Formulating an ethical, therapeutic, and safer approach to managing challenging and violent behaviours: a critical review of policy, guidance, law, research, and experience

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For safer and more humane services

Good staff know how to restrain;

Better staff know when to restrain;

The best staff know when not to restrain.

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List of Abbreviations

ABD	Acute Behavioural Disturbance
ACLU	American Civil Liberties Union
AMCP	Approved Mental Capacity Professionals
BAME	Black, Asian, and Minority Ethnic
BIA	Best Interest Assessors
BLM	Black Lives Matter
BSDGB	British Self Defence Governing Body
BVC	Brøset violence checklist
CAMHS	Children and Adolescent Mental Health Services
CB	Continuous Breathing
CCGs	Clinical Commissioning Groups
CPT	European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
CQC	Care Quality Commission
CRED	Commission on Race and Ethnic Disparities
CTO	Community Treatment Order
DASA	Dynamic appraisal of situational aggression
DoLS	Deprivation of Liberty Safeguards
ECHR	European Convention on Human Rights
ExD	Excited Delirium
FRC	Functional Residual Capacity
ICS	Integrated Care Systems
LPS	Liberty Protection Safeguard Scheme
MHA	Mental Health Act
MHU Act	Mental Health Units (Use of Force) Act
MoU	Memorandum of Understanding
NAACP	The National Association for the Advancement of Colored People
NASMHPD	National Association of State Mental Health Program Directors
NFPS	National Federation for Personal Safety

NHS	National Health Service
NICE	National Institute for Health and Care Excellence
OCF	Organisational Competence Framework
OCTET	Oxford Community Treatment Order Evaluation
OHS	Occupational Health and Safety
PCREF	Patient and Carers Race Equalities Framework
PFD	Prevent Future Deaths
PICU	Psychiatric Intensive Care Units
PIPE	Psychologically Informed Planned Environments
PMVA	Prevention and Management of Violence and Aggression
RCN	Royal College of Nursing
RFB	Reduced Frequency Breathing
RRN	Restraint Reduction Network
RTC	Randomised Control Trial
SOAD	Second Opinion Appointed Doctor
STAMP	Supporting treatment and appropriate medication in paediatrics.
STOMP	Stopping over-medication of people with a learning disability, autism, or both with psychotropic medicines.
SUDEP	Sudden Unexpected Deaths in Epilepsy
UNCRC	United Nations Convention on the Rights of the Child
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
VAAoCB	Violence, aggression, agitation, and other challenging behaviours
VPRS	Violence Prevention and Reduction Standard
YCB	Youth Justice Board

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I first attended LJMU as a law student back in 1994. Progressing with a first-class honours law degree and a master's degree with distinction, completing this professional doctorate perfects an academic hattrick of hard work and dedication to learning.

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Abstract

Violence, aggression, agitation, and other challenging behaviours ("VAAoCB") remain significant causes for concern across many settings in society. Those working within healthcare (especially mental health and learning disability), criminal justice and security are particularly affected. Hardly a day goes by without reading about VAAoCB with countries around the world managing the problem in different ways. Even within the UK, there is a lack of anything approaching a coherent approach to enhancing the safety of people exhibiting these behaviours or of those who have a legal duty to look after them. Education and training have largely moved away from a robust hands-on approach where staff were taught how to defend themselves to an approach where the safety and interests of the subject appear to take priority.

A significant change in legislation was recently brought about following the tragic death of a mental health patient. The Mental Health Units (Use of Force) Act 2018 followed the death of Mr Olaseni Lewis, who died on 4 September 2010 after he was restrained by 11 police officers at a mental health ward in Bethlem Royal Hospital, Beckenham. Given that Mr Lewis was restrained by police officers (and not by hospital staff), and the force used on him was described at his Inquest as *"excessive, unreasonable and disproportionate"*, it is surprising that the only significant requirement imposed on police officers by the 2018 Act is contained in section 12 and relates to the wearing and operation of body cameras, which is something police officers had been doing for many years. The remainder of the Act relates to the oversight and management of the use of force by hospital staff but says very little about safe or unsafe restraint practises operationally. This is very disappointing and a significant missed opportunity to improve safety especially since the *Right Care, Right Person National Partnership Agreement* (2023) has been introduced with the aim of minimising police involvement with people with mental ill-health. The natural consequence of this radical change to policing support is that organisations must have clear policies and strategies in place to ensure they have the necessary capability, competence and capacity to deal with incidents of violence and aggression from persons suffering from mental ill-health without needing police assistance. The 2018 Act provided an ideal opportunity to lay down the requirements for hospital staff when managing violence and aggression from mentally unwell patients but failed to do so. Instead, other organisations, and guidance, have imposed prohibitions and restrictions on what staff can do to manage violence and aggression in as safe a manner as possible, although many of these requirements are unworkable and unsafe.

This thesis will critically examine the multitude of issues involved in this area and will seek to formulate an ethical, therapeutic, and safer approach to managing challenging and violent behaviours.

Declaration of Original Work

Declaration by Candidate:

I herewith confirm that no portion of this original thesis has been submitted previously in support of an application for another degree or qualification of this or any other university or institute of learning.

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Date: 30 July 2024

CHAPTER ONE: INTRODUCTION

1.1 Introduction

Violence, aggression, agitation, and other challenging behaviours ("VAAoCB") remain significant causes for concern across many settings in society. Those working within healthcare (especially mental health and learning disability), criminal justice and security are particularly affected. Hardly a day goes by without reading about VAAoCB with countries around the world managing the problem in different ways.

Within healthcare in the UK, the extent of the problem can be seen from the most recent National Health Service ("NHS") staff survey (NHS, 2023), which produced 636,348 responses from 264 NHS organisations, including all 215 trusts in England. The survey found that 14.7% of NHS staff experienced at least one incident of physical violence from patients, service users, their relatives or other members of the public in the previous 12 months (2022: 15.1%: 2021: 14.4%, 2020: 14.8%, 2019: 15.2%, 2018: 14.9%). The same survey reported that in the ambulance sector, paramedics have experienced a significantly higher volume of abuse (31.4%). The impact on staff is significant, with violent attacks contributing to 46.8% of staff feeling unwell as a result of work-related stress in the last 12 months, with 31.1% said thinking about leaving the organisation (NHS, 2023).

The highly controversial decision to decommission NHS Protect's Security Management Functions from April 2017 saw the end of NHS ownership and control of the Accredited Security Management Specialist training courses previously provided to Local Security Management Specialists. This also meant that the requirement for NHS Trusts to employ Accredited Security Management Specialists/Local Security Management Specialists also came to an end. This apparent lack of commitment to a nationally-led and coordinated approach to managing violence and aggression can also be seen from the removal from the 2022-2023 NHS Standard Contract of any form of security requirement other than counter fraud.[1] Instead, providers are simply required to *"have regard to"* the NHS Violence Prevention and Reduction Standard ("VPRS").[2] Published in January 2021, the VPRS complements existing health and

[1] Service Condition 24. This can be compared to Service Condition 24 from the 2016-2017 contract which required the provider to *"put in place and maintain appropriate arrangements to address security management and counter-fraud issues, having regard to NHS Protect Standards"*. The 2019-2020 contract required the provider to *"put in place and maintain appropriate arrangements to address […] security management issues, having regard to NHS Security Management Standards"*.

[2] General Conditions, clause 5.9. For the VPRS see https://www.england.nhs.uk/wp-content/uploads/2020/12/B0319-Violence-Prevention-Reduction-Standards.pdf [Accessed 27 July 2024].

safety legislation and delivers a risk-based framework that supports a safe and secure working environment for NHS staff, safeguarding them against abuse, aggression and violence. In addition to the VPRS, NHS England and NHS Improvement published on 13 June 2022 a *National Violence Prevention and Reduction Guidance* document to support trusts further in working through the VPRS's aims and requirements.

Further, in October 2023 NHS England announced its intention to establish a new set of security management standards for healthcare which will be mandated through the NHS England Standard Contract. This is not the first time that security management standards have been mooted and this latest initiative appears to be at a very early stage.

The NHS 'Long Term Plan' (www.longtermplan.nhs.uk) and NHS England's 'People Promise' (www.england.nhs.uk/ournhspeople/online-version/lfaop/our-nhs-people-promise) both demonstrate a commitment to the health and wellbeing of NHS colleagues, recognising the negative impact that poor staff health and wellbeing can have on patient care. As already observed, violence and abuse toward NHS staff are just two of the many factors that can have a devastating and lasting impact on health and wellbeing.

Legislation, regulations, and guidance have continued to evolve, some of which are contradictory and will be reviewed throughout this thesis. Most recently, the Mental Health Units (Use of Force) Act 2018 ("the MHU Act") came into force on 31 March 2022 which, given its brevity and vagueness, must be read alongside its Statutory Guidance which was published on 7 December 2021. Despite its good intentions in reducing the amount of restrictive interventions in connection with mental health inpatient units, the MHU Act has not been universally welcomed with one of the UK's leading training providers, the National Federation for Personal Safety, refusing to adopt its principles, describing them as *"unhelpful"* (https://nfps.info/?s=bild).

Finally, following an initial Humberside Police initiative, *'Right Care, Right Person'*, the Metropolitan Police announced that unless there is an immediate threat to life, Metropolitan Police officers will no longer attend mental health incidents after 31 August 2023 (Metropolitan Police, 2023). This was followed by the *Right Care, Right Person National Partnership Agreement* (2023), initially published on 26 July 2023, and which was agreed with government, police and NHS England, with the aim of reducing the 'inappropriate and avoidable' involvement of police in responding to incidents involving people suffering from mental ill-health. Under the Agreement, the threshold for a police response to mental-health related

incident is (a) to investigate a crime that has occurred or is occurring or (b) to protect people, when there is a real and immediate risk to the life of a person, or of a person being subject to or at risk of serious harm. When it comes to police powers under section 136 of the Mental Health Act 1983 ("MHA"), the decision to attend an incident will be determined by the threshold and the decision to use section 136 will be made by an officer at the scene of the incident. Police attendance at section 135 warrants will need to be pre-planned and subject to local partnership arrangements.

The natural consequence of this radical change to policing support is that organisations must have clear policies and strategies in place to ensure they have the necessary capability, competence and capacity to deal with incidents of mental ill-health without needing external support.

In addition to harm to patients, violence causes both short- and long- term physical and psychological harm to staff and has been linked to burnout (Galián-Muñoz, *et al.*, 2014), decreased productivity, increased absenteeism (Gates, *et al.,* 2003), and interrupted patient care (Roche, *et al.,* 2010).

Other settings, such as the prison and police services, experience similar concerns associated with violence and aggression. In the year ending March 2023, there were almost 37,000 assaults on police officers in England and Wales, including British Transport Police (National Statistics, 2023). 25,734 were crimes of *"assault without injury on a constable"* recorded across all forces. This is an increase of 21% compared with 21,321 in the previous year. 11,235 crimes of *"assault with injury on a constable"*[3] recorded across all forces (including British Transport Police) which is a small increase of 1.2% compared with 11,106 similar assaults in the previous year. There were 7,957 assaults on prison staff in the 12 months to December 2022, almost unchanged from the previous 12 months, showing a 0.4% decrease (Safety in Custody Statistics, 2023).

This thesis will focus on healthcare settings, although reference will also be made to other settings either where reasonable comparisons are possible or where valuable cross-sector learning opportunities are present. The reason for the main focus being on healthcare is because this sector, and especially mental healthcare and learning disability settings, has been

[3] The crime code of "assault with injury on a constable" was introduced in April 2017. Previously there was no corresponding crime classification for this category of assault. Instead, they were recorded under the relevant offence classification, such as "violence with injury".

responsible for significant change brought about by new legislation, policies and guidance documents, mandatory accreditation, as well as featuring in many of the untoward incidents that have triggered these changes.

In adult psychiatric establishments, the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) pays particular attention to the use of various types of restraint with psychiatric patients. It emphasises that the ultimate goal should always be *"to prevent the use of means of restraint by limiting as far as possible their frequency and duration"* (CPT, 2017). In this regard, the CPT guidance is no different to that provided for the use of restraint in any other setting and the principles explained in paragraphs 1.2 and 1.3 that *"Means of restraint should always be applied in accordance with the principles of legality, necessity, proportionality and accountability. All types of restraint and the criteria for their use should be regulated by law"* mirrors that used by many organisations typically using the acronym PLAN as an aide memoir (Proportionate, Legal, Accountable and Necessary). The CPT goes further in paragraph 2 and requires that every resort to restraint should be expressly ordered by a doctor after an individual assessment or immediately brought to the attention of a doctor with a view to seeking their approval. This means that blanket authorisations are not acceptable. Furthermore, the CPT expressly prohibits the use of neck holds and techniques that may obstruct a patient's airways or inflict pain (paragraph 3.2). These techniques will be discussed in Chapter 8.

Much of the legal position is straightforward. Employers are under a legal duty *"to ensure, so far as is reasonably practicable, the health, safety and welfare at work of all his employees"* (Health and Safety at Work Act 1974, section 2(1)). This duty can arise in a number of different ways including violence towards staff and violence from patients or those in custody to other patients or fellow prisoners.[4] This duty includes the provision of systems of work that are, so far as is reasonably practicable, safe and without risks to health (section 2(2)(a)); the provision of such information, instruction, training and supervision as is necessary to ensure, so far as is reasonably practicable, the health and safety at work of his employees (section 2(2)(c)); and the provision and maintenance of a working environment for his employees that is, so far as is reasonably practicable, safe, without risks to health, and adequate as regards facilities and arrangements for their welfare at work (section 2(2)(e)). The Health and Safety at Work Act

[4] Beyond providing examples of the different ways in which a duty of care might arise, this thesis will not deal specifically with the duty to prevent violence by one patient or prisoner to other patients or prisoners.

(1974) will be discussed (together with a review of other relevant legislation) in Appendix 1 but, for present purposes, the requirement under section 2(2)(c) for the employer to provide training to his employees will be considered.

The law is clear that where there exists a risk of violence and aggression, organisations need to provide appropriate training to staff, although what amounts to appropriate training remains confused and inconsistently applied. Consequently, staff in many organisations are unable to respond to the consequences of violence and aggression, either appropriately or safely. This frequently results in police being summoned to deal with violence and aggression, including requests for police to restrain patients in order for staff to administer intravenous rapid tranquilisation or other medication. This presents a significant issue for police resources and, in addition, frequent criticism from staff that the police are too heavy-handed when they do restrain these patients. This is an unfair criticism because the training provided to police officers in dealing with violence and aggression is significantly different to the training that is deemed appropriate for healthcare staff. Furthermore, restraining a patient for the purpose of administering medication is not a policing matter. As a result, in addition to the *Right Care, Right Person National Partnership Agreement* (2023) discussed above, in 2017 the College of Policing published a Memorandum of Understanding: '*The Police Use of Restraint in Mental Health & Learning Disability Settings'*, which provides clarity on the role of the police service in responding to incidents within mental health and learning disability settings. The Author was a member of the College of Policing working group that developed the Memorandum and led the workstream on the use of force. The intention of the Memorandum was to outline when and how the responsibilities of the police service fit into the established roles and responsibilities of care providers and is one of the objectives set out in the national Crisis Care Concordat action plan. It also builds upon the 2014 Department of Health's '*Positive and Proactive Care'* programme aimed at reducing restraint and restrictive practices in mental health settings. These need to be read alongside the *Right Care, Right Person National Partnership Agreement* (2023) referred to above.

It is, of course, obvious that requests for police assistance can only sensibly be reduced if appropriate training in the prevention and management of violence and aggression is provided to staff whose work brings them into contact with patients where there exists a risk of violent and aggressive behaviour. However, this task is complicated by the fact that a standard approach to such training has never been implemented despite frequent and almost universal demands for this to happen (e.g. Royal College of Nursing, 2013). Neither is there an agreed

template as to what such training should consist of. Accordingly, there is no single model of training that is universally considered "appropriate". Consequently, it is not uncommon for staff to back off in fear or to lose control of an incident and to call the police to manage the incident and/or to restore order. The vicious cycle is self-evident.

A significant change in legislation was recently brought about by the tragic death from restraint of a mental health patient. Commonly referred to as *'Seni's Law'*, the Mental Health Units (Use of Force) Act 2018 ("MHU Act") started its life as a Private Members' Bill sponsored by Mr Steve Reed MP, and was inspired by the death of Mr Olaseni Lewis, who died on 4 September 2010, aged 23, after he was restrained by 11 police officers at a mental health ward in Bethlem Royal Hospital, Beckenham. At an inquest into Mr Lewis's death in 2017, the restraints which had been used were deemed to be *"excessive, unreasonable and disproportionate"* whilst the actions of healthcare staff and police were condemned (Lynch, 2017). Although the MHU Act received Royal Assent in November 2018, the key provisions of the statute only came into effect on 31 March 2022.[5]

A key purpose of the MHU Act (2018) is to increase the oversight and management of the use of force in mental health units by imposing numerous requirements around the use of force in such units. Section 12 imposes a requirement for police officers attending these units to wear and operate body-worn cameras if reasonably practicable although there is no corresponding requirement for medical staff and others to do likewise. This is particularly disappointing since the majority of uses of force will be carried out otherwise than by police officers. The MHU Act also places positive obligations on such units to provide policies, information, and training in the "appropriate use of force" and to provide techniques for avoiding or reducing the use of force (section 5). Curiously, the MHU Act seeks to regulate the use of force by staff working in mental health units notwithstanding that Olaseni Lewis died following restraint by police officers. The MHU Act uses the word "*appropriate*" to qualify any use of force although it fails to set out what might be considered appropriate. This is particularly disappointing given the wide range of physical techniques taught to staff, some of which are unsafe and ineffective. Even the accompanying statutory guidance, published on 7 December 2021, fails to clarify what is meant by appropriate use of force, preferring instead to set out what that training should cover. Regrettably, it doesn't set out the physical skills that might be appropriate or those that

[5] the following provisions were already in force: section 11(3) (consultation on guidance) which came into force on 28/10/19, and sections 16 (regulations) and 17 (commencement, extent and short title) which came into force on 1/11/18.

might be inappropriate. This exposes a serious lacuna in the legislation and accompanying statutory guidance, especially given that it is often the use of inappropriate restraint techniques that are responsible for the death or injury of the person restrained. It is also worrying because the statutory guidance sets out that *"NHS England and NHS Improvement commissioners will need to assure themselves that organisations or trusts [...] reduce risk and minimise any inappropriate or disproportionate use of force"*.

The Care Quality Commission (CQC), which inspects healthcare organisations, will have regard to the MHU Act and statutory guidance when considering whether providers meet its regulatory requirements. In addition, commissioners will look to ensure that the services they commission are consistent with it. The CQC will seek confirmation that the physical skills used are appropriate despite the fact that it does not have a list of approved restraint techniques or systems of restraint or that its inspectors do not receive training about the appropriateness of restraint training (Care Quality Commission 2020a). The statutory guidance also explains that organisation and trust policies should include a commitment to minimising the use of force and eliminating the inappropriate use of force, setting out what action the organisation or trust will take if the inappropriate or disproportionate use of force is identified. It is difficult to see how this can be achieved in the absence of guidance as to what might be considered to be an appropriate use of force.

On 3 December 2018, the CQC announced a review into the use of restraint, prolonged seclusion and segregation for people with mental health problems, learning disability and/or autism (Care Quality Commission, 2018). The review, commissioned by the then Secretary of State for Health and Social Care, Matt Hancock, was in two phases: phase 1 explores the use of restraint, prolonged seclusion and segregation in mental health wards for children and young people and in wards for people with a learning disability and/or autism. Phase 2 explores the use of prolonged seclusion and segregation in mental health rehabilitation and low secure wards and restrictive practices in social care homes for adults with a learning disability and/or autism, children's residential services and the 13 secure children's homes in England (in partnership with Ofsted).

