A further point about the health consequences of solitary confinement and restraint is the relation to consequent risks of self-harm and suicide. There is an evidential link in respect of solitary confinement. There is an increased risk both of subsequent self-harm and of subsequent suicide.

In relation to restraint, the links have not been definitely shown, but there is some evidence from inquests into the deaths that have occurred in custody of the distress caused as a result of the use of force prior to those people taking their own life. There is certainly a suspicion that restraint is linked to suicide, and there is established evidence that solitary confinement is linked both to self-harm and to suicide.

Q26 Chair: Can I pick up something Glyn mentioned in relation to staffing? Do you suspect that there is greater use of solitary confinement if there is a problem of insufficient staffing levels? Were you implying that, if there are quite low staffing levels, you cannot risk something getting out of control and you have to be more on the front foot on restraint, because once it gets out of control you are up against inadequate staffing levels and you must have a more pro-restraint response? Is that what you were saying?

Glyn Travis: Absolutely. In normal everyday life, anyone who has children knows that a child may become unruly: "Tidy your room". "No, I'm not going to do that". In our homes we can cope with that, because it is an easy setting. We say, "Fine. I'll take your PlayStation off you or I'll prevent you doing certain things".

I was at a secure setting only two weeks ago when a 17 year-old boy who was causing no problems whatever decided to lie down in the middle of an association room while four other activities were going on with five members of staff in the area. The staffing levels were quite reasonable. He chose to lie down and said, "I'm not moving". The reason he was not moving was that his friend had just been restrained and moved from one area to another, so he immediately reacted in support of his friend. He was not doing anything wrong; he just decided to lie down for almost two hours.

For two hours, the other children in that area were prevented from taking part in any form of regime activity. The manager determined that, if at some point the boy did not comply and go back to his room and listen to staff while they tried to de-escalate the situation, they would have to restrain him, remove him from the area and put him back in his room. They did not put him into seclusion; they just put him back in his room for a cooling-down period of perhaps 30 minutes or an hour. Once that had happened, the unit got back into its normal regime, so staffing levels are a really big issue. The Charlie Taylor report has brought forward some positive outcomes in relation to how the service is trying to deal with seclusion or exclusion from areas.

I will not try to paint any other picture of today's method of isolating an individual. Dr Janes said it perfectly: 23 hours of containment in a small room with no access to TV or radio, staring at four walls, is enough to drive anybody stir crazy. What we are looking for in the system, and it is still not sufficient, is that exclusion units, rather than seclusion units, should have a higher number of staff and a lower number of children and offenders so that we can deliver structured regimes while they are in exclusion, which is long overdue.

I completely agree with Dr Chisholm. Seclusion leads to self-harm and potential suicide. It also leads to one of the real problems we see. When a person is in seclusion or exclusion for a long period, they are prevented from engaging in normal activities with their peer group. They are also prevented from accessing unauthorised articles, such as drugs and mobile phones, so their whole life has been quickly pushed into a very small bubble, which has a real impact.

Because we do not have an integration plan, which is a failing of the system, when the individual goes back to their normal routine they are exposed to all the high-risk issues that contribute to self-harm and suicide. I am not sure it is just the seclusion issue. When they go back into the normal regime, they are like a child in a sweet shop. You have had no sweets for a long time and, all of a sudden, you can have anything you want. The whole system is lacking.

Dr Heidi Hales: In a custodial setting, where there are bigger units, an issue is the heat of the unit. Imagine that in the first restraint of the day somebody is assaulted. Staff are taken off sick and have to go to A&E. It is all very traumatising. The next restraint of the day feels much more

heated, and then the next and the next. With smaller units, staff are not exposed to that, and you do not expose young people to the heat of the unit rising and rising. In the Charlie Taylor report, I liked the idea of smaller regional units, which would reduce that risk.

Q27 **Lord Woolf:** Can you give us an impression as to how often, with the best will in the world, you find it necessary to use forcible restraint?

Dr Heidi Hales: When I worked in a custodial setting for young people, as in a YOI—I have not worked in an STC—there was at least one a day, if not more. In hospitals, I have worked in two different secure wards. It is not one a day, but they are much smaller units. I have not worked in a secure children's home, so I do not know about them, but again they are smaller units.

Lord Woolf: When you say at least one a day, what is the range? Obviously, there can be situations where things go wrong.