The CQC reported its interim findings in May 2019 (Care Quality Commission, 2019) with the final report published in October 2020 (Care Quality Commission, 2020). In its interim report, *'Segregation in mental health wards for children and young people and in wards for people with a learning disability or autism'*, the CQC presented its initial findings on the use of long-

term segregation on mental health wards for children and young people and wards for people with a learning disability and/or autism. For the purpose of this review, the CQC defined long-term segregation as *"Nursing or caring for a person in enforced isolation, regardless of whether the procedures and requirements of the MHA Code of Practice 2015 for long term segregation are met. The enforced isolation must have been in place for 48 hours or more. It should still be considered segregation even if the patient is allowed periods of interaction with staff and or peers."* (Care Quality Commission, 2018).

This definition differs slightly from the definition given in the Mental Health Act Code of Practice (2015) which defines long-term segregation as: *"a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and representative from the responsible commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis"* (Mental Health Act Code of Practice, 2015, para 26.150). As well as being segregated, many of the people visited by the CQC were subject to other restrictive practices including physical restraint which was used when staff deemed their behaviour to be endangering to themselves or others.

The CQC's interim findings were based on returns from an information request sent to 89 registered providers of these services and was confined to those people who were held in long-term segregation. These providers reported that there were 62 people who were held in segregation, of whom 16 had been segregated for at least 12 months. During the review, the CQC visited 39 of these segregated people, thirteen of whom were experiencing delayed discharge from hospital with a corresponding prolonged time in segregation due to there being no suitable package of care available in a non-hospital setting. With 26 of the 39 people, staff had stopped attempting to re-integrate them back onto the main ward environment, usually because of concerns about violence and aggression. In 25 cases, staff believed that the person's quality of life was better in segregation than in the less predictable environment of the open ward. The CQC concluded from the review that the current system of care *"has failed people whose care pathway has ended with them being segregated in a hospital. The system is not fit for purpose"* (Care Quality Commission, 2019). One reason given by the CQC for this state of affairs was that the ward staff may not have had specialist expertise to analyse, understand and manage the people's behaviours and therefore considered *"that the only safe course of action was to isolate the person from other patients"* (Care Quality Commission, 2019). As a

consequence, that person became stuck and attempts to move them back into the open-ward environment resulted in heightened distress or behaviours that endangered others, including staff. Regrettably, this reinforced staff's conclusion that segregation was necessary. Another reason for the unacceptably high rate of segregation is the drive to minimise the use of restraint. If a person cannot safely be managed without some kind of intervention, and restraint is discouraged, segregation is often the only meaningful alternative intervention available. This demonstrates that whilst it is possible to minimise the use of restraint, this may be at the expense of increasing other kinds of intervention (Baskind, 2019). This will be discussed throughout this thesis.

In its final report, *'Out of Sight – Who Cares'* (Care Quality Commission, 2020b), the CQC noted that the use of restraint varied significantly across the services they inspected, despite them caring for people with similar needs. They also saw inconsistent reporting and recording of restraint, which they had reported on previously (Care Quality Commission, 2018). In some services, restraint was rarely used and every effort was being made to avoid using it as they were using restraint reduction strategies, such as, HOPE and No Force First; in others it was a daily occurrence. The CQC also found a variety of different types of physical restraint were used. These included arm wraps, supine and prone restraint positions. While most providers claimed to have stopped using prone restraint, some providers still restrained people in the prone position. The Author will examine the use of prone restraint in Chapter 8. Helpfully, the report includes examples of good practice, two of which are using de-escalation techniques to pre-empt early signs that someone might be distressed and the use of safety pods to reduce the risk of harm from physical restraint (Care Quality Commission, 2020c), both of which will be discussed in this thesis. The report was also critical of the overuse of psychotropic medicines, citing the 2015 Public Health England report showing that every day in England 30,000 to 35,000 people with a learning disability are prescribed psychotropic medicines when they do not have a mental health condition (Public Health England, 2015). Patients and their families have described the impact of taking these medicines with some complaining that they were *"drugged up"* or given medicines that made them sleep for days (Care Quality Commission, 2020b). Since using medicines to restrain people is *prima facie* against the principles of both STOMP (stopping over-medication of people with a learning disability, autism or both with psychotropic medicines) and STAMP (supporting treatment and appropriate medication in paediatrics), it is necessary that this form of control can be shown to be necessary and in the

patient's best interests. Regrettably, some of the recommendations made by the CQC have been met with little or no progress. Restraint is one of them (Care Quality Commission 2022).

Questions of restraint safety and policy took an unusual turn following a 2011 BBC 1 Panorama television programme which showed people with challenging behaviour being abused by staff at a private hospital known as *Winterbourne View*. The story of Winterbourne View was one of appalling patient abuse, yet it was hijacked by policymakers and used to promote a ban on the use of a particular form of physical restraint known as "prone restraint". This led to considerable disquiet across a number of sectors expressing concern about removing what is to many a core restraint manoeuvre, and one which is an essential part of the restraint mix, and necessary for staff and patient safety. By a series of subsequent policy changes, the Department of Health sought to clarify that what had been widely seen as a 'ban' on prone restraint was no more than a recommendation not to use it. Regrettably, this confusion persists with many staff reporting concerns about engaging in restraint fearing doing something they have been trained to do but discouraged by subsequent guidance. Staff and patient safety remain compromised. The lawfulness and appropriateness of prone restraint will be discussed in further detail in Chapter 8.

Drawing the above threads together, this thesis will examine the various pieces of legislation, policy and guidance documents, and the practises currently being adopted by the different sectors, namely, healthcare, police, prison, security, and education and, drawing on the Author's 40 years' experience in this area, will suggest ways in which the problems associated with VAAoCB, as well as subject and staff safety, can be improved. The thesis will also consider the possible reasons behind the various, and often conflicting, pieces of guidance and absence of a cross-sector approach to the issues.

1.2 Terminology: from 'PMVA' and 'Physical Intervention' to 'VAAoCB' and 'Safety Intervention'

Although the term 'Prevention and Management of Violence and Aggression' ("PMVA") is widely used, force against a person may also be used in situations that do not involve violence or aggression. For example, a resistive person might need to be restrained to prevent self-harming or for essential medical interventions such as nasogastric feeding. These are two kinds of challenging behaviour which, depending on the setting, can take many forms. The Royal College of Psychiatrists has said that *"Behaviour can be described as challenging when it is of*

such an intensity, frequency, or duration as to threaten the quality of life and/or the physical safety of the individual or others and it is likely to lead to responses that are restrictive, aversive or result in exclusion." (Royal College of Psychiatrists, 2007, p10). The term *'Challenging Behaviour'* was introduced to replace a variety of terms which suggested that the problem was located within the person. It was introduced to move away from this by describing the behaviour as challenging to services (Baskind, 2003). Thus, staff are encouraged to regard this behaviour as the person presenting with a challenge in how to support them as opposed to regarding the person as being difficult. The emphasis was to encourage carers and professionals to find effective ways of understanding a person's behaviour and its underlying causes. Over time, the term has become misused and is now often used as a diagnostic label leading to stigmatisation and exclusion (Challenging Behaviour Foundation, 2020). Regrettably, this can lead to people who are given this label being denied the right to live an ordinary life in their local community and are placed in institutional settings, often far away from their homes and families, due to lack of local support and services that meet their needs. Safely managing challenging behaviour is as important as safely managing violence and aggression. In some settings, for example, learning disability settings, it is likely to be more important.

It must be asked, therefore, whether the term PMVA is the most appropriate in the circumstances? Even where the person is displaying violence or aggression, the cause of such behaviour is often the result of illness, stress, psychological or other factors. Other commonly used terms for dealing with violence and aggression are *'physical intervention'*, *'restraint'*, *'control and restraint'* and *'use of force'*. These terms are widely used to describe the training provided to staff.

It is the Author's view that these terms give the wrong impression about what staff are meant to do when faced with challenging behaviour because they all suggest that their response will be a physical one and deployed at the expense of other kinds of intervention that do not rely on a physical element, such as de-escalation and negotiation. These non-physical interventions are discussed throughout the thesis. Alternative terms such as *'positive intervention'*, *'safer (or safety) intervention'* or *'safer (or safety) resolution'* would be more appropriate in the circumstances as they imply a wider, more holistic approach to the circumstances with the emphasis on safety and positive outcomes.

Throughout this thesis, the term *'violence, aggression, agitation, and other challenging behaviours'* ("VAAoCB") will be used; a term devised by the Author in 2016 when working

with a mental health Trust. Furthermore, where appropriate, the term *'safety intervention'* will be used instead of the more widely used *'physical intervention'*. This reflects the important emphasis not only that interventions need not always be physical but more importantly that a physical intervention should remain just one of the possible responses to VAAoCB to be considered once all other non-physical options have either been exhausted or where the exigency of the situation requires an immediate physical response. Because of the complex and often uncertain and disordered nature of VAAoCB and any resultant intervention, it is not possible to explore the subject in any meaningful way in isolation from the wider issues, especially those relating to the legal and ethical issues, curriculum design, training, staff fitness, safety concerns and the need to minimise the use of all kinds of coercive interventions.

1.3 Objectives

The thesis seeks to answer three main questions:

1. Is it safe to impose an absolute prohibition on the use of any coercive and restrictive intervention (for example, restraint or seclusion)? This is an important preliminary question because some organisations and polices do just that.
2. On the assumption that the first question is answered in the negative, and that some kinds of coercive and restrictive interventions are permitted, is it safe to prevent staff from using certain kinds (for example, prone restraints) and, if so, which ones?
3. Coercive and restrictive interventions are overused. How can this be remedied?

To help answer these overarching questions, this thesis has the following objectives:

1. To examine the current methods of dealing with VAAoCB across a range of different sectors to identify themes of best practice and to consider whether these practices are capable of being used in other sectors.
2. To contribute to the understanding of the current practices into the safer management of VAAoCB so as to develop a safer and more ethical, evidence-based, approach to maintaining both subject and staff safety.
3. To examine how and why regulation and guidance have been drawn up, sometimes disregarding best practice and available evidence.

4. To identify the reasons for the divergence of views in such critical issues as prone restraint positions, pain compliance interventions and mechanical restraint.

5. To explore whether it is feasible to agree on a common approach to managing VAAoCB that all sectors could adopt.

6. To set out a number of recommendations to ensure that the use of force and other coercive and restrictive interventions are minimised and where necessary are as safe as possible for all parties.

There are significant gaps in the existing literature, mainly with regard to the practical aspects of managing VAAoCB, both physically (i.e. restraint) and non-physical (i.e. de-escalation) and how the conflict between the safety of staff and those perpetrating VAAoCB can be resolved. The thesis will contribute significantly to the knowledge base by examining these issues and by providing guidance and recommendations to ensure, insofar as is possible, the safety of everyone involved in these kinds of incidents.

1.4 Interest in the subject area

Over the past 40 years, the Author has advised numerous organisations on violence reduction and the use of force across a wide range of settings. In addition, he has been instructed as an expert witness both in the UK and in other countries in more than 3,000 cases involving restraint-related injuries and deaths. These instructions have come from organisations including the Prison Officers' Association, Police Federation, Home Office/Ministry of Justice, Independent Office for Police Conduct, and the Scottish Prison Service. Amongst the organisations he has recently worked with are the High Secure Hospitals at Ashworth, Rampton, Broadmoor and Carstairs where he was the Independent Expert Advisor to the Violence Reduction Manual Steering Group and the Security Industry Authority where he chaired an expert panel reviewing the management of violence and aggression and use of force in connection with the SIA's licence-linked qualifications.

The Author is currently collaborating with the College of Policing on two projects. He is a member of the Mental Health Restraint Expert Reference Group where he leads the work on restraint practices. He is also a member of the College's Guideline Committee Steering Group, working on the development of Authorised Professional Practice in the use of force. He has also recently been appointed to review the use of force across the Scottish Prisons estate

following the death of Mr Allan Marshall who died on 28 March 2015 after being restrained at HMP Edinburgh where he was being detained (Liddle, 2018).

The Author has also recently undertaken a review of BolaWrap®, a new non-lethal restraint tool, to consider its effectiveness and safety for the restraint of individuals, especially those suffering from mental ill-health, by police and other authorised users (Baskind, 2020).

Amongst the high-profile cases the Author has been instructed in as an expert witness are:

- The death of Jimmy Mubenga who died under restraint by Border Force escort officers during his deportation from the UK.
- Claims against G4S as to whether the routine handcuffing of prisoners during escort is a breach of their convention rights.
- Three police officers who are charged with manslaughter following the death of Thomas Orchard whilst being restrained following his arrest and the Inquest into Mr Orchard's death held in 2023.
- The death of Lorraine Barwell who was killed whilst restraining a prisoner at Blackfriars Crown Court in June 2015.
- The death of Allan Marshall in March 2015 following restraint at HMP Edinburgh where he was serving a term of imprisonment.
- The death of Craig Grant following restraint by door supervisors at the Tonik Bar in Aberdeen.
- The death of Wayne Moore at HMP Nottingham in December 2013 following which 3 prison officers were charged with Misconduct in Public Office.
- The death of Paul Reynolds who died following restraint in Lowestoft in February 2017.
- The death of Shane Bryant who died following restraint by on-duty, off-duty and retired police officers and members of the public during an armed robbery in 2017.

- The fatal shooting by a law professor and senior counsel of a person intruding on his farm in Ireland in February 2022.

- The violence involving armed and unarmed police officers at Manchester Airport in July 2024.

1.5 Methodology

The thesis is analytical and interdisciplinary. It provides a critical analysis of existing legislation, policy and guidance in relation to the operation of often conflicting violence-reduction strategies and the use of coercive and restrictive interventions across a number of sectors: principally healthcare, police, prison and private security and, in particular, the significant safety issues that can arise when these services collide. It will also critically evaluate ethical and theoretical explanations underpinning the numerous guidance documents and considers to what extent these have left staff and those under their care or control at risk of harm.

The ethical framework is largely based on Aristotle's *Nicomachean Ethics*, in which the aim of human beings is to exemplify human excellence of character (Aristotle, 1926). Although not always referred to by name, PMVA trainers will remind staff to ask themselves how they, or their loved ones, would like to be treated should they find themselves in crisis and displaying challenging behaviours. This helps to minimise the use of restrictive and coercive interventions thus helping to maintain the important therapeutic relationship between staff and those in their care. The ethical framework is also grounded in morality, especially utilitarianism which has been described as a consequentialist theory that judges actions based on their consequences, such as pain and pleasure (Little, 2002). It also connects with human rights, notably the Human Rights Act 1998 by laying down requirements by which all public authorities are required to conduct their affairs as well as the Equality and Human Rights Commission Human Rights Framework for Restraint (2019) which reflects the requirements of Article 3 (prohibition on torture, inhuman and degrading treatment), Article 8 (respect for autonomy, physical and psychological integrity) and Article 14 (non-discrimination) of the European Convention on Human Rights with specific reference to the principles for the lawful use of physical, chemical, mechanical and coercive restrictive interventions, including restraint.

The thesis will explore the practises currently being adopted by staff across the various sectors and, drawing on the Author's 40 years' experience in this area, will suggest ways in which the

problems associated with violence and aggression and the safety of individuals and staff can be improved.

Various judgments of the courts, ministerial and departmental guidance, journal articles and other sources have also been used to inform the analysis and debate as these frequently provide thought-provoking insight into the issues. Both Westlaw and Lexis-Nexis have been used as the primary sources from which the relevant cases and journal articles have been selected. In addition, the British and Irish Legal Information Institute (BAILII) and its successor, The National Archives, have been used to check on any late developments of cases which have not yet been digested in any of the law reports.

A literature review was conducted by searching the following databases for keywords '*violence*', '*aggression*', '*workplace violence*,' '*physical restraint*', '*physical intervention*', '*mechanical restraint*', '*seclusion*', '*long-term segregation*', '*restrictive intervention*' and '*coercive intervention*'. These databases are: PubMed, Scopus, Medline, Embase, ScienceDirect, Cochrane Database, and PsychINFO. From the published papers identified, those published between 2000 to 2024 were selected for further review. Together with other literature that fell outside of this initial review, 387 papers were ultimately selected to conduct a comprehensive review of the subject matter. Together, these sources helped facilitate the broadest possible focus across the available literature which ensured as comprehensive a review as possible.

1.6 Key definitions

The terminology used to describe the topic varies across settings (Hart and Howell, 2004) rendering accurate comparisons impossible. For this reason, unless the context otherwise requires, the following definitions will be used throughout this thesis.

Acute Behavioural Disturbance	A term used to describe a situation in which a person is extremely agitated and distressed, often in a public place, and in such a state of agitation that they may be at risk of a potentially fatal physical health emergency.
Breakaway techniques	Physical skills intended to help separate or break away from an aggressor in a safe manner. Breakaway techniques may be followed by the use of physical restraint.

	Breakaway techniques are sometimes referred to as 'escape and rescue' techniques.
Challenging behaviour	Behaviour can be described as challenging when it is of such an intensity, frequency, or duration as to threaten the quality of life and/or the physical safety of the individual or others and it is likely to lead to responses that are restrictive or coercive. The level of intensity needed to satisfy the definition will vary depending on the setting and population.
Chemical restraint	The use of medication which is prescribed and administered for the purpose of controlling or subduing disturbed/violent behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness.
Coercion/coercive intervention	Any action or practice undertaken which is inconsistent with the wishes of the person in question or undertaken without the person's informed consent.
De-escalation	The use of strategies, including verbal and non-verbal communication skills, which are aimed at preventing potential or actual behaviours from escalating and supporting the person to be calm.
Duty of care	The legal responsibility of a person or organisation to avoid any acts or omissions that could reasonably be foreseen to cause harm to others.
Escape and rescue techniques	See breakaway techniques.
Excited Delirium	An older term used to describe a situation in which a person is extremely agitated and distressed, often in a public place, and in such a state of agitation that they may be at risk of a

	potentially fatal physical health emergency. Acute Behavioural Disturbance is now the preferred term.
Hyperextension	An excessive joint movement in which the angle formed by the bones of a particular joint is opened, or straightened, beyond its normal, healthy, range of motion.
Hyperflexion	The flexion of a limb or part beyond its normal limit.
Isolation	See 'seclusion'.
Long-term segregation	A situation where a person is prevented from mixing freely with other people who use a service. It is used with patients who present an almost continuous risk of serious harm to others and for whom it is agreed that they benefit from a period of intensive care and support in a discrete area that minimises their contact with other users of the service.
Mechanical restraint	A method of restraint involving the use of mechanical devices, such as handcuffs, leg restraints or restraining belts.
Motor skills	Co-ordinated patterns of movements acquired through practise involving the ability to execute movements effectively and with precision to achieve intended outcomes. There are two kinds of motor skill: 'gross' and 'fine', the former involving the co-ordinated use of large muscle groups to perform tasks such as walking or kicking a ball, while the latter involves the use of smaller muscle groups to perform smaller, more intricate movements with the wrists, hands, fingers, and feet. There is usually a retention loss of fine motor skills over a period of non-use.
PMVA	Prevention and management of violence and aggression. A generic term describing methods used to prevent and

	manage incidents of violence and aggression. The term also encompasses challenging behaviour.
PRN (pro re nata)	'*As the thing is needed*'. PRN medication refers to the use of medication as part of a strategy to prevent situations that may lead to harm to the person or others.
Pain-compliance techniques	A technique that deliberately uses a painful stimulus to control or direct a person's actions. It is typically used to break the cycle of harmful, violent or resistant behaviour and achieve compliance with instructions.
Physical restraint	Any direct physical contact or force where the intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person.
Planned intervention	A necessary intervention where there is no urgency or immediate danger.
Psychological restraint	Psychological restraint can occur when staff use communication strategies to put psychological pressure on a person to do something they don't want to do or stop them from doing something they want to do. In certain circumstances, constantly telling a person not to do something, or that doing what they want to do is not allowed, or is too dangerous. It may include depriving a person of lifestyle choices by, for example, telling them what time to go to bed or to get up.
Rapid tranquilisation	Use of medication, usually intramuscular or, exceptionally, intravenous, and used where oral medication is either impossible or inappropriate and urgent medical sedation is necessary.
Red-flag agitation	An alternative and more recent term often used to describe Acute Behavioural Disturbance.

Refresher training	Training undertaken by a person to refresh their previously learned knowledge and skill. Often contains an element of new or improved skills that have been introduced or amended since the person's initial training.
Restraint minimisation	Initiatives designed to minimise the intensity and/or duration of physical restraint techniques that are used within specific settings, in relation to a specific population, or specific individual.
Restraint reduction	Initiatives designed to reduce the number of times restraint techniques are used within specific settings, in relation to a specific population, or specific individual.
Restrictive intervention	An intervention that restricts a person's freedom of movement. This can include observation, seclusion, physical or mechanical restraint, rapid tranquilisation and chemical restraint.
Restrictive practices	An umbrella term for making a person do something they don't want to do or preventing them from doing something they want to do.
Safety intervention	Any intervention intended to keep all parties safe. This could include non-physical interventions such as conflict resolution and de-escalation as well as physical interventions such as restraint.
Spontaneous intervention	See 'unplanned intervention'.
Seclusion	The supervised confinement and isolation of a person, away from other users of services, in an area from which the person is prevented from leaving. Its sole aim is the containment of severely disturbed behaviour which is likely to cause harm to others. Seclusion is also known as 'time out', 'isolation', and 'single separation'.

Time out	See ‘seclusion’.
Training needs analysis (TNA)	A process designed to identify skill gaps that can be remedied by training.
Unplanned intervention	where there is an immediate threat to someone’s life / limb or to the security of an establishment and staff need to intervene immediately. Also known as spontaneous interventions.

1.7 Chapter outlines

Chapter 1: Introduction

This is the introductory chapter to the thesis and sets out its aims and objectives, methodology and definitions used. It also explains the importance of using the appropriate terminology if, as it must, the use of physical interventions is to be minimised. It introduces the idea of the ‘safety intervention’ rather than ‘physical intervention’ to reflect the important emphasis not only that interventions need not always be physical but more importantly that a physical intervention should remain just one of the possible responses to violence, aggression, agitation, and other challenging behaviours to be considered once all other non-physical options have either been exhausted or where the exigency of the situation requires an immediate physical response.

Chapter 2: Typology of Violence and Aggression, and the Different Types of Intervention

Having explained the importance of using the appropriate terminology, this chapter explores the different kinds of behaviour that might require staff to intervene. The chapter examines the typology of violence and aggression and the different approaches that might be needed. It builds on the previous chapter by exploring the different kinds of safety intervention that may be considered and emphasises the need for physical interventions to be minimised. The chapter identifies alternatives to physical responses and discusses how they should be prioritised over physical responses. The chapter also explores the meaning and purpose of restraint and discusses how it fits, or ought to fit, into the mix of safety interventions.

Chapter 3: Violence, Restraint and Mental Health Inequality in the Black, Asian and Minority Ethnic Communities

Many cases from around the world have sought to identify whether race has a bearing on how staff deal with challenging behaviour and, if so, to what extent? This chapter provides a detailed

examination of the mental health inequalities in the Black, Asian and Minority Ethnic (BAME) communities and explores how these relate to the particular issue of restraint. Two high-profile cases are considered in details: George Floyd (USA) and Sheku Bayoh (UK).

Chapter 4: The Need For Minimisation of Restrictive and Coercive Interventions

Numerous commentators have described the harm that can result from restraint. Knox and Holloman (2011) describe restraint as inherently dangerous and even if used appropriately can result in physiological and/or physical harm (Sequeira and Halstead, 2001). Cobb (2018) notes that physical restraint can be humiliating, terrifying and even life-threatening. Accordingly, with the exception of acting in self-defence, the use of physical intervention should be based on an assessment that it will cause less harm than not intervening. The chapter examines the need for all kinds of restrictive and coercive interventions to be minimised. It explores alternatives to these kinds of intervention pointing out that it is relatively straightforward to eliminate some by simply prohibiting their use (e.g., in policy documents) or making it impossible (i.e., by not permitting certain equipment to be purchased). However, eliminating some kinds of intervention merely pushes the problem elsewhere. The chapter, therefore, explains why it is important to appreciate that violence, aggression, agitation, and other challenging behaviours, or their management, should be viewed in isolation from other kinds of behaviour or intervention. The chapter examines the Mehrabian Theory Mehrabian (1971) and the false claims said to derive from it. It also discusses Zero Tolerance Policies and examines whether they are effective in reducing violence and aggression. The chapter also examines a number of alternatives to restrictive and coercive interventions explaining why they ought to be regarded as primary kinds of intervention.

Chapter 5: Staff Training and Curricula Design

Whichever way an organisation decides to manage incidents of violence, aggression, agitation, and other challenging behaviours, the training of its staff is paramount. Before any training can be carried out, the organisation needs to design a curriculum which in turn will draw upon risk assessments and training needs analysis. This chapter explores the historical developments in staff training and considers why it is important to remove as many complex motor skills as possible as well as simplifying and minimising the number of physical skills taught. It discusses the importance of a modular approach to training delivery and explains why training needs to be carried out with a degree of chaos and physical resistance. The chapter also identifies the need for periodic refresher training and identifies which skills staff should be refreshed in.

Finally, the chapter identifies the difference between planned and unplanned interventions and explores why planned interventions should be preferred whenever the opportunity arises.

Chapter 6: Emotions, Safety and Evidence

Chapter six examines the various policy and guidance documents published by the various government departments and agencies. The chapter examines these documents and seeks to identify the evidential basis for the guidance and rules they provide. The chapter examines the *Winterbourne View* case (Winterbourne View Serious Case Review, 2012) which, although not involving restraint *per se*, brought about significant changes to the restraint landscape, with many arguing not for the better. The chapter will reflect on politics and emotion continuing to play a large part in the development of policies and guidance even where the evidence indicates that a different approach is needed. The Author remains critical of fallacious claims and assertions, some of which have appeared in peer-reviewed journals. This is discussed in the chapter together with examples, including the false assertion that the use of mechanical and physical restraint is against the law in Britain (*Steinart, et al*, 2009:136; *Mantovani, et al*, 2010; *Ziaei, et al,* 2019). The collection of accurate data, and the way it is used, is key to understanding what is happening both within a particular sector as well as across the different sectors. Good policy making relies, at least in part, on accurate data collection of incidents. The chapter examines how the different methods used for data collection as well as significant inconsistencies in what is collected make it more difficult to understand the true position of what is happening. Together with the recent encouragement for more comprehensive and accurate reporting of data, understanding the true picture and comparing it to previous periods is made more difficult.

Chapter 7: Safety Issues in the Management of Violence, Aggression, Agitation, and other Challenging Behaviours

One of the most difficult questions concerns the balancing of competing considerations and to weigh different rights against each other. This is particularly evident in cases of assault where it is often necessary to balance the rights of the aggressor or assailant against the rights of the victim. This is often an impossible task which makes the question of safety difficult to quantify. Nevertheless, this chapter will identify the various safety issues and discuss how the safety of all parties can be improved. The chapter discusses the main medical risk associated with restraint and considers when it might be necessary to avoid restraint. The chapter concludes with a pro-forma report aimed at enhancing safety of restraint by adapting the Coronial

Regulation 28 Report (more commonly referred to as a Report on Action to Prevent Future Deaths) to cases where injury, rather than death, has occurred.

Chapter 8: Controversial Interventions

Once it has been determined that use of force is needed, it is necessary to consider which kind of intervention should be used. Beyond the controversies which attach to these actions generally (as restraint is a controversial subject), there are specific interventions that attach specific controversy. These are: prone restraint positions, pain-inducing restraints and mechanical restraints. This chapter will explore the reasons behind these controversies and examine the causes and possible solutions.

Chapter 9: The Need for a Common Set of Guidelines

Violence, aggression, agitation, and other challenging behaviours never present themselves in a vacuum yet this is typically the way policymakers approach the subject, its prevention and its management. Although guidelines exist in different sectors, apart from a few common messages, too often little or no consideration is given to many of the wider issues in play. In comparison to other settings, the use of coercive and restrictive interventions in healthcare services is highly regulated, and rightly so. For example, in the United Kingdom, the National Institute of Health and Care Excellence (NICE) Guideline NG10 'Violence and aggression: short-term management in mental health, health and community settings' (NICE, 2015) aims to safeguard both staff and people who use services by helping to prevent violent situations and providing guidance to manage them safely when they occur. Further, since April 2021, certification of training services has been a requirement for certain NHS-commissioned services and the Care Quality Commission (CQC) will expect regulated services to use certified training (Restraint Reduction Network, 2019). The call for the regulating and accrediting of the use of physical interventions is not new and in recent years has become more vocal. At the 2013 Royal College of Nursing (RCN) Annual Congress, the motion calling for accredited and regulated national guidelines of approved models of physical restraint was passed by 99.8% of delegates. This chapter will examine these issues and consider the likelihood of common guidelines being adopted.

Chapter 10: Conclusion and Recommendations

Chapter 10 concludes and draws together the various strands examined throughout this thesis and provides a number of recommendations aimed at improving safety both for staff and those in their care or custody.

Appendix 1: Legal considerations

Managing violence, aggression, agitation, and other challenging behaviours is fraught with difficulties, including many complex legal consideration that are not easy to reconcile. A clear understanding of the legal principles is important which managers and staff need to understand. These legal principles are noted throughout the thesis and Appendix 1 provides a more comprehensive legal analysis of the issues that arise in the various settings.

CHAPTER TWO: TYPOLOGY OF VIOLENCE AND AGGRESSION, AND DIFFERENT TYPES OF INTERVENTION

2.1 Typology of violence and aggression

The Global Campaign for Violence Prevention describes violence as a leading worldwide public health problem (World Health Organisation World Report on Violence and Health, 2002). There are different causes of violence and the typology of violence devised by the Californian Division of Occupational Health and Safety (1995) ("CDOHS") has been cited with approval by several authors across the world (Beale *et al,* 1998, Bowie, 2000, Chappell and Di Martino, 2000, Hoel, *et* al, 2001, Mayhew & Chappell, 2002). Originally identifying three types of violence, the CDOHS now identifies violence by four categories:

Type 1	Workplace violence committed by a person who has no legitimate business at the workplace, and includes violent acts by anyone who enters the workplace with the intent to commit a crime.
Type 2	Workplace violence directed at employees by customers, clients, patients, students, inmates, or visitors.
Type 3	Workplace violence against an employee by a present or former employee, supervisor, or manager.
Type 4	Workplace violence committed in the workplace by someone who does not work there, but has or is known to have had a personal relationship with an employee.

Although violence of any kind often occurs within the same workplace, Mayhew and Chappell (2002) point out that the perpetrators may have different characteristics and the preventative strategies, control and management will be markedly different (Leather *et* al., 1998).

PMVA strategies need to cover all four types of violence as well as all kinds of challenging behaviour from persons who are vulnerable. The Author has added to the above categorisations by categorising the behaviours from these people as types 5 and 6. The reason for these additional categories is the person's vulnerability and/or lack of malice or intent to cause harm and the corresponding different appropriate responses.

Type 5	Aggression, violence or challenging behaviours directed at or towards others or self by persons suffering from physical and/or mental ill-health or other illnesses, whether or not workplace related, but without malice or criminal intent.
Type 6	Aggression, violence or disturbed behaviour directed at or towards others or self by children or adolescents, whether or not workplace related.

Type 5 is the kind of challenging behaviour that might result from dementia, anaesthesia, pain, and various illnesses or disabilities. It also covers violence to oneself (self-harming). The distinguishing feature of this category of behaviour is the vulnerability of the person and the absence of malice or intention.

Type 6 covers a range of behaviours by children or adolescents directed at or towards others or themselves. The distinguishing feature of this category of behaviour is the vulnerability of the person.

For present purposes, the main importance of distinguishing between some of the different kinds of perpetrator behaviour concerns the term 'therapeutic intervention'. This is important in all type 5 and many type 6 incidents because of the vulnerability of the people in these groups. Therapeutic interventions are discussed later in this chapter. Furthermore, discussions on violence and aggression often bring into sharp focus the tension between the safety of the subject and that of the staff and others. This is because, unlike with type 5 behaviour where the subject often acts without malice or criminal intent but suffers from physical and/or mental ill-health or other illnesses, the other types of behaviour are often associated with malice and/or intention to cause harm which is often criminal in nature. In such cases, it is understandable that staff may wish to prioritise the safety of themselves and others over that of the perpetrator. Type 5 incidents often arise in settings where staff are employed to care for patients/service users and, in such cases, it is generally accepted that the interests of such patients/service users take a high priority. Such a laudable patient-centred approach is not without problems. Staff may need to resort to the use of restrictive interventions, including restraint, such as is necessary for the maintenance of a safe therapeutic environment for all patients and for the safety of staff and visitors which may, where circumstances require it, override the individual therapeutic requirements of an individual patient. This is not because security objectives trump treatment objectives, but because security is a necessary part of the background to treatment (Auld, 1998).

2.2 Non-physical interventions – de-escalation

Professional guidelines and experienced practitioners recommend that coercive measures should not be considered as first-line interventions for potentially violent incidents (Haimowitz *et al.,* 2006, Khwaja and Beer, 2013, National Institute for Health and Care Excellence, 2015). Instead, they endorse the use of de-escalation, with more restrictive measures being used only in the event of its failure to avert violence or where an immediate physical response is needed, typically for the safety of the patient. De-escalation is the recommended first-line response to potential violence and aggression in healthcare and other settings (NICE 2005; NICE 2015; NICE 2017). Related scholarly activity has increased exponentially since the 1980s, but there is scant evidence about the efficacy of de-escalation in practice and no guidance on what constitutes the gold standard for practice (Hallett and Dickens, 2017). These authors go on to observe that given the many guidelines on de-escalation that have been produced by well-respected authorities this *"might mean that staff assign more significance to them than the scant evidence behind them warrants"* (Hallett and Dickens, 2017, p19).

The term '*de-escalation*' was first observed in discussions about violence prevention in health and social care settings in the mid-1980s (Kaplan & Wheeler, 1983; Infantino & Musingo, 1985). Prior to that, in the late 1970s the term was used in the context of police training in the management of domestic violence (Bell, 1979). It is now used widely across all settings. Terms other than de-escalation are also used to describe similar approaches to de-escalate a potentially violent situation, including '*conflict management*', '*conflict resolution*', '*crisis resolution*', '*defusing*' and '*talk-down*'. Finfgeld-Connett (2009) and McDonnell (2010) use the terms *"authentic engagement"* and "*low arousal approach"* to describe related strategies.

2.2.1 Components of de-escalation

The various components of de-escalation can be identified from the following account that was provided by a psychiatric nurse when describing an incident on a psychiatric ward involving a child, his parents and nursing staff (Johnson and Hauser, 2001, p.657):

> *"I came running on the unit and there were about five staff members holding this child in the middle of the hallway […]. His parents were almost on top of the staff members […]. So, it was really, really intense […]. And believe me, my heart was pounding […]. And the mother was kneeling next to the child. The child was screaming. The father was on top of the mother, yelling at the staff. [The physician]*

was trying to kneel down and it was just mass chaos and escalating […]. So, the first thing I decided that I had to do was intervene with the parents. So, I went up to both of them and very purposefully used touch - touched them on the back - used a very calm voice because there was a lot of anxiety and a lot of tension, a lot of yelling. And said, 'Excuse me. I need you both to come with me for just a minute. Just give me a moment of your time. I know that you're very worried about the situation. The situation is very frightening.' So I think I tried to validate what they were seeing, tried to use my voice to calm them, tried to use touch to get them to look at me, but very gently so they didn't turn around and hit me […]. And they both stood up and then I used my hands and said, 'Please just step over here with me for one moment.' I said to them, 'This has to be very frightening to you. I would like you to give me an opportunity to try and de-escalate this situation. Will you let me do that?' So, I tried to engage with them on the fact that it was very scary […] I said, 'I know you're concerned about your son. There are five people on top of him right now.' And I tried to get them into a position to say yes, to give me permission to do this rather than just bust in. But, I had confidence at that moment that they would say yes."

This account demonstrates the five themes of de-escalation; these being communication, self-regulation, assessment, actions, and safety. The nurse used a range of communication skills with the parents, whilst acknowledging the intensity of the situation and the effect it had (*'my heart was pounding'*), thus demonstrating self-regulation. Assessment of the situation led to the nurse intervening with the parents first, attempting to create a safe space by moving them away (i.e., actions and safety) (Hallett and Dickens, 2017).

A number of studies have described these components which can be seen in the Table 1 below.

Table 1. Studies describing the components of de-escalation (Hallett and Dickens, 2017)

THEMES/ATTRIBUTES	**SOURCE**
Communication	
Forming a connection with the potential aggressor as early as possible (through the use of a previously developed relationship where relevant).	Bowers (2014), Chigbundu (2015), Garnham (2001), Hodge & Marshall (2007), Johnson & Hauser (2001), Lian (2001), Littrell and Littrell (1998), Muralidharan & Fenton (2006), National Institute for Clinical Excellence (2005)

Using open-ended questions.	Bowers (2014), Hankin *et al*. (2011), Hodge & Marshall (2007), National Institute for Clinical Excellence (2005), Richter (2006), Stevenson (1991)
Offering choices or alternatives.	Bernstein and Saladino (2007), Berring *et al*. (2016), Ford (2012), Lowe (1992), Morales & Duphorne (1995), National Institute for Clinical Excellence (2005), Price & Baker (2012), Richmond *et al*. (2012), Saheed (2013), Swart *et al*. (2011)
Problem-solving, working out agreements, identifying causes, offering solutions, and seeking resolution.	Bernstein and Saladino (2007), Davis (2007), Drach Zahavy *et al*. (2012), Duperouzel (2008), Hallett & Dickens (2015), Hankin *et al*. (2011), James *et al*. (2012), Liberman (2011), Maunder (1997), Mavandadi *et al*. (2016), Nau *et al*. (2010), Price & Baker (2012), Stevenson (1991), Smith *et al*. (2001), Stringer (2016), Turnbull *et al*. (1990), Wand & Coulson (2006)
Exploring opportunities for agreement.	DelBel (2003)
Reminding patients of behavioural expectations.	Chabora *et al*. (2003)
Acknowledging the aggressor's feelings/situation.	Berring *et al*. (2016), National Institute for Clinical Excellence (2005), Richter (2006), Stevenson (1991), Wand & Coulson (2006),
Expressing one's own feelings or using limited self-disclosure as a means of developing a rapport.	Buback (2004), Garnham (2001), Hankin *et al*. (2011), Hodge & Marshall (2007), Lowe (1992), Paterson *et al*. (1997), Smith *et al*. (2001),
Redirecting the conversation to a less charged topic.	Hankin *et al*. (2011)
Using clear, concise language.	Corbo and Siewers (2001), DelBel (2003), Hankin *et al*. (2011), National Institute for Clinical Excellence (2005), Richmond *et al*. (2012), Saheed (2013), Stevenson (1991), Sim *et al*. (2011), Su (2010), Turnbull *et al*.(1990)
Paraphrasing / summarising to demonstrate and ensure understanding.	DelBel (2003), Dubin & Ning (2008), Hankin *et al*. (2011), Richter (2006), Smith *et al*. (2001), Sotile & Sotile (1996)
Using humour when appropriate.	Hallett and Dickens (2015), Sotile & Sotile (1996)
Being honest, not making promises that can't be kept.	Dubin & Ning (2008), Maunder (1997)
Using '*fiblets'* or '*therapeutic lies*' with older adults.	Soreff & Siddle (2004)
Offering reassurance of safety.	Petit (2005), Su (2010)