Dr Heidi Hales: You can have really bad days when you hear the alarm going all the time. In a bigger custodial establishment, if a restraint has already happened when I start work at nine, it has already set everybody on edge. You know that the atmosphere in the unit will be quite troubled anyway by then. It escalates and escalates, especially if there are staff shortages and people have been in their cells for longer. You can have pretty bad days when you feel it is just one alarm after another.

Lord Woolf: Mr Travis, what is your experience of the pattern? Would you say that normally it would happen at least once a day?

Glyn Travis: In secure training centres, you are looking at between six and eight incidents every day.

Dr John Chisholm: The Youth Justice Board collects data on the use of restraint, because there is a requirement to record and report. In 2016-17, there were over 4,600 use-of-force incidents across the youth secure estate.

There are claims by the Government that solitary confinement is not used, because other linguistic terms are used to describe the reality of solitary confinement. The problem in relation to solitary confinement is that there is no requirement to record or report. One of the recommendations that we hope you might be minded to make is to require that data on solitary confinement are collected in the same way as they already are on restraint.

Lord Woolf: Is there any limit to putting people in solitary confinement or its equivalent? What is the time limit, or is there no time limit?

Dr Heidi Hales: There is no time limit.

Dr John Chisholm: None. There have been cases in excess of 80 days.

Dr Laura Janes: There are periodic reviews. Following the Supreme Court case in 2015, some reviews were built in, but there is no longstop time limit in this jurisdiction, although there is in other jurisdictions.

Q28 **Ms Karen Buck:** Laura, I think you said the numbers are going up. Can you give us an indication of the trend in restraint in the youth custody sector?

Dr Laura Janes: The number of children in custody has plummeted; it has reduced by two-thirds. The numbers wholesale seem to have gone down, but, if you look at the incidence of MMPR, the latest data from the Youth Justice Board show that there were over 9,000 incidents of each MMPR technique being used.

Chair: Could you explain the initials? This is a public session.

Dr Laura Janes: Of course. I am very sorry. If you look at the number of times that the restraint technique for children was used in 2016-17, the figure is over 9,000. In 2014, it was 4,500, so that is a huge increase at a time when the child prison population is decreasing.

Ms Karen Buck: There can only be a couple of reasons for a change in the trend: a change in the total number, and we know that the total number is going in the opposite direction; a change in the circumstances or needs of young people; or a change in practice in the institutions.

Dr Heidi Hales: Other people can talk about staffing and similar issues. One suggestion is that we have gone down from nine or 10 young offender institutions to four or five, which end up as quite big houses, with lots of different gangs and the most unsettled young people. We have not diluted the young people there. Each institution has ended up with the same staffing levels, or maybe lower ones because of staffing issues, but staff are dealing with a much more complex, high-need and multi-gang society in those places, with less relational care, although we are trying to improve that with things such as the Secure STAIRS initiative by the NHS.

The difficulty is that you end up with more complexity in each institution. In a smaller unit, staff would be better able to separate the gangs, so that they were not fighting each other if they met each other along the corridor. If you did not have such complexity, you would reduce the problem markedly.

Ms Karen Buck: Glyn, do you agree? I interpret it as meaning that the response to the falling number of young people in custody, which is a good thing, is effectively more than neutralised by a change in the way those young people are contained and managed.

Glyn Travis: The complexity of the needs of young people who are now being detained, in secure training centres or anywhere, has increased tenfold. About three and a half years ago, I visited the person who deals with organised crime in Medway, prior to the exposé about the treatment

of young people, which was not good for anyone. Of the population in Medway, there were 109 gang members from the London area. You have a group of people coming into a secure environment from the child population in the community outside, and there are 109 different gang members we have to control, manage, isolate and deal with, in some extreme circumstances.

Ms Karen Buck: Is gang membership itself the issue, or is it a manifestation of an increasing level of vulnerability in that child population?

Dr Heidi Hales: It sets them up to fail. If two people who are vulnerable in the community are put together and locked up in a situation where they are at risk, you are setting them up to fail. We may have individual care plans for young people in need, and we may be trying to reduce their risk of violence and help them to be calmer and have a different social attitude, but we are putting them in a situation that is much more violent. That is the difficulty.

The Committee suspended for a Division in the Commons.

Chair: Thank you very much for bearing with us. In order that we do not keep you here all night, for the next part of the session perhaps you could just answer the questions directed to you.

Q29 **Baroness Lawrence of Clarendon:** Quite a bit of my question has already been answered. You have talked about the practice of restraining young people. What is the impact on staff when they see children's behaviour? Is it a vicious circle? What is the impact on staff in the prison or the ward of the use of these practices? We have listened to all you have said. Dr Janes referred to BME in the Prison Service. The information we have is that they are more likely to be isolated and to be under restraint. Mr Travis, would you like to say a little more about your experience?