Avoiding jargon or threats.	Davis (2007), National Institute for Clinical Excellence (2005), Stevenson (1991)
Avoiding indecisive or uncertain language	Buback (2004)
Avoiding appearing confrontational, overbearing, belittling, patronising, or provocative.	Davis (2007), Distasio (1994), Hankin *et al*. (2011), Hodge & Marshall (2007), National Institute for Clinical Excellence (2005), Richmond *et al*. (2012), Richter (2006), Saheed (2013), Twemlow (2001)
Conveying professional concern	Petit (2005)
Listening for content and meaning	Richter (2006), Saheed (2013)
Active listening	Lian (2001), Mavandadi *et al*. (2016), Soreff & Siddle (2004), Stringer (2016)
Using an appropriate tone of voice.	Chigbundu (2015), DelBel (2003), Distasio (1994), Drach-Zahavy *et al*. (2012), Gillespie (2008), Hankin *et al*. (2011), Hallett & Dickens (2015) Irwin (2006), Liberman (2011), Maier (1996), Price & Baker (2012), Richter (2006), Ryan & Bowers (2005), Smith *et al*. (2001), Sotile & Sotile (1996), Stevenson (1991), Stringer (2016)
Awareness of one's own body language and adoption of an open, non-threatening posture.	Buback (2004), DelBel (2003), Distasio (1994), Dubin & Ning (2008), Gertz (1980), Hallett & Dickens (2015), Inglis & Clifton (2013), Maunder (1997), National Institute for Clinical Excellence (2005), Paterson *et al*. (1997), Stevenson (1991), Stringer (2016), Turnbull *et al*. (1990)
Establishing and maintaining eye contact in a non-threatening manner.	Buback (2004), Dubin & Ning (2008), Garnham (2001), Lian (2001), Maunder (1997), McDonnell (2010), Paterson *et al*. (1997), Price and Baker (2012), Stringer (2016), Turnbull *et al*. (1990)
Maintaining a neutral facial expression.	Distasio (1994), Garnham (2001), Hankin *et al*. (2011), Paterson *et al*. (1997), Price & Baker (2012) Turnbull *et al*. (1990)
Using touch to calm patients, based on the belief that closeness and holding are calming and comforting.	Carlsson *et al*. (2000)
Congruence between actions and speech.	Lowe (1992)
Cultural awareness since cultural differences in verbal and nonverbal communication styles, could compound problems.	Inglis & Clifton (2013), Paterson *et al*. (1997)

Demonstrating empathy in verbal and non-verbal modes of communication.	Davis (2007), Distasio (1994), Ford (2012), Garnham (2001), Hallett & Dickens (2015), Hankin *et al*. (2011), Lane (1986), Mavandadi *et al*. (2016), National Institute for Clinical Excellence (2005), Petit (2005), Procter (2011), Richter (2006), Stringer (2016), Turnbull *et al*. (1990), Twemlow (2001), Wand & Coulson (2006)
Slowing things down, gaining time	Maunder (1997), Richter (2006), Sotile & Sotile (1996), Stringer (2016)
Using silence to allow the individual time to clarify their thoughts.	DelBel (2003)
Self-regulation	
Remaining calm.	Bernstein and Saladino (2007), Carlsson *et al*. (2000), Chigbundu (2015), Corbo and Siewers (2001), DelBel (2003), Duperouzel (2008), Gertz (1980), Lian (2001), Lowe (1992), McDonnell (2010), Petit (2005),Ryan & Bowers (2005), Sim *et al*. (2011), Steen (2011), Su (2010), Virkki (2008)
Separating one's feelings about the aggressor/patient and the problem. Avoiding making judgements about the aggressor. Avoiding taking the aggression personally.	Altmiller (2011), Paterson *et al*. (1997), Steen (2011), Su (2010)
Emotional regulation, assertiveness, self-control and confidence.	Daffern *et al*. (2012), Davis (2007), Distasio (1994), Lian (2001), Lowe (1992), Maier (1996), Maunder (1997), Mavandadi *et al*. (2016), Muralidharan & Fenton (2006), National Institute for Clinical Excellence (2005), Nau *et al*. (2010), Petit (2005), Price & Baker (2012), Richter (2006), Stevenson (1991), Virkki (2008)
Personal reflection following an incident to what went well or poorly and what could be improved.	Altmiller (2011)
Assessment	
Assessing the potential aggressor's emotional state or the immediate situation.	Duperouzel (2008), Hanieh *et al*. (2014), Johnson & Hauser (2001), Steen (2011), Stevenson (1991), Wand & Coulson (2006),
Assessing the risks associated with interventions	Richter (2006)
Observing and recognising known early-warning signs of aggression.	Hallett *et al*. (2016), Inglis & Clifton (2013), Mackay *et al*. (2005), Morales & Duphorne (1995), Muralidharan & Fenton (2006), Steen (2011)

Judging the anticipated trajectory of the situation in the context of the individual patient, using existing knowledge of the patient	Delaney & Johnson (2006), Lovell *et al*. (2015), Berring *et al*. (2016)
Knowing when to intervene.	Lovell *et al*. (2015)
Using all five senses to assess the situation	Corbo and Siewers (2001)
Actions	
Use of activities to help the patient to displace anger and frustration and to distract the individual by providing a change of activity.	Kaplan & Wheeler (1983), Garnham (2001), Chabora *et al*. (2003), Bernstein and Saladino (2007), McDonnell (2010), Liberman (2011), Hallett & Dickens (2015), Hallett *et al*. (2016), Reade and Nourse (2012)
Limit-setting, that is nonconfrontational and based on respect	Dubin & Ning (2008), Finfgeld-Connett (2009), Hallett *et al*. (2016), Hankin *et al*. (2011), Hodge & Marshall (2007), Irwin (2006), Lowe (1992), Morales & Duphorne (1995), Paterson *et al*. (1997), Price & Baker (2012), Reade and Nourse (2012), Richmond *et al*. (2012), Su (2010)
Redirecting the individual's attention / distraction.	Distasio (1994), Hallett *et al*. (2016), Soreff & Siddle (2004), Stringer (2016), Swart *et al*. (2011)
Standing if the individual is standing, sitting if they are sitting.	Dubin & Ning (2008)
Removing the potential aggressor, or others, from the situation, thus creating a safe space.	Bowers (2014), Chabora *et al*. (2003), DelBel (2003), Hallett & Dickens (2015), Hallett *et al*. (2016), Kaplan & Wheeler (1983), Lian (2001), Liberman (2011), Maunder (1997), Smith *et al*. (2001)
Bringing in a different person to interact with the individual.	Gillespie (2008)
Decreasing environmental stimuli	Lian (2001), Reade and Nourse (2012), (Somes *et al*., 2011)
Recognising and alleviating causes of agitation (older adults) e.g. pain, hunger etc.	Somes *et al*. (2011)
Stress management and relaxation exercises as ways in which patients could reduce their own aggression.	Chabora *et al*. (2003)
Using an individualised treatment plan	Littrell and Littrell (1998)
Safety	

Making a safe and cautious approach to the aggressor through use of slow, careful movement to avoid further agitation or surprise.	Distasio (1994), Hankin *et al*. (2011), Hodge & Marshall (2007), Lian (2001), Muralidharan & Fenton (2006), Paterson *et al*. (1997), Sim *et al*. (2011)
Being aware of the environment in terms of planning escape routes, and avoiding vulnerable positions and isolation.	Distasio (1994), Maier (1996), Hankin *et al*. (2011), Hodge & Marshall (2007), Garnham (2001), National Institute for Clinical Excellence (2005)
Seeking support or being aware of backup should it be needed.	Bowers (2014), Davis (2007), Hallett & Dickens (2015), Maunder (1997)
Being aware, and removal or moderation of potential weapons, dangers and triggers.	Distasio (1994), Duperouzel (2008), Hankin *et al*. (2011), Hodge & Marshall (2007), Lian (2001), Mackay *et al*.(2005), Soreff & Siddle (2004), Stevenson (1991),
Acknowledging that agitated individuals may require more personal space, or a greater buffer zone, than usual.	Bowers (2014), Corbo and Siewers (2001), Davis (2007), Dubin & Ning (2008), Garnham (2001), Hankin *et al*.(2011), Mavandadi *et al*. (2016), McDonnell (2010), Paterson *et al*. (1997), Price & Baker (2012), Richmond *et al*. (2012), Richter (2006), Saheed (2013), Stringer (2016)
Debriefing following an incident in order to identify strategies for de-escalation that may prove useful in future crises.	Azeem *et al*. (2015), McDonnell (2010)

The Author, as Chair of the British Self Defence Governing Body, devised a 20-point strategy for de-escalation which is described in the Table 2 below. This strategy is now used in a variety of different settings where the Author has been engaged.

Table 2. 20-point strategy for de-escalation (Baskind, 2003)

1.	Stay calm	Take deep breaths and remain calm and aware. By remaining calm, we can best influence what others perceive and how they will react.
2.	Exude calmness	Lower your tone of voice, use open-hand palm-up gestures, relax your face and shoulders, create spatial distance. Smile when appropriate.
3.	Listen	If the other person(s) is speaking, listen carefully to what they say, the words they use, and any words or themes they repeat. What they first say is often the most important. No matter how illogical or emotional, listen and acknowledge that you are receiving their message. That does not mean you agree. Listening is often seen as the first stage of effective de-escalation.

4.	Validation	Validation lets others know that what they have to say matters, that you are listening, that you are empathetic. You may not agree with them: validation is recognition - not necessarily agreement. From our earliest years, we all want to be recognised and validated. Effective validation typically involves summarising what they have said, where appropriate, using their own words.
5.	Show interest	Ask open-ended questions and show genuine interest in the other person's experiences and perspectives and, in doing so, try to put yourself in their position. Remain empathetic: it might assist to say something like: "I'm so sorry to hear that; it must have been awful". Understand that something has brought them to this point; perhaps it has built up over time; perhaps no one has taken the time to listen to them before; perhaps they are having psychological issues or other crises.
6.	Don't judge	Sitting in judgment is rarely helpful in these situations. Thus, don't tell them that they are wrong, or what they are saying has no merit, or that they should not feel that way. Allow them to talk and vent their concerns.
7.	Lose your ego	Leave your ego at the door. This is not a battle that needs to be won; rather, you should concentrate on achieving a state of emotional harmony. Being 'right' is unimportant; there is little point in winning an argument if you lose the relationship. Words matter, and your words in those precious key moments will be long remembered. Forget animosity and concentrate on achieving emotional equanimity.
8.	Think long-term	This is especially important when dealing with colleagues or anyone where a continuing relationship is important. Think long-term harmony and appreciate that this is a process that will have long-term benefits.
9.	Silence	Sometimes, silence is preferable to speaking. Don't interrupt the other person. With silence, you can acknowledge that you are listening by eye gestures, nodding, and posture. Where appropriate, smiling, providing it is genuine, can often help put people at ease and create a positive atmosphere.
10.	Avoid barriers	Do not cross your arms or legs, as this can create the illusion of a barrier between you and the other person. Instead, try to adopt an open, relaxed posture.
11.	Reassure and support	If the other person is feeling anxious or uncomfortable, offer reassurance and support. Let them know that you are there to help and that you care about their position and well-being. If the other person is in shock, perhaps crying or screaming, avoid any inclination to leave to avoid your own discomfort and to give them space. Instead, make sure you stay in the room with them. You can verbalise your support by assuring them that you are there if they need you.
12.	Maintain space	Be mindful of the other person's personal space and their personal property and avoid getting too close to them. This is also important for your own safety.
13.	Address them properly	If you don't know the other person, ask them their name. If they reply with a title, be respectful and use it when addressing them.
14.	Positioning	Don't feel you have to stay rigidly in one place. It may help to relieve tension by suggesting alternative positions to being

		opposite the other person by positioning yourself side-by-side or even suggesting moving to another location or going for a walk.
15.	Take a break	If the situation is escalating and emotions remain high, consider taking a break. Let the other person know that you want to engage, but you are human also and may need to consider what has transpired so far. This can help both parties to calm down, reassess options, and approach the situation more rationally.
16.	Express willingness and positivity	Where appropriate, use positive language to create a more positive environment. For example, instead of saying "I can't help you with that," say something like "Let me see what I can do to help."
17.	Look for common areas	Try to find areas of agreement or shared interests. This can help to build rapport and create a more positive interaction.
18.	Offer a solution	Where possible, propose a solution or options that might help to resolve the issue. This can demonstrate that you're willing to work together to find a positive outcome. Try to avoid long silences.
19.	Serious threat	If a weapon is produced, maintain a safe distance and consider escape routes. Try to remain calm. Concentrate on your de-escalation strategies and try to reinforce any positive responses achieved thus far. Seek help.
20.	Reward	Don't forget to reward individuals who begin to de-escalate by relaxing even further and thanking them for considering proposals discussed thus far.

Although the majority of PMVA training programmes now include information about de-escalation skills (Livingston *et al*., 2010), there is an absence of clear guidance about what constitutes de-escalation or what might be considered best practice. There is also an absence of evidence-based guidelines about how de-escalation techniques should be taught to staff (Hallett and Dickens, 2017). It is the Author's experience that most de-escalation training provided to staff is poor, and frequently criticised as being little more than a tick-boxing exercise that staff need to follow. This is likely to go some way in explaining the conclusion reached by Price *et. al.* (2015) in their systematic review of de-escalation training which found that there was only limited evidence of improvements in de-escalation performance post-training. On the question of whether or not there was any reduction in assaults post de-escalation training, the evidence was sparse. Henk and Joost (1997) and Sjöström *et. al.* (2001) found that there was no reduction in assaults following de-escalation training, whilst others (Needham *et. al.* (2004), Rice *et. al.* (1985), Whittington and Wykes (1996)) found that there was a reduction. One further study found an increase in assaults although this might be due to improved reporting (Martin, 1995). There was consensus between studies that found de-escalation training resulted in a reduction of the use of physical restraint (Jonikas *et. al.* (2004), Laker *et. al.* (2010), Moore (2010), Needham *et. al.* (2004)). This is extremely encouraging,

although it should hardly be surprising that skilful de-escalation of a potentially violent situation will lead, in a significant number of cases, to a resolution that does not involve restraint or actual violence.

It is important that de-escalation is seen as a continuous process and repeat attempts may be necessary at any point during the interaction. Adapted from Richmond *et. al.* (2012) Table 3 shows the Royal College of Emergency Medicine (2022) suggested model for de-escalation:

Table 3: Royal College of Emergency Medicine suggested model for de-escalation (Royal College of Emergency Medicine, 2022)

Respect personal space:	• Identify exits • Stay out of arm's reach
Do not be provocative:	• Ensure body language is non-confrontational • Keep hands visible • Do not challenge, insult, or engage in argument
Establish verbal contact:	• Avoid multiple staff talking to the patient • Introduce yourself, explain why you are there, reassure the patient you are aiming to keep them safe
Be concise:	• Short sentences, give time to respond • Repetition may be needed
Identify wants and feelings:	• Identify expectations, empathise
Listen closely:	• Use clarifying statements
Agree, or agree to disagree:	• Consider fogging techniques (agree with the truth, agree in principle, or agree with the odds)
Set clear limits:	• Clearly inform patient as 'matter-of-fact' not as a threat
Offer choices and optimism:	• Offer acts of kindness • Offer oral sedative medications
Debrief patient and staff:	• Explain why intervention was necessary • Restore therapeutic relationship • Identify potential improvements

As noted above, unless the de-escalation training provided to staff itself is fit for purpose, which in the Author's experience of working with organisations both nationally and internationally generally it is not, it is unrealistic to expect staff to be able to de-escalate a situation satisfactorily.

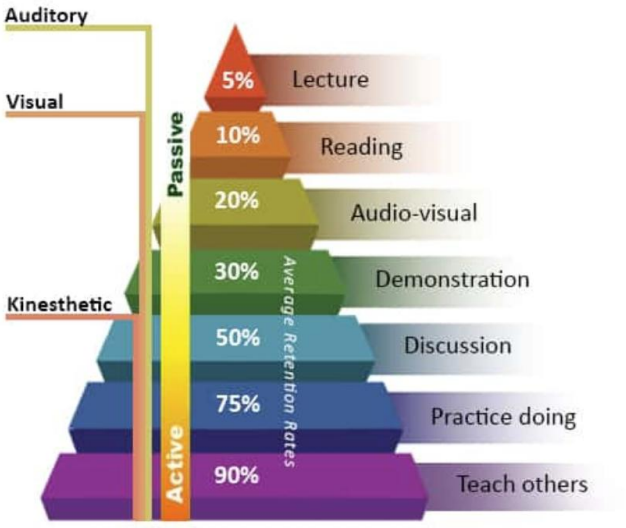
Although not noted in any meaningful way in the literature, comparing the way in which de-escalation training is typically delivered to the way physical restraint training is delivered

highlights the problem. It is first necessary to consider the pedagogy that underpins this kind of training.

Popularised by the American philosopher, John Dewey, the phrase '*learning by doing*' places significant emphasis on student engagement rather than the more traditional notion that learning happens through lectures and rote memorisation or by passively receiving information (Boser, 2022). Dewey argues that we learn best when we engage deeply with the material. He believes that the best way to achieve that is to create a practical curriculum that has relevance to students' lives and experiences and then have them participate as actively as possible in the learning.

This is best shown by the Learning Pyramid (Fig. 1, below) which has been adapted from the National Training Laboratory Institute for Applied Behavioural Science (https://ntl.org). This suggests that students generally only remember about 5% of what they hear in lectures, 10% of what they read from textbooks, but will retain 75% of what they learn by practising the skills and 90% through teaching others.

Figure 1. Learning Pyramid. National Training Laboratory Institute for Applied Behavioural Science



This model holds that practice-by-doing is one of the most effective methods of learning and study. It encourages students to take what they learn and put it into practice, promoting deeper understanding and moving information from short-term to long-term memory. Practice by doing makes material more personal, and thus more meaningful to students. It also leads to more in-depth understanding of material, greater retention and better recall. The model,

although widely accepted in practical skills learning, remains controversial elsewhere (Masters, 2019).

Restraint training is a practical skills activity that cannot satisfactorily be achieved merely by reading about it or being told about it. It requires practice, and plenty of it. It also needs to be carried out with a degree of chaos and realism, subject to the confines of safety, so as to provide students with experience of the kind of behaviour they are likely to face operationally. The legal implications associated with restraint training are discussed throughout this thesis and in Appendix 1. Provided the skills are practiced this way, with the appropriate skills taught the students' recall will be as good as is possible to achieve in the circumstances, and they will be deemed competent to perform them when required.

This practical method of teaching and practising these skills can be compared to the passive way in which de-escalation training is generally provided. Not only is it delivered passively, it also lacks engagement, relevance and purpose (Baskind, 2022). It is the Author's experience that most de-escalation training is poor with many organisations regarding it as a tick-boxing exercise that must be completed before the 'proper stuff' begins. This is a real pity and a great opportunity lost. In one sense, conflict resolution training can be seen as being more important than physical skills training because if these strategies are successful there will be no need to intervene physically, safety will not be compromised, and the staff-service user relationship can be enhanced (Baskind, 2006). It is, therefore, essential that de-escalation training is not provided in a passive way but is embedded into the training with as much practical experience as possible.

2.3 Meaning of restraint

Before considering the meaning of restraint, it is important to acknowledge that there are other kinds of coercive and restrictive interventions, such as seclusion, which although referred to in this thesis, will not form the basis of substantial discussion. That said, many of the issues discussed in this thesis will also apply, where relevant, to the other forms of coercive and restrictive interventions.

Restraint is a physical intervention and in one form or another is often, but by no means always, deployed as a result of violence, aggression, agitation, or other challenging behaviours. Sometimes, restraint is needed to provide essential care (e.g., nasogastric feeding) to a resistive patient or to protect an individual from self-harming. Securing a person to a seat with a seatbelt

is also a form of restraint. So, too, is the strapping of a patient to a stretcher or tilt-table test apparatus to prevent them falling off. But these latter examples are not restraints within the meaning of PMVA.

Two points need clarifying here. First, it is generally accepted that restraint following violence is the more controversial because the interests of the individual and those of the staff will often collide (Baskind, 2006). Secondly, although inconsistently applied, in many settings it is only restraint within the meaning of PMVA that generally needs to be reported/recorded in the organisation's records.

There is no single generally agreed definition of physical intervention or restraint. Harris (1996) describes physical intervention as *"any method of responding to challenging behaviour which involves some degree of direct physical force to limit or restrict movement or mobility"* (page 99). Aiken, *et. al.* (2011) defines restraint as "*the lawful use of force involving the restriction of movement by physical holding"* (page 147). The Department of Health (2014) refers to restraint as *"any direct physical contact where the intervener's intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person"* (para 67). A similar definition of restraint is provided by the Care Quality Commission (2018). Weissberg (2018) defines restraint as *"any manual method, physical or mechanical device, equipment or material, that meets all of the following criteria: (a) is attached or adjacent to the person's body; (b) it cannot be removed easily by the person; and (c) it restricts the person's freedom of movement or normal access to his/her body".* The Mental Capacity Act 2005 defines restraint as when someone "*uses, or threatens to use force to secure the doing of an act which the person resists, or restricts a person's liberty whether or not they are resisting*". The Equality and Human Rights Commission Human Rights Framework for Restraint (2019) explains that restraint as "*an act carried out with the purpose of restricting an individual's movement, liberty and/or freedom to act independently".* This Framework goes on to explain that restraint "*may or may not involve the use of force. Restraint does not require the use of physical force, or resistance by the person being restrained, and may include indirect acts of interference for example removing someone's walking frame to prevent them moving around*". In contrast, a more simplified definition of physical restraint is provided by the Colorado Foundation for Medical Care as "*anything near or on the body which restricts movement".*

Similar definitional inconsistencies arise when one considers the meaning of the different forms of restraint, such a mechanical restraint.

In the mid-1980s, the UK prison service's use-of-force methods, which were then known as "control and restraint" were used a basis for other physical intervention training in different settings, including healthcare (Stubbs, *et. al.,* 2008). Although the development of PMVA has advanced in healthcare settings, remnants of the initial control and restraint training can still be detected, especially in relation to pain-compliance techniques and team restrains where the person is restrained by several staff, usually 3 or 4 in number.

2.4 The purpose of restraint

The purpose of restraint ought to be about safety. However, historically, it was virtually impossible to discern any coherent purpose or justification for the way some mentally-ill patients were treated, supposedly in the name of restraint. Hollins (2010) points out that ever since psychiatry has evolved as a professional discipline, those working in mental healthcare settings have had to intervene physically to manage physically aggressive patients. The same can be said of many other settings, both within healthcare and elsewhere. Doubtless, everyone would like to eliminate the use of all coercive measures, including restraint, but this remains an aspiration rather than an outcome that is, at least for now, achievable.

In 18th century England, one of the leading mental-health hospitals (or as they were then known 'lunatic asylums' or 'hospitals for the insane') was Bethlem, where chains and fetters were used for all *'pauper lunatics'*. One saw *"naked men and women patients chained by an arm and a leg to the wall*, *apparently for no reason other than imbecility and poverty"* (Hill, 1967, page 140). This practice of restraint held true into the 19th century at Bethlem Hospital, which was at the time directed by John Halsam. A typical description of what occurred upon the admission of a 'lunatic' is necessary in order to appreciate the incredible brutality that was common in the major asylum of the day:

> *"When an unruly patient enters a common lunatic house, he is bled, dressed in a strait waistcoat, has his head shaved, is subjected to the shower bath, put upon a low diet, kept in darkness, and compelled to swallow some active purgative medication".* (Hill, 1967, page 140).

If this treatment failed to quieten him, other methods were used:

> *"Starvation, imprisonment, loneliness, and threats are then resorted to; or if the proprietor of the house happens to be very alert, some desperate, or some unjustifiable experiment is tried; whirling round upon an horizontal wheel, intoxication, or some strange method of astonishing the patient; such as leading him blindfold and headlong into a cold bath"* (Hill, 1967, page 141).

Although we are now clearer about the purpose of restraint, it is impossible to state a single purpose for the use of force or restraint as this depends on the typology of the aggression or violence, the setting, and the specific circumstances. Thus, statements such as *"physical restraint ... should be used ... in a therapeutic manner"* (Rich, 1997) might be appropriate in a care or child setting but do little to explain its purpose in other settings, especially policing or custodial settings where the violence arises from criminal intent.

There may be several reasons why a person might choose to use force against another, and these include the need to defend oneself or another against an attack; to protect property; to prevent crime; to effect or assist in the lawful arrest of offenders; to protect the subject against harm (including self-harm); or to maintain good order and discipline. Sometimes, the use of force might result from more than one of these reasons. It can be seen, therefore, that the use of force for therapeutic purposes is just one of the possible reasons where force might be used. The Author suggests that the purpose of restraint can conveniently be broken down as shown in Table 4 below. The Author has mapped these purposes against the typologies (discussed above).

Table 4: The purpose of restraint

Purpose 1	for the protection of the subject or where it is in the subject's interest. Includes self-harm.	Typology: 5, 6.
Purpose 2	for the protection of staff, others and property from the subject's violent or aggressive behaviour.	Typology: 1, 2, 3, 4.
Purpose 3	for the maintenance of good order and discipline. This mainly (but not exclusively) arises in connection with educational and custodial settings.	Typology: 1, 2, 3, 4, 5, 6.

All uses of force must be justifiable and the person(s) using it are often required to justify their reasons for doing so. Such justification should always be provided when completing forms post-intervention and might also arise if the incident is investigated or if court or tribunal proceedings are instigated.

2.4.1 Therapeutic interventions

Difficulties arise when one attempts to justify the use of force by conflating the intended purpose with the act itself. This is frequently seen with so-called '*therapeutic interventions*'.

Merely describing a use of force as a '*therapeutic hold*' or one designed for '*therapeutic effect*' does not, without more, make it so any more than defining '*therapeutic holding*' as *"a treatment technique in which members of staff physically restrain a violent patient"* (Sourander *et al*, 2002). It is submitted that only where a therapeutic element or therapeutic outcome in an intervention can specifically be identified that one might properly justify the use of a '*therapeutic'* label. An example of a definition that describes a therapeutic intervention is:

*"An intervention using approved techniques whereby staff use restraint (or other approved interventions) with the specific aim of assisting and supporting an out-of-control person to regain control" (*Baskind, 2016*).*

Several theories have been advanced which attempt to explain the therapeutic use of restraint in children, the most notable being the '*attachment'* theory (Bowlby, 1973; Cline, 1979 and Zaslow and Breger, 1969) and the '*psychodynamic'* theory (Winnicott, (1965).

Stirling and McHugh (1998) postulate that through the process of bonding, holding the subject fosters a positive client-caregiver experience enabling the subject to develop trust whilst encouraging effective problem-solving and coping skills. It is less certain to what extent the attachment theory might be useful outside of children or adolescent settings, especially those with certain disorders such as borderline personality disorder, autism, sociopathy and reactive attachment disorder as these groups are more likely to have failed in infancy to develop a secure attachment with a parent or primary carer (Bath, 1994). These issues often lead to defensive, rigid and mistrustful behaviours with the child developing maladaptive self-control and coping skills leading to aggressive and violent behaviour as well as developing difficulties with interpersonal contact (Day, 2008). Various holding techniques have been described as part of the attachment theory including holding to reduce rage (Zaslow and Breger, 1969; Cline, 1979) and the Z-process approach (Zaslow and Menta, 1975). *"Since the child acts like a baby, he is being held like a baby"* (Zaslow and Menta, 1975). Zaslow and Menta's (1975) Z-process involves the therapist or therapists holding the child in the cradle position so as to incite intense, rageful resistances and hostility towards the therapists. The ensuing therapy releases an enormous amount of the child's rage and forces it into a confrontation with his feelings and with the therapist with the aim of disrupting the child's "*passive-aggressive sickness style of relating*" (Zaslow and Menta, 1975). As the therapy progresses, the child's responses move from increasing angry arousal to violent rage and eventually to affectionate attachment before returning to appropriate behaviour. This therapy reinforces the notion that genuine affection is

facilitated by the release of repressed aggression which is an essential ingredient to the child responding to and returning an affectionate response. Rich (1997) observed that from a psychodynamic perspective these interventions are proactive and consist of three phases: holding, verbal and resolution, with the final stage providing the child with an opportunity to address any unresolved issues and which might take up to several days to achieve.

It can be seen, therefore, that restraining an aggressive or violent child without an appropriate therapeutic component can be hugely counter-productive. The same must also apply to other vulnerable persons.

Terminology is important. People often talk in terms of using force to "control" the person. Hollins (2010) rejects this description preferring to use the word "*stabilising*" to demonstrate that the use of force *"should be applied objectively within an emotionally neutral context, and not one within which staff perceive that its achievement signifies success or denotes a victory or a win"*.

This chapter examined the typology of violence and aggression, and the different types of intervention, the understanding of which lays down a strong foundation for the following chapter which critically reviews violence, restraint and mental health inequality in the black, Asian and minority ethnic communities.

CHAPTER THREE: VIOLENCE, RESTRAINT AND MENTAL HEALTH INEQUALITY IN THE BLACK, ASIAN AND MINORITY ETHNIC COMMUNITIES

3.1 Does race play a part in managing challenging behaviour?

Many cases from around the world have sought to identify whether race has a bearing on how staff deal with challenging behaviour and, if so, to what extent? In a detailed examination of the mental health inequalities in the Black, Asian and Minority Ethnic (BAME) communities, Khwaja, *et al.*, (2023) explores how these relate to the particular issue of restraint.

Race, culture and ethnicity are not the same. Race is a classification of people based on physical or biological characteristics, such as skin colour, facial features, blood type and stature. Culture is defined as the values, beliefs, attitudes, art, languages, symbols, rituals, religion and behaviours unique to particular group of people and passed from one generation to the next. Ethnicity is a classification of people based on national origin and/or culture; members of an ethnic group may share a common heritage, geographic location, language, social customs and beliefs. The term BAME has been criticised for being an umbrella term that pools together individuals from diverse backgrounds (Mistlin, 2021) and one that the UK Government no longer uses (Race Disparity Unit, UK Government, 2022). However, ethnic groupings remain useful for monitoring, discussing and addressing discrimination and inequalities, and as there is as yet no universally accepted alternative terminology, this is the term used in this thesis, not least because it is widely understood.

3.2 BAME Mental Health Inequality

There is clear evidence that the mental health of those from BAME backgrounds is often worse than for their white counterparts (Institute of Race Relations, 2023). It is also known that more white people receive treatment for mental health issues than people from BAME backgrounds and that they have better outcomes (Race Disparity Unity Unit, UK Government, 2017). The reasons for this are multifactorial and may include the impact of mental health stigma, racism and discrimination, as well as social and economic inequalities (Mental Health Foundation, 2021).

Worryingly, a disproportionate number of BAME patents have died as a result of excessive force, restraint or serious medical neglect (Baskind, BBC Panorama, 2021). *'Big, Black and Dangerous'* is the subtitle of a report published almost 30 years ago: the 1993 Report of the Committee of Inquiry into the deaths of three African-Caribbean patients, Michael Martin, Joseph Watts and Orville Blackwood, all of whom died in Broadmoor Hospital after being placed in seclusion cells (Special Hospital Service Authority, 1993). The report showed that Black people were more likely to have police involvement in their admissions to hospital, more likely to be detained and more likely to receive secure care. The impression that these patients were *'big, black and dangerous'* was given so frequently to the committee that they included it in the title of their report.

In October 1998, the death of David 'Rocky' Bennett at the Norvic Clinic in Norwich, a forensic unit providing medium secure services to the counties of Norfolk, Suffolk and Cambridgeshire, raised particular issues concerning the use of restraint in BAME patients (Institute of Race Relations, 2014). On the night of his death, Bennett was removed from his ward after fighting with another patient who had 'racially' abused him. While resisting the move, Bennett assaulted a nurse. Five nurses then used restraint measures, holding Bennett face down while immobilising his arms, ankles and upper chest for an estimated 25 minutes. After some time, the nurses realised that he was no longer struggling and was not breathing. They were not able to revive him and he was pronounced dead a short time later. The report of the Inquiry into Bennett's death noted, amongst other things, that the nurses were not aware of Bennett's cultural needs and treated him as a *"lesser being"* (Blofeld, *et al.*, 2003; p.58). The report also noted that *"unless there are sufficient resources and sustained management, which is both dedicated and committed, these problems cannot be solved. At present people from the black and minority ethnic communities, who are involved in the mental health services, are not getting the service they are entitled to. Putting it bluntly, this is a disgrace.*' (Blofeld, *et al.*, 2003; p. 58).

The 2002 Sainsbury Centre for Mental Health review of the relationship between mental health services and African and Caribbean communities reported a *"circle of fear"*, with *"black people mistrusting services, and staff often wary of the black community, fearing criticism and not knowing how to respond, and fearful of young black men"*. This circle of fear, *"is fuelled by prejudice, misunderstanding, misconceptions and sometimes racism"* (Sainsbury Centre for Mental Health, 2002; pp 6 - 8). The report acknowledged that young Black men in particular

are heavily over-represented in the most restrictive parts of the mental health service and generally have a negative experience of services. Furthermore, these same communities were not *"accessing the primary care, mental health promotion and specialist community services which might prevent or lessen their mental health problems. They are getting the mental health services they do not want but not the ones they do or might want"* (Sainsbury Centre for Mental Health, 2002; p. 6).

Twenty years on from the Sainsbury Report, disparities in the use of the Mental Health Act ("MHA") persist, as highlighted in the 2018 Independent Review of the MHA which confirmed that Black people were four times more likely to be detained and eight times more likely to be subject to a community treatment order than white people (Department of Health and Social Care, 2018).

Black people of Afro-Caribbean or African descent were also disproportionately subjected to use of section 136, had longer average lengths of stay in hospital, higher rates of repeat admissions, higher rates of seclusion, were less likely to be offered psychological therapies and had higher drop-out rates from cognitive behavioural therapy for psychosis (Department of Health and Social Care, 2018). Section 136 is part of the MHA that gives police emergency powers. Police can use these powers if they consider a person has a mental disorder, they're in a public place and need immediate help. Police can take, or keep, such a person in a place of safety, where their mental health will be assessed.

The review concludes that profound inequalities exist for people from ethnic minority communities in accessing mental health treatment, their experience of care and their mental health outcomes. The reasons behind this are multiple, involving longstanding experience of discrimination and deprivation and structural factors that engender racism, stigma and stereotyping. The authors of the review consider that there is no single or simple remedy to resolve this situation (Walstenholme, 2020).

Amongst the review's recommendations is the development and rollout of an organisational competence framework (OCF) and patient and carer (i.e., service user) experience tool across health and care organisations. In response to the recommendation, NHS England and NHS Improvement have developed the Patient and Carers Race Equalities Framework (PCREF) (National Collaborating Centre for Mental Health, 2018). The framework is an important part of NHS England and NHS Improvement's Advancing Mental Health Equalities Strategy and

is being used to support NHS trusts to improve ethnic minority community experiences of care in mental health services. The framework has three key components:

1. Statutory and regulatory obligations: expectations on all mental health trusts in fulfilling their statutory duties under core pieces of legislation, such as the Health and Social Care Act and the Equalities Act;

2. Organisational competency: a competency framework to support trusts to improve patient and carer experience for ethnic minorities;

3. Patient and carers feedback mechanism: to embed patient and carer voice at the heart of the planning, implementation and learning cycle.

In February 2022, the NHS Race and Health Observatory published their rapid review of ethnic health disparities (NHS Race and Health Observatory, 2022). The review identified evidence of health inequalities faced by ethnic minority communities, including in seeking help for mental health issues, improving access to psychological therapies, receipt of cognitive behavioural therapy for psychosis and compulsory admission and harsher treatment (including the use of prone restraint and seclusion) during admission, particularly for Black groups.

A striking finding of the review was that Black children were ten times more likely to be referred to Children and Adolescent Mental Health Services (CAMHS) via social services than via a general practitioner. Commenting on the review, Smith, *et al*., (2022) highlight this statistic, explaining that *"clearly there are barriers to accessing primary care that are not noticed, that are neglected, and thus remain unaddressed. This inaction in the face of need is the very essence of systemic discrimination*". Furthermore, marginalisation and exclusion from society start early in a person's life, and by the time patients get to mental health services they've often been failed many times over by institutions across education, health, social services, housing, and the justice system.

3.3 BAME and Restraint

Much has been written about Black people being subjected to stereotypical assumptions and being perceived to be more threatening than White people (Trawalter, *et al*., 2008; Angiolini, 2017; Vox, 2017; Wilson, 2017). The stereotyping of young Black males as 'dangerous, violent and volatile' is a long-standing trope that is ingrained in the minds of many in our society.

People with mental-health needs also face the stereotype of the mentally ill as ‘mad, bad and dangerous’ (Angiolini, 2017).

In this context, recent data on police Taser use is a cause for concern. Home Office data, albeit based on police officer perception, indicates that Black people are more likely to have a Taser used against them than White people. Black people are involved in around 20% of Taser incidents in three years’ worth of data despite making up less than 4% of the UK population (GOV.UK, 2020). In 2019–20, Black people were subjected to Taser use at a rate between five and eight times higher than White people (Home Office, 2020). This can be contrasted with the data on Asian people, who were involved in 6% of Taser incidents in 2017/18, and in 7% of incidents in both 2018/19 and 2019/20. People of mixed ethnicity were involved in 3% of Taser incidents in all three years (Home Office, 2020). Although much of this data relates to the use (but not necessarily the discharge) of a Taser, there is no reason to suspect that other uses of force would be different. Indeed, Home Office data indicates that Black people were involved in 16% of use-of-force incidents in 2018–19 and 2019–20 despite representing less than 4% of the UK population (Home Office, 2020). As well as the stereotypical assumptions described earlier, this disproportionality is often explained by police officers describing the Black males they have restrained as having *“superhuman strength”* and, often incorrectly, as the *“biggest man I have ever encountered”* (Angliolini, 2017). It is hardly surprising, therefore, to see that these perceptions translate into disproportionate uses of force against Black males, even in cases where no force can objectively be justified (Baskind, 2021).

The tragic death of Kevin Clarke, an acutely mentally unwell Black man who was restrained by up to nine officers from the Metropolitan Police in 2018, illustrates the dehumanising effect restraint can have, to the almost total exclusion of the well-being of the person restrained. The inquest jury concluded that Mr Clarke was generally cooperative up until the point when police officers laid hands on him and restrained him. It is the Author’s opinion, that Mr Clarke should have been treated as a medical emergency rather than being forcibly restrained.

There is no doubt that restraint training has improved considerably over the years, but much more is needed to educate staff and others about the needs of those whose presentation or behaviour all too often leads to restraint. Improvement is necessary in other areas as well. For example, the CQC has reported that there was a higher proportion of people from a Black or Black-British background in prolonged seclusion on CAMHS wards: 24%, compared with 6% of all people on CAMHS wards in England. Similarly, for learning disability wards, 11% of

those in prolonged seclusion were from Black or Black-British backgrounds, compared with 5% of all people on these wards (Care Quality Commission, 2020). Organisations should implement mandatory training covering the nature of discrimination, including race issues, ensuring sufficient attention is paid to confronting discriminatory assumptions and stereotypes. This will help to ensure that staff are able to challenge the stereotypes which often lead to restraint techniques or other coercive measures being more likely to be used. Consideration should also be given to how this training could take the form of a meaningful two-way dialogue allowing staff to hear first-hand the experiences of people from BAME backgrounds.

Khwaja, *et al*., (2023) suggests that organisations should also ensure that issues of race and discrimination are considered as an integral part of their work to help ensure the well-being of everyone who uses their services. This requires careful monitoring at a senior level, with a *'lessons learnt'* approach in appropriate cases and managers being alert to whether any discriminatory attitudes may have caused or contributed to adverse outcomes. Discrimination issues should be addressed robustly in line with the organisation's policies. Managers should be alert to similar cases involving the same staff (Baskind, 2014).

Two cases in particular have raised concern across the globe: George Floyd in America, and Sheku Bayoh in Scotland.

3.3.1 George Floyd

The unlawful killing of George Floyd in Minneapolis, Minnesota, USA during arrest and restraint by the hands of a police officer on 25 May 2020 reopened a psychological wound for black people and revealed unique challenges within mental health services (Lola, 2020). George Floyd's tragic death gave rise to Black Lives Matter (BLM) protests across the globe. The protests energised the call for discrimination to be robustly addressed within mental health services and in society in general. The BLM movement is often criticised by those who say in response to BLM highlighting discrimination and racial inequality experienced by Black people, that 'White lives matter also'. The inference being that that those supporting BLM are not valuing white lives, when in reality the movement is simply asking for Black lives to be valued equally to those of their white neighbours. Researchers use the term 'racial gaslighting' to describe a way of maintaining a pro-White/anti-Black balance in society by labelling those that challenge acts of racism as psychologically abnormal (Wolstenholme, 2020).