Glyn Travis: The whole system seems to be extremely biased towards BME young people and adults. The prison population is grossly over-represented by BME people. The number of BME people who are restrained is significantly higher than the number of white people. There is no evidence to suggest why that should be so, but it is a worrying trend, and the Lammy report identified some of the key points.

You asked how the use of restraint affects staff. It is very traumatic for staff, because a lot of them are young mums and young fathers who have to deal with young children of their own. No one wants to use restraint unless it is absolutely necessary. Whenever you use control and restraint, whether it is required as a hold or a physical restraint, it is never a pleasant experience. Staff are affected by it, but hopefully changes that come in will reduce the requirement for it, because currently the number of restraints across the whole system is far too high.

By the same token, the number of assaults on staff and on other young children and prisoners is continuing to rise. There is a problem in the system that has to be dealt with. As a trade union, we have been extremely concerned for over 10 years about the disparity in the number of BME prisoners and children subject to restraint and/or imprisonment.

Q30 Baroness Lawrence of Clarendon: You write a report after each incident. Is that given to the governor? Does it have an effect? Do they think, "Let's see how we are treating these individuals separately", because at the end of the day they are just young men and young women in this situation?

Glyn Travis: With the rollout of body-worn cameras across the estate, every incident of restraint is and should be recorded. That is reviewed by a manager who assesses the actions of the individuals who observed and supervised the restraint and movement, and the individuals there. More and more staff are now subject to disciplinary action for lessons learned about the way they restrained an individual.

The paperwork should identify all the key components. Why was the restraint necessary? What actions were taken for de-escalation and preventive measures? The name, date and ethnicity of the individual are recorded. All that data should be captured, and we should be able to evidence how and why situations occur. You cannot get away from the reality that occasionally one individual simply does not want to conform to the regime and the rehabilitation programme being offered. That can be a person from a BME background or a white person, but it should be the exception rather than what seems to be the norm.

Baroness Lawrence of Clarendon: Dr Janes spoke about body-worn cameras that individual officers turned on as and when, so they did not give a full picture of what was happening to an individual in that experience.

Glyn Travis: Under the current policy, whenever an individual fails to comply, the officers concerned should immediately turn on the body-worn cameras and record all the issues. If there are three individuals and a supervising officer, there should be four cameras identifying the issue. If not, it should be part of the lessons learned from that incident, and people should be investigated, questioned and disciplined if they have not complied.

Chair: You mentioned record-keeping. Obviously, record-keeping is very important justification for serious actions such as restraint and confinement. We will be asking to look at some of those records, to get a sense of how the incidents are described, and the adequacy of the records and how they match the circumstances.

Q31 Ms Karen Buck: Laura, before the vote I think you were about to

describe your take on the rising number of restraints. Is your analysis the same as Glyn's?

Dr Laura Janes: I agree with Dr Hales about the risks in large units; in large Prison Service establishments, the heat can rise and it can be very difficult. I am very anxious not to blame the children. We are talking about circumstances that give rise to violence inflicted by adults on vulnerable children. We do not have any objective evidence that children in custody are intrinsically more difficult than they were. It may be that, as the numbers have fallen, the children have stayed the same and there is less of a mix; we just do not have the evidence.

I am sure there are issues about gangs, but I do not think it is appropriate to use that to justify the overuse of restraint or solitary confinement. Quite often, young people and children tell me when they are talking about gangs that they are not in a gang in the community, but, when they come into prison, they are asked where they are from and they feel they need to be part of it. If you scratch the surface, it is not really an issue; it can be dealt with. It is about culture and relationships, and it is important for staff to have the time to work through these things with children, and a diversity of staff able to do that is also very important.

Ms Karen Buck: We have been talking about the trend in the total numbers compared with the falling population in detention. What is the balance between planned and unplanned restraints, as you understand it? What is the trend in that?

Glyn Travis: I would say that 95% of incidents are unplanned and 5% are planned. That is where the balance is wrong.

Ms Karen Buck: Has that changed over time?

Glyn Travis: No.

Ms Karen Buck: You would not say it is affected by changes in staffing, the nature of the estate or anything of that kind.