There remains a need to challenge false narratives and narrow review and interpretation of evidence to undermine the existence of racism (Dissanayaka, 2020). For example, the recent report of the Commission on Race and Ethnic Disparities (CRED) concluded that there was no evidence of systemic or institutional racism in the United Kingdom (Commission on Race and Ethnic Disparities, 2021). The report was heavily criticised by, amongst others, the Royal College of Psychiatrists who stated that *"[T]he report implies that, in the claimed absence of structural or institutional factors, individuals or families are to blame for the negative experiences and discrimination they face and that the authors have relied on outdated information and selective review of the available evidence to make their recommendations, meaning the methodology, as well as the conclusions, are flawed"* (Iacobucci, 2021).

Although the impact of racism must be properly acknowledged, it is equally important not to assume that the inequalities identified (e.g. the differences in detention rates and rates of restraint) are entirely due to racism. There is no published study that demonstrates unequivocally that race is the most important factor contributing to increased detention and use of restraint, and so blame directed solely on racism is, at best, premature, and most likely wholly fallacious. The complexity of researching health inequalities for causal factors is well-made in a recent systematic review and metanalysis considering ethnic variations in compulsory detention under the MHA (Barnett, *et al*., 2019). The review found that BAME and migrant groups are at a greater risk of psychiatric detention than are majority groups, and that the *"most common explanations for the increased risk of detainment in BAME populations included increased prevalence of psychosis, increased perceived risk of violence, increased police contact, absence of or mistrust of general practitioners, and ethnic disadvantages"* (p. 313). The authors advised that *"attempts to explain increased detention in ethnic groups should avoid amalgamation and instead carry out culturally specific, hypothesis-driven studies to examine the numerous contributors to varying rates of detention"* (p. 305). There are no published studies as of yet that are able to avoid such amalgamation of possible contributory factors, and the latter are going to be difficult, if not impossible, to separate.

3.3.2 Sheku Bayoh

Sheku Bayoh was born on 30 September 1983 in Sierra Leone and died on 3 May 2015 after being restrained by police in Kirkcaldy, Scotland. His death sparked considerable controversy, and an independent government Inquiry (https://www.shekubayohinquiry.scot). The aim of this Inquiry is twofold: first, to establish the circumstances surrounding his death and make

recommendations to prevent future deaths in similar circumstances. Secondly, the Inquiry will assess and establish the following aspects of the case: (a) the post incident management process and subsequent investigation and make any recommendations for the future in relation to these; and (b) the extent (if any) to which the events leading up to and following Bayoh's death, in particular the actions of the police officers involved, were affected by his actual or perceived race and to make recommendations to address any findings in that regard.

The Inquiry's findings, not due "for some time" (https://www.shekubayohinquiry.scot/faq) are likely to be far-reaching and come at a time when the chief constable of Police Scotland admits his force is institutionally racist (Brooks, 2023) and, perhaps more worrying, that institutional racism isn't confined to Police Scotland (Linklater, 2023).

During a recess in the Inquiry's proceedings, BBC Scotland engaged the Author to contribute to a documentary to evaluate the evidence that had so far been given to the Inquiry. This documentary was broadcast by the BBC on 21 November 2022. The BBC assured the Author that nothing in the documentary would prejudice any aspect of the Inquiry.

This chapter critically reviews violence, restraint and mental health inequality in the black, Asian and minority ethnic communities and seeks to put into context claims that some institutions are 'institutionally racist'. Excessive and unnecessary uses of force, and other kinds of coercive and restrictive interventions, not only affect BAME communities and the next chapter examines the need for the minimisation of restrictive and coercive interventions throughout all communities.

CHAPTER FOUR: THE NEED FOR MINIMISATION OF RESTRICTIVE AND COERCIVE INTERVENTIONS

4.1 Restrictive and coercive interventions

There is no question that restrictive and coercive interventions are overused: the real question is why? In short, restrictive and coercive interventions are umbrella terms for making a person do something they don't want to do or preventing them from doing something they want to do. A restrictive intervention is an intervention that restricts a person's freedom of movement. This can include observation, seclusion, long-term segregation, physical or mechanical restraint, rapid tranquilisation and chemical restraint, coercion and enforced medication.

As this chapter will show, there have been numerous initiatives designed with the ultimate aim of promoting and protecting the human rights of vulnerable people, children and adults, at both national and international levels. A key objective of many of these initiatives has been to minimise or eliminate the use of restrictive interventions, especially restraint, but also seclusion as well as a range of other coercive practices including the imposition of blanket restrictions.

These initiatives have taken many and varied forms, including guidance for service providers and standards for practice and training (Restraint Reduction Network, 2019). Good practice has been illustrated, the content of training programmes specified, and service providers subjected to inspection, accreditation and increasing levels of external regulation and scrutiny (Paterson, *et. al.*, 2014). Such approaches when complementing whole organisation, public health-based systems and explicit coercive-intervention reduction strategies have had some success in some services, but not enough to consider them a success (Tyrer, *et al*, 2023). In some settings, restraint has actually increased (Adams, 2018) although this might be due to improved reporting. Injuries to staff and service users during restraints have also increased (Robinson, *et al*, 2017).

Paterson (2020) argues that issuing guidance at a national level has not changed practice. Furthermore, Murphy (2019) has observed that specifying the content of training does not appear to have had an impact on changing dysfunctional cultures. Paterson (2020) also observes that the accrediting of training providers has not led to the consistent decreases in the use of physical interventions that had been anticipated, and that in some settings there have been marked increases in the use of restraint and seclusion, and increases in the restrictiveness of the interventions used. Training providers are, in the main, engaged by employers to provide

physical skills training to their staff. Hence, it should not be surprising when staff deploy the very skills they have been taught. This is why staff also need to be trained to anticipate challenging behaviour and manage it as safely as possible, ideally without deploying restraint or secluding those who need care. This was discussed in detail in Chapter 2, section 2.2.

Despite the various initiatives discussed throughout this thesis, the scandals associated with the misuse of restraint and broader concerns over abuse have not gone away (Lintern, 2020). This is hardly surprising because, gesturing aside, nothing has fundamentally changed. The maxim stands good: *'if you keep on doing more of the same, you will get more of the same'*.

Paterson (2020) appears to be critical of the schemes for regulation:

> *"Regulation schemes, whether for service providers or training providers, practice standards and inspection programs have repeatedly failed to deliver sustained consistent improvements in practice at the level of the individual service users or prevent abuse from happening. There is little reason to suspect therefore that the new standards, accreditation scheme, or regulatory regime will work at least on their own… The current UK accreditation schemes for service and training providers are both complex and costly. The money, time and effort currently invested in those edifices might better be invested elsewhere"*.

The "new standards" that Paterson refers to are the Restraint Reduction Network ("RRN") Training Standards and the "accreditation scheme" is the BILD Association of Certified Training. The regulatory regime can be found in the Mental Health Units (Use of Force) Act 2018 as well as the CQC, both of which require mental health units to be accredited by BILD ACT as confirming compliance with the RRN training standards.

Paterson's criticism is curious because he is a regular speaker at BILD-RRN events where he supports their work and encourages others to adopt it, including settings other than mental health inpatient units and organisations from other countries, both of which are examples where the 2018 Act has no jurisdiction or application.

4.2 Restraint minimisation and last resort principles

There is a growing international drive for minimising the use of restrictive practices, including restraint, in services across a broad spectrum of settings, and in particular mental health (Bowers, 2014) and children and young persons' services (Challenging Behaviour Foundation, 2020). Mulcahy (2018) points out that even in custodial settings, the use of coercive restrictive

practices, including solitary confinement, must be minimised so as not to traumatise or re-traumatise prisoners.

Efforts to reduce the use of restrictive practices globally have been met with varying degrees of success (Maguire *et.al*., 2012) although comparing rates of restrictive practices between countries and settings has been significantly hampered because of the different definitions and methods of data collection used (Lepping *et.al.,* 2016).

Although there is a general determination to reduce all kinds of restrictive and coercive interventions it is neither possible nor safe to eliminate them altogether (Baskind, 2016). McDonnell (2021) goes even further and advocates a ban on the use of most restrictive practices, especially restraint, instead preferring what he terms a "low arousal approach" to managing challenging behaviour. This has merit in some settings, for example, those caring for people with learning disabilities, but will not be safe in many other settings, such as custodial settings, the police, or many parts of the NHS including Emergency Departments.

There are, however, a couple of issues that must be addressed when speaking of a complete hands-off approach. First, a distinction needs to be made between *stopping the use* of and *eliminating the need* for restraint. Anyone, anywhere, can immediately stop using restraint, but this does not mean that they have eliminated the need for it.

Further, it is the Author's experience from advising healthcare organisations that, although most see the reduction of restraint as their primary goal, some organisations believe that seclusion is the bigger concern and have even designed their new buildings without dedicated seclusion rooms. It is important to appreciate that none of these behaviours, or their management, should be viewed in isolation from other kinds of behaviour or intervention. A good way of examining these issues is to consider them as a balloon where they are relatively easy to suppress simply by squeezing that part of the balloon that is considered to be undesirable or less desirable than the alternatives. But, just like squeezing the balloon, the problem merely moves elsewhere often with unintended consequences which might result in interventions that are more restrictive and potentially more harmful.

Restrictive practices, including restraint, can be characterised as an exercise of power by one or more people over another person. Powers *et. al.,* (1990) describes how powers can be abused including by relying on harsh or unfair ways to modify a person's behaviour. To help ensure that these powers are not abused, comprehensive safeguards need to be in place and monitored

to ensure proper compliance with appropriate laws, policies and guidelines. The type and frequency of restrictive practices vary considerably between countries and settings (Lepping *et. al.,* 2016; Kuivalainen *et. al.,* 2017) and are influenced by a number of factors, notably, legislation and policy issues; as well as environmental and organisational factors, especially the type of setting and its mood/atmosphere; and staff and subject characteristics, including, for staff, issues of training, experience, skill and gender and, for patients, their diagnosis and propensity for violence and aggression (Kuivalainen *et. al.,* 2017; Price *et. al.,* 2018).

The overuse or excessive use of these interventions fall into three main types, the first of which can simply be described as it relates to abuse; often an abuse of power. It has nothing to do with restraint *per se*, as in this category the use of any kind of restrictive intervention is usually neither necessary nor warranted and will, in all but the exceptional case, be unlawful, amounting to a criminal offence. This was exemplified by the Winterbourne View case, discussed in Chapter 6. The second category relates to an excessive use of force. In this category, some kind of intervention may be warranted, but not of the kind or at the level actually used. There are several reasons why staff might resort to the use of excessive forms of coercive intervention including inadequacies in training, indifference, and fear. Unless staff are trained in minimum force strategies it is difficult to see how they could be expected to use minimum force when an incident requires a physical intervention. Some staff are indifferent as to the feelings of those in their care or custody and this category is little different to abuse. Fear is a significant factor in excessive force cases and refers to situations where the principal goal of staff is to avoid harm to themselves or colleagues. Although it is not possible to *"weigh to a nicety"* the exact measure of force needed, and this is reflected in the law (Palmer, 1971), appropriate training in PMVA skills is important so as to equip staff with the knowledge necessary to ensure that only necessary and proportionate force is used, and for the shortest possible time. The third category is closely related to the second and is seen in cases where the incident could have been satisfactorily managed without the need for any force to be used, yet staff nonetheless resorted to restraint.

The requirement to minimise all uses of restraint and other coercive interventions in now embedded into most PMVA training programmes and has been laid down as requirements in many policy and guidance documents (Department of Health, 2014; NICE, 2015), as well as in the recently enacted Mental Health Units (Use of Force) Act 2018. This Act requires the responsible person for each mental health unit to provide training for staff that relates to the

use of force by staff who work in that unit (section 5(1)) and that this training must including training in the use of techniques for avoiding or reducing the use of force (section 5(2)(e)).

Although these requirements are extremely welcome, the way in which they are implemented is often inconsistent. Merely re-stating that all other options should be exhausted or that staff should attempt to de-escalate the incident before resorting to any use of force is far too simplistic to offer any meaningful insight into the matter. There is also a degree of confusion about the meaning of 'last resort' and precisely at what stage staff should intervene, and how. Many training manuals advise staff to ask themselves: *"Have I exhausted all reasonable options?"* (see, e.g., HOMES, 2014; v11.3, p. 6) and some guidance documents require physical interventions to be used as a last resort (see, e.g., Department of Health, 2014, page 13). This document also suggests that the legal and ethical basis for organisations to allow their staff to use restrictive interventions is founded on the principle of last resort, emphasising that *"restrictive interventions should only ever be used as a last resort"* (Department of Health, 2014; page 25). Some authors also refer to last resort principles as essential requirements in the practice of PMVA (see, for example, Sacks-Jones, 2017).

While staff need to consider all reasonable options, this question suggests that all reasonable options need to be exhausted prior to considering any form of physical response. This is correct in many situations but there will be others where a physical response should be considered as a first option. Examples where this might be the case are in cases of emergency, for example, to prevent a person attacking another or about to cause serious harm to themselves. In such cases, delaying a physical response to try to de-escalate the situation might prove dangerous or even fatal. It would be more helpful to make sure that staff are trained only to attempt non-physical options if there is a reasonable chance of them being effective, with a rebuttable presumption that they will be. The better question to ask, therefore, should be *"Have I considered all reasonable options?"* (Baskind, 2014).

A number of studies have shown that restraint itself can be an antecedent to violence (Blomhoff *et. al.,* 1990; Harris *et. al.,* 1986; Sullivan and Yuan, 1995; Hillbrand *et. al.,* 1996; Flannery *et. al.,* 2003; Chou *et. al.,* 2001; Cooper and Medonca, 1991; Quanbeck *et. al.,* 2007). In one of these studies, restraint was attributed to 70% of 88 incidents involving violent patients within a Norwegian inpatient acute psychiatric ward (Blomhoff *et. al.,* 1990). Segregation or seclusion, and in particular, long-term segregation or long-term seclusion, can also place patients into an aggression-coercion cycle with the door becoming an almost-total barrier to

treatment (Baskind, 2016). Finally, a recent Randomised Control Trial ("RCT") into the use of police Tasers showed that the presence of a Taser by a police officer is causally linked to statistically significant increases in the use of force more generally, with a doubling in assaults on officers, and an increase in aggression against police officers (Ariel *et. al.,* 2019). These studies and observations should serve as further reminders for staff to use coercive interventions, including restraint, judiciously.

A tiered or hierarchical approach, such as that described by Gournay (2003) and discussed in greater detail below, not only demonstrates a holistic and patient-centred approach to PMVA, it also minimises the risk of harm, enhances the therapeutic relationship between staff and patient, and because of the reduced likelihood for restraint to be used, has been known to lead to greater patient cooperation (see, e.g., the work of the French Physician, Philippe Pinel, 1745-1826).

Provided that every reasonable effort has been taken to avoid the use of restraint and other coercive measures, then least restrictive interventions, using the minimum force necessary to achieve the lawful objective, should be used for the shortest possible time. It is self-evident that only where staff possess effective communication and other de-escalation skills that they will be capable of substituting powers of persuasion for physical power, and thereby reduce the risk of physical injury to themselves and the people with whom they are dealing (Haberfeld, 2002).

Although this section is discussing restraint, in many cases where staff have managed to deal with an incident without using force, other strategies have been used in its place. It is hoped that no one would argue that strategies such as environmental changes, de-escalation and calming tactics are not generally preferable to any use of force, but other strategies that might obviate the need to use force are also controversial. These include seclusion and medication in the form of chemical restraint.

Although these interventions are often discussed as alternatives to the use of force, in many cases they are used in conjunction with force. It must also be acknowledged that, by substituting restraint for an alternative intervention, usage of this alternative intervention will necessarily increase. This might not sit too easily with everyone, especially in settings or organisations where the use of alternatives to restraint, and in particular, seclusion, is discouraged (see, e.g., NICE, 2015; paras 5.7.1.37, 6.6.3.14, 6.6.3.30, 8.1.1.1, 8.3.2.9 and 8.4.8.1; Department of Health, 2014; para 87). Lyon and Pimor (2004) argue that seclusion should be used only in

extreme cases and should be considered as an emergency procedure, to be used only where there is a sufficient degree of risk.

Paley (2009) identifies three possible rationales for the use of seclusion. First, as *'positive therapy'* intended to assist a service user to calm more quickly and enable them to learn to manage their own emotional states by reflecting on their behaviour and emotional expression. This approach sees seclusion as leading to some kind of beneficial therapeutic change in the individual. Second, as a method of '*containment'* whereby placing the service user alone in a room and preventing them from harming others when in a state of crisis. As with positive therapy, this approach sees seclusion as leading to some kind of beneficial therapeutic change in the individual. Finally, as a method of punishment where seclusion is seen as an intentional aversive intervention with the intention of withdrawing the individual from all positive experiences. Nelstrop *et. al.,* (2006) conclude that there is insufficient evidence to determine whether seclusion and restraint are safe and/or effective interventions for the short-term management of disturbed or violent behaviour in adult psychiatric inpatient settings. They conclude, therefore, that these interventions should be used with caution and only as a last resort once other methods of calming a situation and/or the service user have failed.

It is obvious that not every intervention can be designated *'last resort',* and it is only where it is safe and appropriate for no intervention to be used that a perfect solution can be said to exist. Following the Planned Intervention Flowchart (see Fig. 6, section 5.7) will assist organisations in substituting restraint for no-force alternatives.

Calls for the elimination of restraint and seclusion have taken various forms. For example, in 2018, the Children and Young People's Commissioner Scotland called for a temporary but total ban on restraint and seclusion, following a formal investigation into restraint and seclusion in Scotland's schools which began on 30 March 2018. Before criticising this ban, it is important to set out the background to the investigation and the resulting report: '*No Safe Place: Restraint and Seclusion in Scotland's Schools*' (Children and Young Person's Commissioner Scotland, 2018). The investigation focussed on two main elements. First, the existence and adequacy of policies and guidance which reflect the law and the obligations of the State under international human rights instruments. These instruments include the European Convention on Human Rights (ECHR), the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and the United Nations Convention on the Rights of the Child (UNCRC). The Commissioner noted that these are essential pre-requisites to accountability and redress.

Secondly, it is important to reflect the extent to which incidents are recorded and reported at local authority level. Recording of incidents of restraint and seclusion was noted by the Commissioner as being recognised internationally as a critical means of ensuring that practice is appropriately monitored and scrutinised, as well as fully rights-compliant.

The Commissioner required all 32 local authorities throughout Scotland to provide copies of their policy documents and recording forms governing restraint and seclusion as well as to complete an online evidence gathering form. Four of these local authorities had no policies or guidance in place to govern the safe and lawful use of restraint and seclusion. The Commissioner noted that although children's rights are referenced in a number of policies, they are not given meaningful expression in terms of how they should impact on practice. The Scottish Government were criticised for not producing a national policy to ensure consistent and lawful practice for restraint and seclusion. More specifically:

> *"This means that in some local authorities, children may be subject to restraint and seclusion without any policy or guidance in place to support lawful and rights-compliant practice. Even where policies do exist, they create the potential for significant variations in practice across local authorities."*
>
> ('No Safe Place: Restraint and Seclusion in Scotland's Schools', Children and Young Person's Commissioner Scotland, 2018).

Insofar as the recording of incidents of restraint and seclusion is concerned only 18 out of the 32 local authorities recorded all such incidents within their area and 4 local authorities did not record any of these incidents. It is clear that the number of restraints and seclusions are significant: of those local authorities that did record the data across the school year 2017-18 there were 2,674 incidents of restraint and seclusion relating to 386 children. The dearth of such data is deeply troubling and despite calls from the United Nations for it to do so the Scottish Government does not record data on restraint and seclusion (Children and Young Person's Commissioner Scotland 2018, p. 12). This is wholly unacceptable not least because the recording of incidents of restraint and seclusion is recognised internationally as an essential means of ensuring that practice is rights-compliant and appropriately monitored and scrutinised. Without accurate data, it is impossible to identify with any degree of certainty how many such incidents take place, who are most affected, and other critical information such as frequency, severity and outcomes of the incidents.

Restraint was noted as being inconsistently defined across the 32 local authorities. Only 18 local authorities clearly set out that restraint should be used a last resort when the child or

another person is at immediate risk of harm. Further inconsistency was identified with the permitted use of restraint with some local authorities permitting restraint to be used to prevent damage to property. This is particularly worrying given that the use of restraint may be a violation of children's rights to respect for their bodily integrity under Article 8 of the European Convention on Human Rights. Similarly, the use of seclusion may constitute a deprivation of the child's liberty resulting in a breach of their rights under Article 5 of the ECHR. The Commissioner reported that local authority guidance on seclusion generally does not reflect the legal tests to ensure compliance with the ECHR pointing out that *"only one local authority recognised that deprivation of liberty is only lawful if authorised by a court or tribunal"* (page 217). Without clear guidance, it is difficult to imagine how staff would know when or if seclusion might constitute a lawful intervention or when it might be an unlawful deprivation of the child's liberty.

It is against this background, that the Commission recommended that:

> *"Local authorities should, as a matter of urgency, ensure that no restraint or seclusion takes place in the absence of clear consistent policies and procedures at local authority level to govern its use."* (page 312).

This recommendation has rightly been condemned (see, e.g., CALM, 2019). It is unworkable, unlawful and unsafe. It is also unsafe and poor practice to remove any kind of intervention before undertaking a risk assessment and thoroughly understanding the consequences of such a move. Presumably, the Commissioner gave thought to what might fill the void left by the removal of restraint and seclusion, although this is not evident from the report. If the prohibition against the use of restraint and seclusion were to be implemented what are staff expected to do when a child self-harms, assaults another or is causing serious property damage? Staff in some schools and other establishments are tasked with supporting children with significant behavioural issues which may place themselves and others at risk of immediate and serious harm. Doing nothing risks harming the child and others. The duty of care owed to children and others is not suspended pending the satisfactory implementation of the policy documents, training and other omissions identified by the Commissioner leaving staff and their employers liable to legal action. Neither staff, nor employers, will have available to them a defence on the ground they were merely following the Commissioner's recommendations. In the meantime, until the defects identified by the Commissioner are remedied, immediate steps are needed to ensure that all schools and other relevant establishments review their policies and practices in line with best practice and the other recommendations set out in the Commissioner's report. It

can only be hoped that the Commissioner's work will lead to National Guidance that has been informed by appropriately experienced experts and best practice. Although it is undesirable for staff to use restraint and seclusion unless underpinned by appropriate policy and guidance and supported by appropriate training, at least this will present the least-worst option in the quest to protect those who are amongst the most vulnerable in our society.

Over the years, there have been many initiatives and strategies designed to eliminate or minimise the use of restraint, some of which have been successful and are still in operation and others that have proven to be ineffective and even counterproductive. The main strategies will now be discussed below.

4.3 Conflict resolution strategies

At one time, staff training in managing violence and aggression consisted almost entirely of physical skills, often known as '*self defence*', '*personal safety*' or '*restraint'* training. Much of this training was based on one or more of the martial arts or combat systems, with training typically delivered by staff who were well versed in some form of self defence, such as karate or wrestling (Lion, 1987). Given that such training was typically confined to teaching physical defence and restraint skills with little or no attempt to teach staff how to prevent or de-escalate an incident, it was hardly surprising that staff were using physical intervention skills when, in many cases, none were needed. The principal objection to this old-style physical-only training is that it teaches staff that a physical response is the only, or main, solution to violence and aggression. This is reminiscent of the *'law of the instrument'*; a kind of cognitive bias whereby over-reliance is attached to a familiar strategy or tool: *"I suppose it is tempting, if the only tool you have is a hammer, to treat everything as if it were a nail.*" (Maslow, 1966) is the quote often used in PMVA training extolling the virtues of non-physical aspects of the training.

In one sense, conflict resolution training is more important than physical skills training because, if these strategies are successful, there will be no need to intervene physically and the staff – service user relationship will not be harmed and may even be enhanced (Baskind, 2006).

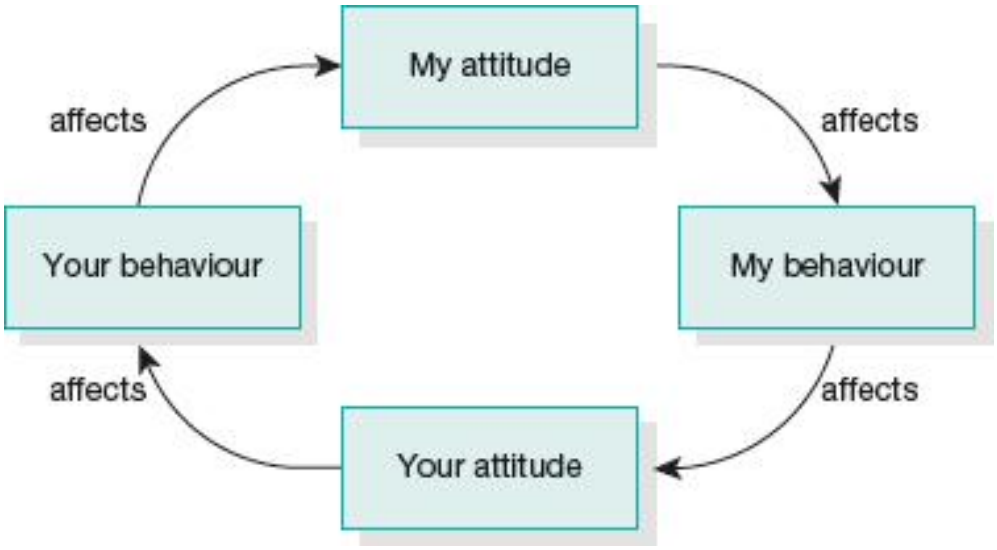
A hierarchical approach to PMVA provides the opportunity for organisational change and staff training. The correct order should be prevention, de-escalation, breakaway techniques, and finally physical intervention in the form of restraint (Gournay, 2003). The Benjamin Franklin maxim that *'an ounce of prevention is worth a pound of cure'* is extremely important in managing VAAoCB and its principles are endorsed throughout this thesis.

The primary focus for any organisation must be to concentrate on the prevention and diversion of violence and aggression (Hollins, 2010). De-escalation is an intervention using emotional regulation or self-management techniques to avert aggressive or violent behaviour (NICE, 2015). 'The assault cycle' typically includes a trigger phase, escalation phase, crisis phase, recovery phase and depression phase (Kaplan, 1983). De-escalation is a complex range of skills designed to abort the assault cycle during the escalation phase, and this includes both verbal and non-verbal communication skills (CRAG, 1996). It comprises *"verbal and physical expressions of empathy, alliance and non-confrontational limit setting that is based on respect"* (Cowin, *et. al.,* 2003). Roberton, *et. al.,* (2012) point out that, although there is no clear guidance on the specific de-escalation techniques that clinical staff should use, various commentators have identified various elements of de-escalation that ought to be used (see, e.g., Richter, 2006; Stevenson, 1991; NICE, 2005). Although NICE (2005) identifies the need for staff to recognise patient triggers, and for staff to be aware of their own verbal and non-verbal behaviour (so as to utilise de-escalation techniques), it provides little explanation of precisely what these techniques might be. Unfortunately, NICE (2015) fails to advance this much further, despite referring frequently to de-escalation, merely stating that *"de-escalation or defusion refers to talking with an angry or agitated service user in such a way that violence is averted and the person regains a sense of calm and self-control"* (NICE, 2015; p.30). The RRN provides the following description of de-escalation: *"The use of techniques (including verbal and non-verbal communication skills) aimed at preventing potential or actual behaviours of concern from escalating. PRN medication can be used as part of a de-escalation strategy, but PRN medication used alone is not de-escalation. De-escalation techniques can include verbal strategies, such as maintaining a calm tone of voice and not shouting or verbally threatening the person; and nonverbal techniques, including an awareness of self, body stance, eye contact, and personal safety (Cowin et al, 2003; Spencer and Johnson, 2016). Effective de-escalation approaches are personalised and include openness, honesty, support, self-awareness, coherent communication, non-judgemental approaches, and confidence, without arrogance (Price and Baker, 2012). They have the aim of preventing escalation and supporting the person to be calm."* (RRN, 2019; Glossary; p.167).

A key principle behind de-escalation can be seen in the *Betari box* (see Fig 2, below). It is unclear who or indeed what Betari was, but the Betari box (also referred to as the '*Cycle of Conflict*') is a classic model used extensively in conflict management training. It helps the learner to understand the impact of their behaviour and attitudes

of others and demonstrates how easily one can descend into spirals of negative communication. Put simply, if X feels negative about Y, X will display negative behaviour towards Y. This in turn will change the way Y feels, often resulting in negative behaviour towards X, and possibly others. Conversely, a positive attitude from either party can create a virtuous circle to which everyone will benefit.

Figure 2. Betari box – the cycle of conflict



Although de-escalation strategies are generally accepted as the preferred option when dealing with VAAoCB, it is noted that two studies have reported that de-escalation was actually an antecedent to violence. Writing on violence in a UK psychiatric hospital, Casseem (1984) notes that one of the causes of violence included talking and reassuring an aggressive patient. Another study into 1,945 reported incidents of patients engaged in assaultive behaviour noted that attempting to calm an already aggressive patient was an antecedent to further violence in 22% of the cases (Rasmussen and Levander, 1996). It is important, therefore, that in addition to de-escalation training, staff should also be taught skills in how not to escalate an already hostile or potentially hostile incident. Non-escalation should therefore be considered part of de-escalation (Baskind, 2006).

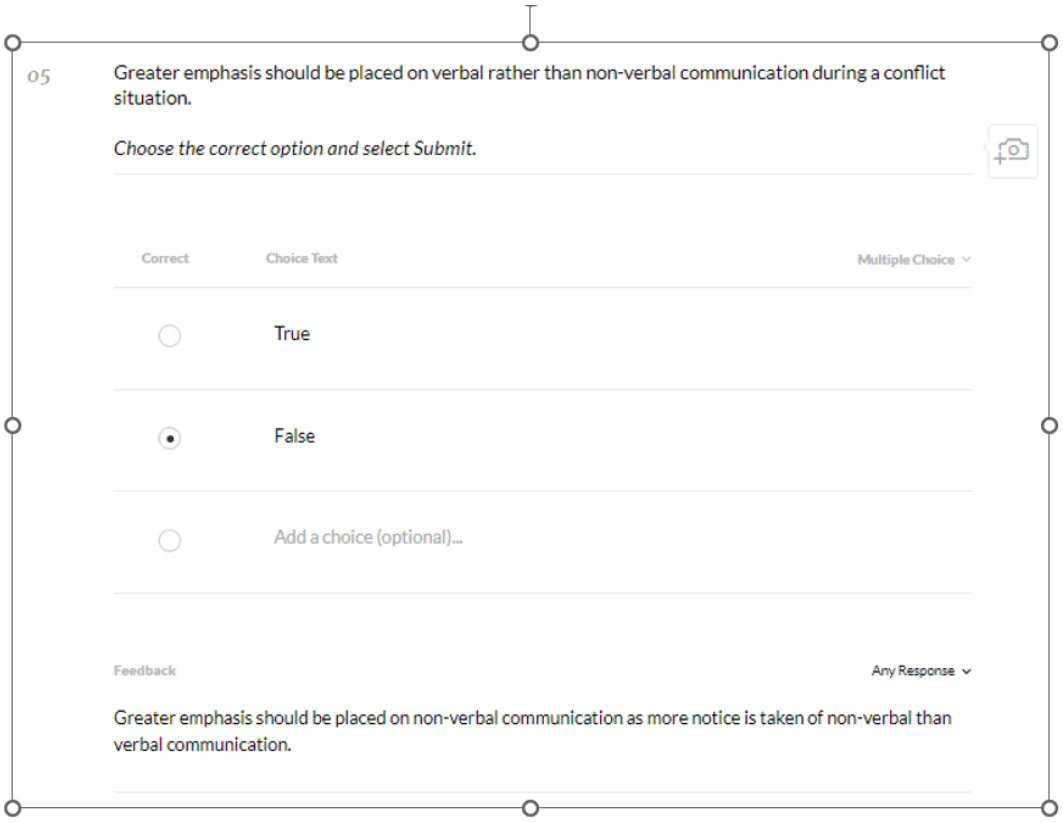
4.3.1 The ’Mehrabian theory’

The so-called ‘Mehrabian theory’ is almost universally cited in the literature discussing the management of VAAoCB. According to the literature, Mehrabian (1971) makes the following claims:

1. Our body language conveys 55% of the message
2. The tone of our voice represents 38%
3. Our actual words convey only 7%

Many training programmes have incorporated the principles of the Mehrabian theory into their training with the result that the spoken words are considerably less important than the way they are delivered. However, the *‘55-38-7 principle’* has been widely misinterpreted, with claims that in any communication, the meaning of a message is conveyed mainly by non-verbal cues, rather than by the meaning of words. This can lead to defective and unsafe practice as seen in Fig. 3 below which shows an assessment screen from NHS England’s Conflict Resolution package that assesses staff’s understanding based on this misunderstanding (NHS England (2021), online – only accessible to NHS staff). It can be seen from Fig. 3 below that the feedback provided *“Greater emphasis should be placed on non-verbal communication as more notice is taken of non-verbal than verbal communication”* is wrong and is another example of erroneous and misleading information being repeated and republished.

Figure 3. Conflict Resolution, NHS England (2021)



This is what Mehrabian (2009) actually said about the 55-38-7 principle:

> *"Total Liking = 7% Verbal Liking + 38% Vocal Liking + 55% Facial Liking. Please note that this and other equations regarding the relative importance of verbal and non-verbal messages were derived from experiments dealing with communications of feelings and attitudes (i.e., like–dislike). Unless a communicator is talking about their feelings or attitudes, these equations are not applicable. Also see references 286 and 305 in Silent Messages – these are the original sources of my findings"*

(Mehrabian, 2009; online, *https://law.temple.edu/aer/2021/05/03/brain-lessons-the-seven-percent-delusion*).

In Mehrabian's study, he conducted experiments dealing with communications of feelings and attitudes via the use of single spoken words that could engender positive or negative emotions (i.e., like-dislike), and concluded that the above-noted disproportionate influence of tone of voice and facial expression becomes effective only when the situation is ambiguous. Such ambiguity appears mostly when the words spoken are inconsistent with the tone of voice or facial expression of the speaker (Mehrabian, 2009). The theory is appliable only when one is describing one's own feelings and attitudes and not in any other situations. Thus, Mehrabian

never asserted that 93% of our communication is non-verbal. Non-verbal signals play a role in communication, but they are not more important than the actual words used.

4.4 Zero Tolerance

1999 saw one of the earliest major initiatives of zero tolerance of violence and aggression towards healthcare workers when Frank Dobson, as Secretary of State for Health, announced that staff and their colleagues have a right to work without fear of being attacked or abused. Although such an initiative cannot, in principle, be criticised its implementation has proven to be problematic. Paterson *et. al.,* (2014) describes zero tolerance as a *"blunt, ineffective instrument that fails to address the issues"*. The former chair of the National Association for Healthcare Security, Nick Van der Bijl describes four main problems. First, while a significant number of staff may have been assaulted by patients, it is not known how many assaults were intentional and how many were not intentional. Secondly, some NHS Trusts, in particular those associated with mental health services, lack skilled security managers able to investigate incidents, educate staff and recommend appropriate protective measures. Thirdly, when Trusts cut costs, among the first to be made redundant are security staff because they are seen to be an overhead rather than an asset. Transferring the risk to the police inevitably increases risk because the police do not have the resources, experience and training to handle some people in hospital and especially those with mental ill-health. Fourthly, there is a continued lack of a proper security function at the Department of Health to coordinate protective security (Van der Bijl, 2019).

Setting tolerance at zero is unhelpful and can be counterproductive. The problem is that it implies non-negotiability which itself is inconsistent with the necessary elements of negotiation and de-escalation that are known to reduce the number of incidents where physical restraint is used. Zero tolerance was mainly seen in healthcare although other sectors that have adopted a zero tolerance approach to aggression include the railways and some retail operations, albeit the latter is mainly targeted towards their refund departments. Although rigidly following rules will likely produce predictable decision-making, it is unlikely to assist staff in taking account of the particular problems and take proper advantage of the conflict resolution skills they have been taught.

Despite its widespread criticism, and described by Baskind (2019) as *"an exercise in gesture politics"*, Matt Hancock as Secretary of State for Health and Social Care, reintroduced Zero

Tolerance in 2018, (NHS, 2018), with the all-too-familiar aim being to protect the NHS workforce against deliberate violence and aggression from patients, their families and the public. Criticised by Van der Bijl (2019) as *"a bland and time-expired political statement that lacks credibility"* the new policy also aims to ensure perpetrators are punished quickly and effectively. The strategy includes a new system to enable staff to record more easily assaults and other incidents of abuse and harassment; the NHS working with the police and Crown Prosecution Service to help victims give evidence and get prosecutions in the quickest and most efficient way; the CQC scrutinising violence as part of their inspection regime and identifying trusts that need further support; improved training for staff to deal with violence, including circumstances involving patients with dementia or mental illness; and prompt mental health support for staff who have been victims of violence (Royal College of Nursing, 2018). These policy initiatives follow on from the Assaults on Emergency Workers (Offences) Act 2018 which has seen the maximum prison sentence for assaulting an emergency worker double from 6 months to a year. The definition of *'emergency worker'* in section 3 of the Act is wide and includes a police, prison and fire officer and *"a person employed for the purposes of providing, or engaged to provide […] NHS health services or services in the support of the provision of NHS health services, and whose general activities in doing so involve face to face interaction with individuals receiving the services or with other members of the public"*. The maximum sentence following conviction for an offence under the Act is a term of imprisonment for a term not exceeding 12 months and/or a fine (section 1(2)). To suggest that this might deter an assault is not supported by evidence and anecdotal evidence suggests it is will not have any such effect.

Without wishing to condone patient aggression in any way, tackling the root cause of aggression is also a key ingredient in preventing aggression and assaults on staff. This factor was expertly summed up by Charles Moor in *The Spectator* when he said:

> *"There are eternal reasons, such as the inherent nastiness of some people, and wider social ones, such as drug abuse. Are there also specific NHS-related ones too, though? The worst aspects of the NHS are not usually medical: they are to do with a bureaucracy which puts patients last. It is utterly extraordinary, for example, that a waiting time of four hours in A&E is now the norm or even, it would seem, the (often missed) target. Often have I sat there wondering not at the aggression of patients, but at their quiet acceptance of such ill treatment. It is wrong when patients attack, but not surprising."* (The Spectator, 3 November 2018, online).

There are many criticisms of a zero-tolerance policy, one of which is that it deals with all forms of VAAoCB in an almost identical manner. Some people express themselves unacceptably but

will never resort to physical violence. Zero tolerance should not be the only response. Taking a zero-tolerance approach to verbal aggression can be counter-productive as it may be seen by the subject as a refusal to discuss the issue and contradicts any conflict resolution and de-escalation strategy. It also demonstrates a refusal to listen. Showing a willingness to listen is often the best way to calm a person down. Encouraging a person to calm down is a good way to get them to alter their behaviour and engage in a rational conversation where their concerns can be addressed. This is also the best time to challenge the subject to behave differently next time. Conversely, issuing punitive threats of sanction is hardly conducive to holding a calm and rational conversation and is likely to reinforce the person's belief that medical staff are part of the establishment to fight, rather than a helpful support that should be valued. Restoring a good relationship with a difficult patient can be extremely rewarding and saves pushing the problem on to others. A zero-tolerance approach is unnecessary to protect healthcare workers from violence. If staff feel physically threatened, they should withdraw to a place of safety and summon security or the police.