Glyn Travis: It has been a consistent problem for a very long time. Staff react by intervention, following de-escalation or whatever, and sometimes it is unnecessary. The chief inspector's reports identify a disproportionate number of unplanned responses and restraints compared with planned ones. This is not an excuse; it is the reality of lack of staff. Rather than trying to contain and then restrain, we simply opt for unplanned restraint, and that can often lead, although not so much with young children, to a disproportionate number when you look at the overall picture.

Q32 **Ms Karen Buck:** You may not be able to answer this. Do you think it has resulted in a change in the use of restraint or behaviour management—I am trying to remember the words you used—as opposed to a risk situation? From the evidence you have given,

there will always be some potential for a risk-based use of restraint or confinement when there is danger to self or others, but you have described it as being used on occasions to manage a situation and a group.

Glyn Travis: All too often, individuals use a situation where it is very simple to disrupt and exploit the position they find themselves in. I am sure we have all seen very young children lying on the floor, or stamping their feet, shouting and screaming. You leave them alone for five minutes, and they think nobody is paying attention to them so they carry on playing. Individuals in secure youth training centres use that situation. In an ideal world, if we had the resources, we would be able to contain the situation simply by saying, "That's fine, I'll pull up a chair and sit and talk to you all day", and we would never need to restrain or move an individual.

Ms Karen Buck: If that was the case, you would have expected it to be reflected in the use of restraint five or six years ago when there was a significantly larger prison officer resource.

Glyn Travis: Yes.

Ms Karen Buck: That is the fact, is it?

Glyn Travis: That is the fact. An awful lot of the time restraint is used as a means to bring normality to the regime of the establishment. If somebody was sitting on this table, it would be classed as an incident at height. If I stood on the table now, doing nothing wrong at all, it would be classed as an incident at height. Because I am standing on the table and there is a risk of harm to myself and others—I do not know who the others are—it requires that entire area of the prison to be locked down. Everybody has to be locked away. Specialist units have to be deployed and brought in from the national centres to say, "Are you going to come down?" If the individual says, "No, I'm going to stay here", it can disrupt a prison for between six and 24 hours.

Ms Karen Buck: Are you saying that five or six years ago, when the ratio of staff to detainees was different, that incident would have been handled without restraint?

Glyn Travis: Yes.

Chair: A lot of the points Harry was going to ask have already been dealt with, so shall we go to Sally's question about remedy and challenge?

Q33 **Baroness Hamwee:** It is about challenge, and I guess it is different in the two settings. The question is whether a child in prison or on a mental health ward can challenge a decision either to restrain or to confine. How do they do it? Apart from your helpline, where you find the sort of complaint that you have already described to us, what formal routes are there?

Dr Laura Janes: There is an internal complaints procedure. Mr Travis may want to say more about that. In young offender institutions, it is identical to the adult system. You fill in a form. You go through a first stage, and there are five days to respond.

Chair: Do they know how to complain? How do they know whether they can do all this filling-in of forms?

Dr Laura Janes: That is a major issue. In theory, as part of the induction process, children are told how to complain, but in my experience there are a number of issues that prevent children complaining. A lot of them struggle with writing. As in the case study earlier, there is simply no point because it will not go anywhere; it will not make any difference. The Prisons and Probation Ombudsman has said that, although children and young people account for 1% of the prison population, they represent only about 0.1% of the complaints that reach the ombudsman.

It is an old-fashioned written complaints system that goes through a first and second level internally, and then complaints can go to the Prisons and Probation Ombudsman. Rarely do they get to the Prisons and Probation Ombudsman because quite often children give up. In many instances, where I or my team at the Howard League have assisted children to complain, they are out of custody by the time the ombudsman gets to it, and often it will be the word of the adult prison officer against that of the child.

Q34 **Baroness Hamwee:** How do they know to contact you? As well as being told that there is a complaints system, are they given information about an advocate for them, or assistance in that situation?

Dr Laura Janes: There is an advocacy contract, run by Barnardo's, throughout secure training centres and young offender institutions. There are one or two advocates per establishment who try to see the young people and let them know about their rights; sometimes, they also explain their legal rights. But that is one or two advocates, sometimes working only a few days a week, for more than 150 children. Although they are an important presence, there is not necessarily a strong rights-based culture in my experience. Children not only need the information; they often need encouragement to complain. I suspect that the calls that get through to the Howard League are very much the tip of the iceberg.

Dr Heidi Hales: When I was working in a custody setting, one of the good things was that multiple agencies were working there. You hope you are not a total institution; you have people going in with fresh eyes who can say, "I'm not part of the prison establishment. I'm here for your health or for your education or to do advocacy, to work with you about what you want and how to do it". That is a very good thing, but it can pit the agencies against each other in incidents such as these.

I used to send lots of people to Laura at the Howard League and say, "Why don't you make a phone call if you want?" I think that is one of the reasons why the Royal College of Psychiatrists is so much in favour of a BMA document about it, or of asking for support in this place. If you are one of the external agencies going into a custodial setting, which is not necessarily the way you have been trained, or it is not your moral disposition or way of working, and you want to improve the situation for the people there and look after their health and education, it is easier to do that if there is understanding of that role and support for it, because it can be very tiring to push for that kind of thing all the time.

Glyn Travis: The complaints system is there, but the culture in the custodial population, from young children through to adults, is, "Why bother, because nothing will happen? Will I be seen to be soft if I complain rather than just toughing it out?" The facility is there, but the means to access it, and giving individuals confidence to use it, are significantly failing.

Baroness Hamwee: If I were to go back one step and ask whether young people in either of the two situations always know that it is appropriate to complain and have a right to complain that the treatment is inappropriate, you will say that they do not even get to square one.

Dr Heidi Hales: In hospitals, the legal setting is different. Somebody will sit down with them to explain their rights once a month, so they know that bit. The advocates visit the wards regularly and make themselves accessible. The units are smaller, because they are based on health and psychological well-being. The system is rights-based under the Mental Health Act. We try to work to that, but it is not possible in a big custodial setting. People are much more disempowered in the custodial setting, whereas in a hospital setting the whole drive is to try to empower people, because that is what recovery is.

Q35 **Baroness Lawrence of Clarendon:** Would there be a backlash for individuals who put in complaints? They feel that nothing will happen anyway and there is no point in complaining, but is the other side of it that if they complain about individual officers there is a backlash?

Dr Laura Janes: Certainly, in my experience some young people fear that. I have come across young people who said that officers told them that if they put in another complaint, or contact the Howard League, they will get into trouble. I am not saying that is routine; it is clearly not policy, but it is a fear. There is an inherent power imbalance, where young people see the law and procedural fairness as something that works against them quite often.

Baroness Lawrence of Clarendon: It is about the power structure and who holds the power.

Dr Laura Janes: Yes.

Glyn Travis: One of the things that has been lost in the service is that probably 10 years ago we had more visible leadership in the uniformed ranks, so when a young person was in a secure setting they would be able to recognise a senior manager in uniform, go to that person and have more confidence, whereas now visible leadership in the uniformed structure and day-to-day interaction has been watered down.

Chair: Are you talking about visibility to the young person or to junior staff?

Glyn Travis: Visibility to the young person. Years ago, they would say, "I'm going to see the principal officer or the ward manager". They knew that person was there and that, if they went with a complaint, it had to be justified and validated; otherwise, they would get short shrift. They had confidence. They did not have to write out the complaint. If they were struggling to read or write, there was someone they could go to and say, "Excuse me, sir. Have you got five minutes?"

That interaction with young people has been lost, and it is a large part of the reason why complaints are not progressed as well as they should be. I am not saying the complaints are justified, but at least an individual should have a right to say, "I'm not happy with what's going on and what's happening, and I need somebody there". The lack of senior uniformed management in areas has created a lull in how complaints are progressed.

Dr Heidi Hales: If we are talking about rehabilitation, as we should be, this is the last resort; the aim is not to get to restraint, seclusion or solitary confinement. If we want to improve the lives of young people in this setting, or stop them getting into it, the more empowerment they have and the more pro-social modelling you do, the better it is.

A complaint could be a good opportunity to show good adult behaviour in how to resolve a situation and think it through. You could use that for the benefit of a treatment or rehabilitation package. The request would be to have a driver to make sure that we use such opportunities. Nobody will ever be perfect, but if you show that you can admit your imperfection, learn from it and change, and work with the young person to help them think it through, it will also help them to think about it when those situations arise.

Baroness Hamwee: I absolutely take that point. If a young person is segregated for 23 hours, does that require a written form to complain about it? Surely, it is escalated within the officer structure.

Glyn Travis: Segregation of that nature is dealt with by a governor or a director. They determine whether that level of segregation is required. It would never be decided at officer level; it is always done by senior management based on information and reports and behavioural patterns. Some of the lengthy periods of segregation of young children are astounding.

In today's society, unless someone is extremely violent or at great risk of self-harm, seclusion is not the right method. We need a plan that deals with the individual in a managed process. To manage somebody simply by closing the door and leaving them is of no benefit to anybody. I have never come across anybody working in a custodial setting who welcomes that strategy. We would sooner have a means of interacting with the individual to try to get them back to a normal location and the mainstream population, so that they do not feel as though they have to prove themselves, which is often a consequence of segregation.

Dr John Chisholm: From the available data, perhaps one in three detained children will spend time in solitary confinement. The duration of confinement can be as long as 80 days. The average appears to be of the order of eight days. That is really significant. That is not a short period of separation to deal with a particular incident until things have calmed down. In some cases, it seems to be used as punishment, which is counterproductive. It damages the health of the individual, and then, when they come out of solitary confinement, that too can create trouble.

Dr Laura Janes: You asked about the opportunity to make representations or to complain. It is supposed to be built into the isolation process before a child is removed from association. Over a decade ago, there was a case in the High Court called SP. The ruling in that case was that children were to have an opportunity to make representations before it happened. I have never known that to happen. Children do not know about it, and I am afraid that often members of staff do not know about it.

Q36 Lord Woolf: From what I am hearing from you, there seems to be great deterioration in the position that existed when I was involved in the Strangeways inquiry, with a breakdown in relationships between staff and inmates. Is the fact that you have bigger units part of the problem, in that they do not enable the building of relationships, which are important, so that young people have trust in the people looking after them, and vice versa?

Glyn Travis: The interaction between staff and young person or staff and prisoner, depending on age, has definitely deteriorated over the last 10 to 15 years. In the Government's drive for prison reform under the White Paper and in how we address rehabilitation, quality time with an offender of any age has certainly gone. Staff report to us that they do not have time to sit down and have a conversation with a young person and say, "What's your problem? What's going on?" It is like a non-stop escalator. You get on and you go up and down; there is constant movement. The Taylor report and the work in the juvenile area mean that there are some benefits coming, but they need to be reinforced to deal with the issue. It is not always about having more staff; it is about having more time with people. If you only have four people but you can spend 10 or 15

minutes with a small group, you can understand what the problems are. Drugs—NPS—in all settings are a real problem. We just do not have the time to understand where the problem is and how it is coming. You are absolutely right, Lord Woolf; that is where the real problem lies.

Dr John Chisholm: We recurrently talk about problems with staffing, resources and culture. It is very worrying that the annual report of the Chief Inspector of Prisons in 2016-17 concluded that in the youth custody estate not a single establishment was inspected where it was safe to hold children and young people. That is an appalling indictment from the chief inspector. We hope that you will note that, and argue that there has to be a serious look at the youth custody system to address the issues. Staffing and resources are inevitably part of the answer.

Lord Woolf: In larger units, it is more difficult to have the sort of relationships that you referred to. In small units, even in a big establishment divided into smaller units, you can build up those relationships.

Dr Heidi Hales: There is definitely a need for smaller units. The difficulty with a large establishment that has smaller units, certainly from my experience of working in two YOIs, is that the alarms ring everywhere. To say that it was entertainment sounds horrible, but the young people knew more about what was happening in the institution than I did. They knew who was coming, who was going, who was in segregation, who had just been restrained, even if it was on a different wing, who had been assaulted, or who was going to do the assault because it was shouted out of the windows during the night, and who had self-harmed, which was my particular research when I was younger. That in itself is quite damaging for young people. If you can have relational contact between people in smaller units, that is absolutely fantastic, but in bigger buildings you have to think about noise pollution.

I might be wrong about this, but I think there was a moment after the Mubarek inquiry when people tried to be really humane, and there was a desire to think much more about rehabilitation. Things calmed down, but then they changed. Clinically, my experience is that things were quite difficult, then a terrible tragedy happened and there was an attempt to bring about a sea change in how people were treated in YOIs, but then things changed and became harsher. I might be wrong. You would have to look at the numbers to see if that was the case.

Chair: Thank you very much indeed. As people who work in the field, you have given us really good insight into what is happening and have left us in no doubt of the importance of the focus of our inquiry. We will be talking to the Ministers responsible in September, and taking forward the points you have made.

We are very concerned always to hear from people whose human rights are at issue—the unmediated voice—and the people who are working for and with them. We might ask you to help us with that, and perhaps we can approach Barnardo's as well, so that we can

have in the public domain first-hand evidence of what it is actually like from the point of view of the young person who is undergoing restraint and confinement and, as we are all hoping, achieving rehabilitation, and how they see the complaints system. We may ask you to help us find a way to do that. Thank you very much indeed. This has been a very useful evidence session.