Although the NHS has stepped back from the rigours of its 2018 Zero Tolerance policy, with the introduction of an education pathway which focusses on the public health approach of understanding the root causes of violence and aggression (NHS, 2021), some Trusts have maintained their strict Zero Policy approach. This is disappointing, not least because the pathway strongly supports staff in moving away from a zero-tolerance approach and instead considers why incidents are occurring, for example, due to individual-specific factors (such as trauma and distress) and structural, environmental, and societal factors (such as the impact of health inequalities). This lack of consistency between Trusts, and sometimes between hospitals within a Trust, is unacceptable and shows a lack of understanding in such a key area of staff and patient safety. It also sends out a confused message to patients who are likely to be dealt with differently by different hospitals when presenting identically unacceptable behaviours.

4.5 Other initiatives designed to enhance safety

Other initiatives designed to enhance safety in healthcare settings include *Safewards, Six Core Strategies, ReStrain Yourself, No Force First*, *HOPE(S)* and the Restraint Reduction Network. A detailed analysis of these initiatives is beyond the scope of this thesis but a brief discussion follows.

A study by Ward-Stockham, *et.al.*, (2022) found most staff and service users reported *Safewards* improved therapeutic relationships, cohesion, and ward atmosphere. Staff and

service users reported improved ward atmosphere, leading to service-user centred, recovery-oriented care. *Safewards* improved the experience of safety from the perspective of staff and service users when combined with ongoing training, leadership and time for consolidation.

In 2002, the National Association of State Mental Health Program Directors' (NASMHPD) Office of Technical Assistance received funding to develop a curriculum to address the problem of restraint and seclusion use in inpatient settings, which typically resulted from conflict, coercion, and violence in the care setting. NASMHPD staff conducted a thorough review of the literature, met with individuals with lived experience of restraint and seclusion, and convened multiple working sessions with national experts, all of whom had successfully reduced restraint and seclusion in their work settings and sustained the reduction for a number of years (Huckshorn, 2006; Huckshorn and LeBel, 2009; NASMHPD, 2014). The experts identified similar themes and methods used in their respective reduction efforts, which formed the basis of the Six Core Strategies (Huckshorn, 2006; Huckshorn and LeBel, 2009; NASMHPD, 2014). The Six Core Strategies model was articulated and embedded into a prevention-oriented, trauma-informed care framework that approached the problem of restrictive procedure use from a quality improvement perspective. The specific core strategies are (a) active leadership toward organisational change; (b) using data to inform practice; (c) developing the workforce; (d) using restraint and seclusion prevention tools; (e) actively including service users and advocates in the care setting; and (f) rigorously debriefing events of restraint and seclusion after they occur (Huckshorn, 2006; Huckshorn and LeBel, 2009; NASMHPD, 2014). Each strategy was developed into a didactic presentation using current literature, practice-based evidence, and pragmatic examples of specific implementation tasks associated with each strategy. In addition, an action planning template and implementation checklist were developed to accompany the curriculum (NASMHPD, 2014). Together, these tools support the development of a restraint and seclusion reduction and prevention action plan and provide organisations with specific tools to assess their change efforts against multiple activities over time (Human Services Research Institute, 2009; NASMHPD, 2014).

The main implementation of the *Six Core Strategies* in the UK has been by way of an adaptation called *ReStrain Yourself*, the primary aim of which is to reduce the incidence of harm caused to patients and staff in acute mental health wards through a 40% reduction in physical restraint and to evaluate any changes in patient safety outcomes. The process involves implementing the following components: leadership walkarounds; debriefing; service user–led initiatives including advanced directives; service user and staff experience; measurement for

improvement; early warning signs/scores; safety climate and physical environment; failure mode and effects analysis; and *'Plan-Do-See-Act'* cycles. The project implementation plan has four key components: training the trainers; implementing training across participating teams; improving collaboration to support learning, sharing, and adoption; and evaluation.

A study by Haines-Delmont *et.al.*, (2022) into the efficacy of *No Force First* observed a 17% reduction in incidence of physical restraint. Significant reductions in rates of harm sustained and aggression/violence were also observed. The prevalence of physical restraint was significantly higher in inpatients on forensic learning disability wards than those on forensic mental health wards. Physical assault was a significantly more prevalent risk factor of restraint use than other forms of violence/aggression, especially that directed to staff, rather than to other patients.

The newest of the initiatives is the *HOPE(S)* model. Developed by Mersey Care NHS Trust and funded by NHS England, the *HOPE(S)* model is an ambitious human rights based clinical approach to working with individuals held in segregation. Its purpose is to reduce the use of long-term segregation sometimes experienced by autistic adults, adults with a learning disability, and children and young people. The *HOPE(S)* model is designed to encourage teams to:

- **H**arness the system through key attachments and partnerships; to create
- **O**pportunities for positive behaviours, meaningful and physical activities; to identify
- **P**rotective and preventative risk and clinical management strategies; to build interventions to
- **E**nhance the coping skills of both staff and people in services; and whilst engaging in these tasks clinical teams and the
- **S**ystem needs to be managed and developed to provide support throughout all stages of the approach.

Perhaps the most significant development in reducing the use of restraint is the work carried out by the Restraint Reduction Network. Working with Health Education England, the RRN has produced a set of ethical training standards *"that protect human rights and support the minimisation of restrictive practices"* (Restraint Reduction Network, 2019). These training standards (*'RRN Training Standards'*) are intended to apply to *"all training that has a restrictive intervention component and will provide a national and international benchmark*

for training in supporting people who are distressed in education, health and social care settings" (Restraint Reduction Standards, 2019).

The intention of the RRN Training Standards is to ensure that training is *"directly related and proportional to the needs of populations and individual people and that training is delivered by competent and experienced training professionals who can evidence knowledge and skills that go far beyond the application of physical restraint or other restrictive interventions"* (Restraint Reduction Network 2019). Mental Health Units as defined by the Mental Health Units (Use of Force) Act 2018 are required to have all training in the use of force certified as complying with the RRN Training Standards (Statutory Guidance to the Mental Health Units (Use of Force) Act 2018). A detailed analysis of this requirement is provided in Chapter 9.

It is hoped that this chapter provides the evidence to support the need for the minimisation of restrictive and coercive interventions throughout all communities. Clearly, not every incident can be managed without these kinds of interventions and the next chapter examines staff training and seeks to address who should be trained, in what skills, and how training should be carried out.

CHAPTER FIVE: STAFF TRAINING AND CURRICULA DESIGN

5.1 Historical developments in staff training

At one time, staff training in dealing with violence and aggression consisted almost entirely of physical skills, often known as 'self-defence', 'personal safety' or 'restraint' training. Much of this training was based on one or more of the martial arts or combat systems, with training typically delivered by staff who were well versed in some form of self-defence such as karate or wrestling (Lion, 1987). Perhaps the best known of these systems was taiho-jutsu (literally, *'techniques of arrest'*) with techniques derived mainly from judo and Tomiki-aikido. Taiho-jutsu was, from 1975 until 1996, the system of self defence adopted by all police forces throughout England and Wales, with the exception of the Metropolitan Police Force. The Author chaired the registration body for the system and was responsible for maintaining a list of approved trainers on behalf of the (then) National Police Training College, Harrogate. Even after the police moved away from martial arts training in 1996 its replacement 'Unarmed Defensive Tactics' and later 'Officer Safety Training' concentrated significantly on physical skills.

Whitfield (2010) recalls that *"during his thirty-year police career he could not recall ever being given the kind of guidance available to traffic wardens on the kind of psychological techniques that can be used to calm down irate members of the public"* (p. 289). He describes a typical Officer Safety Training session taking place twice a year and would include specific technical training in how to wield a long baton; how to apply rigid handcuffs, and the use of what was then referred to as CS spray. Officers were taught:

> *"[To] adopt an aggressive pose when confronting members of the public. The standard approach to a crowd of demonstrators was to raise one's baton above his head, to project the other arm with open hand in the direction of the public and to shout the phrase 'Get Back'. No training was ever given at these sessions on methods for reducing tension. On the contrary, every aspect of the training was overtly aggressive".* (Whitfield, 2010, p. 290*).*

Whitfield's observations accord with an academic study of officer safety training carried out by Buttle (2007). Buttle's research was conducted on frontline officers in a largely rural constabulary involving uniformed constables and sergeants. This was because these officers were seen as the officers most likely to be assaulted (Christopher and Noaks, 1990; Brown, 1992; Moxey and McKenzie, 1993) since they have to deal with the more challenging and

dangerous aspects of policing (Philips and Cochrane, 1991). The study consisted of 21 semi-structured interviews, observation of officer training sessions, and subsequent discussions with participants. Buttle argues that "*officer safety training is structured in a way that encourages pre-emptive uses of force, which is exacerbated by the ambiguous nature of guidelines and rules of engagement that fail to adequately regulate the use of force*" (Buttle, 2007; p. 177).

The earliest recorded official guidance for staff working in the High Secure Hospitals was in March 1976 when the (then) Department of Health and Social Security ("DHSS") sent to Broadmoor Hospital a circular giving guidance to doctors and nurses on the management of violent patients. This circular, which included a section on dealing with a violent episode, had been prepared jointly by the Royal College of Psychiatrists and the Royal College of Nursing and it recommended that information and instruction on the principles and practice of dealing with violence should form part of the training of all staff employed in the hospital (Ritchie, 1985). Despite this recommendation, no practical training in the use of physical restraint was provided to staff and this remained the case until the death in July 1984 of Mr Michael Martin who had been detained in Broadmoor Hospital's Special Care Unit, *'Norfolk House'*, which housed the most disturbed patients in the hospital. Nursing staff, who were on duty in Norfolk House in July 1984, had been made aware of the contents of the DHSS circular and, in particular, they were advised that a patient who has to be restrained should not be gripped by the throat unless this was unavoidable. The following is an extract from the circular:

- *"Staff have a responsibility to go to the assistance of any victim of the violent patient's attack, no matter who that victim might be.*
- *If a member of the staff is attacked, he must obviously use the most appropriate means available to defend himself and this of course will be a matter for personal judgment. If it is possible for the member of staff to remove himself from the immediate vicinity of his attacker, he should do so but only if it can be accomplished without putting at risk the other patients in his charge.*
- *As a general principle, clothing rather than limbs should be held to effect restraint and if limbs have to be grasped, they should be held near a major joint in order to reduce the danger of fracture or dislocation. Every effort must be made to safeguard the patient's vulnerable areas, for example, the neck, throat, chest or abdomen.*
- *A patient who has to be restrained should, when possible, not be gripped by the head, throat or fingers. A bear hug from behind to pinion the arms to the side is valuable and it*

is better to grip the legs together just above the knees and around the calves rather than separately. If the patient is brought to the ground, he can be very quickly subdued if sufficient members of staff lie with their weight across his legs and trunk and thus immobilise him until further action is decided upon. In exceptional circumstances, as for example, when a patient is biting, the hair may have to be firmly held."

The above extract from the DHSS circular is remarkable. First, it explains that staff have a responsibility to assist any victim of violence but provides no meaningful training in how to do so safely or effectively. Secondly, it provided vague advice that the member of staff should *"obviously use the most appropriate means available to defend himself and this of course will be a matter for personal judgment"*. Since when is personal judgement a substitute for evidence-based guidance or proper training? Thirdly, far from training staff in what they should do, the circular merely explains that when a patient needs to be restrained, he should, *"whenever possible, not be gripped by the head, throat or fingers"*. The only positive guidance given is that *"a bear hug from behind to pinion the arms to the side is valuable and it is better to grip the legs together just above the knees and around the calves rather than separately"*. This was ridiculous advice even by the standards of knowledge of the 1970s and in any event couldn't easily be achieved without instruction and training which was, at least initially, not provided. Evidence pointing to the total lack of understanding of even the most elementary safety aspects of restraint can be seen from the advice that *"if the patient is brought to the ground, he can be very quickly subdued if sufficient members of staff lie with their weight across his legs and trunk and thus immobilise him until further action is decided upon"*. Placing any weight across a person's trunk is extremely dangerous and has led to numerous deaths from positional asphyxia.

Ritchie (1985) notes that the staff working in Norfolk House were aware of the dangers of a neck hold *"but the great majority of them took the view that in the initial stages of physical restraint of an extremely violent patient it was the only immediately effective method of control"*. Importantly, the staff had not been instructed never to grip a patient by the throat and most of them admitted to doing so on previous occasions. Indeed, the nurse who first sought to restrain Mr Martin felt that it was necessary in the particular circumstances of Mr Martin's violent outburst to hold him round the throat. Ritchie (1985) points out that the methods of restraint used by staff were often learnt by watching more experienced staff as well as from their own experience by trial and error.

As early as 1981, and quite likely even earlier, both nurses and doctors at Broadmoor Hospital were expressing concern that there was not available to them any formal practical training in physical restraint. Enquiries by the DHSS at that time revealed that there was no safe and effective system which met the particular needs of staff at a high secure hospital (Ritchie, 1985). The change came in 1983 when Mr Keith Mann and Mr Aiden Healy from the Prison Service Physical Education Department devised a training programme in restraining violent patients which was first introduced at Rampton Hospital in the early part of 1984. On 4 July 1984, just two days before the death of Mr Martin, members of the Broadmoor Hospital Management Team saw a demonstration of the newly introduced methods and were so impressed by the techniques being taught that they immediately decided to introduce them at Broadmoor although initially staff attended the training on a voluntary basis.

Nowadays, a substantial amount of training time is devoted to non-physical skills, such as communication and other kinds of de-escalation training although pockets of this old-style training still exist. Winship (2006) observes that as long as patients (and no doubt others, such as visitors) engage in violent or dangerous behaviour, the use of restraint by staff will remain an option. Hollins (2010) points out that in the UK restraint training programmes typically follow a didactic approach in which trainers provide step-by-step instruction in how to carry out the techniques followed by the staff practising them with little emphasis on the underpinning theory. Staff are then assessed by their ability to replicate the techniques, often in the confined space of a gymnasium or empty classroom. The Author is critical of this approach to training. The following section explains why.

5.2 The simplification of skills – removing complex motor skills

One of the most significant changes in the characteristics of a skills training course is the simplification of skills. At one time, many trainers felt the need to impress their students by demonstrating and teaching a substantial number of techniques without any proper thought to their safety, efficacy or even whether they would work outside the confines of the training room when performed on cooperative partners.

Motor skills are co-ordinated patterns of movements acquired through practise involving the ability to execute movements effectively and with precision to achieve intended outcomes. There are two kinds of motor skill: ‘gross’ and ‘fine’, the former involving the co-ordinated use of large muscle groups to perform tasks such as walking or kicking a ball, while the latter

involves the use of smaller muscle groups to perform smaller, more intricate movements with the wrists, hands, fingers, and feet. There is usually a retention loss of fine motor skills over a period of non-use (Petancevski, *et. al.,* 2022).

Stress, arousal, anxiety and fatigue are all factors when considering the effects of motor skill which are highly significant in the application of restraint. The optimal performance level for these factors is moderate. An example of an insufficient arousal state is an overqualified worker performing menial, repetitive jobs. An example of excessive levels of stress, arousal, anxiety or fatigue can often be seen in a person during periods of restraint. Fatigue can be caused by over-arousal and can have a significant impact on an individual, including a deterioration of performance when a stressful task continues for a lengthy period of time. Perceptual changes, in which visual acuity or awareness decreases, slowing of performance, reaction times, movement or speed irregularity of timing, and overall disorganisation of performance are all factors that can adversely affect a person's performance (Oxendine, 1968).

It was previously understood that complex tasks are performed better when a person's drive is low, while simple tasks are performed better when drive is high (Yerkes, *et. al.,* 1908) although it is now better understood that a high level of arousal interferes with performances involving complex skills, fine muscle movements, coordination, steadiness, and general concentration. Carron (1965) reviewed several research studies in this area and concluded that in tasks of low difficulty, high anxious subjects were found to be superior to low anxious subjects. However, in tasks of high difficulty, low anxious subjects proved superior. Stress seemed to be particularly detrimental when persons were largely unacquainted with a particular activity. However, experience in the activity tended to reduce the adverse effects of stress. Furthermore, there is little question about the distracting effects of extreme levels of emotion on any type of performance involving reasoning powers. Such interference may be particularly harmful when the performer is in an activity requiring quick thinking or fast decision-making. Extreme examples of this interference occur when the individual freezes or their mind goes blank. In terms of physical restraint:

> *"You are summoned to an incident where people are being attacked. Your emotional arousal heightens as you rush to the incident. You are then expected to apply the fine motor skills that you learned some time ago to control a violent person. People wonder why so often restraint goes wrong. If you were asked to run around the block several times and then thread some cotton through the eye of a needle, you would probably struggle even though you would not be emotionally aroused, anxious or stressed. Similar factors arise with restraint but with the*

> *additional difficulties of stress addling our minds and causing our legs and other parts of our bodies to shake uncontrollably. Trying to use complex skills in these circumstances is virtually impossible. Given that we train for reality, why teach skills with such complexity?"* (Baskind, 2003).

Too often we hear of staff reporting that when faced with violence they cannot recall what they have been taught, especially in a seriously out-of-control incident. This criticism is especially important given the requirement for staff to minimise the use of physical interventions. Used less in practice, staff will not have the opportunity to practise these skills until the next time they attend a refresher course. Teaching fewer skills and making them simpler is therefore extremely important. Whichever way PMVA training is provided, it must be carefully designed, properly structured and competently delivered by appropriately qualified and experienced trainers. Otherwise, it will almost inevitably result in poor performance outcomes (Hollins, 2010). Staff must also be allowed sufficient time to practise the skills so that they can apply them effectively and safely when they are needed, which will often be in times of stress.

Rogers *et. al.,* (2007) describes the content of a physical breakaway training course delivered to staff at Broadmoor High Secure Hospital. The duration of the training day was seven and a half hours training during which time 21 different physical breakaway techniques were taught, consisting of 104 component parts. The training consisted of two demonstrations provided by the trainers for each of the 21 techniques followed by supervised student practice. The total demonstration time for all techniques was 146.5 minutes with a mean average demonstration time per technique of 6 minutes and 58.57 seconds. The total practice time for all 21 techniques was 134 minutes with a mean average practise time per technique of 6 minutes and 22.86 seconds. The total supervised practise time for all techniques was 134 minutes with a mean average student practise time per component part of 1 minute and 25 seconds. As an average, the mean average time (for the two trainer demonstrations and student practise time) per technique, was 13 minutes and 22.86 seconds. The authors conclude with *"considerable alarm [that that it was] not plausible to train staff in 21 different techniques, containing 104 component parts in seven and a half hours, and then expect them to be able to recall and apply such techniques any time in the next year with little or no notice"*. Rogers, *et. al.'s* (2007) study builds on their earlier study (Rogers *et. al.,* 2006) which found that staff who were trained in breakaways *"were not easily able to recall the techniques in a clinical environment with little notice"*. The authors go on to question whether the training actually causes harm, on the ground that *"some staff were focusing on trying to recall what to do, instead of breaking away from a dangerous situation"*. They conclude that it is possible that breakaway training may actually

"inhibit a person's natural responses when being strangled, in favour of a taught response, which they cannot recall". It was hardly surprising, therefore, that Hollins (2010) observed that *"focusing so closely on developing competence in applying a topographically correct technique and spending so little time doing just that is arguably little better than providing no training at all"*. But, as Hollins (2010) correctly points out, this does not mean that no training should be provided to staff. This is because when staff are not trained, or are inadequately trained, the resultant knowledge gap will invariably be filled by what they think instinctively might be appropriate, often by using strength alone to control the patient. This presents one of the greatest risks to both patients and staff. There is no substitute for properly trained staff.

Consequently, several PMVA training programmes have simplified their approach to restraint training. Grimley and Morris (2001) suggested that in order to extend the retention interval of learners the number of skills taught should be no more than seven. This is about right for many organisations, although different organisations will have different risks and needs. Accordingly, rather than setting a maximum number of skills taught, these should be kept as low as possible based on the organisation's training needs analysis. For example, the Home Office Manual for Escorting Safely (2016), a restraint training manual for border force and escorting officers, has reduced the number of core techniques to twelve; these being: 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. 8 - wrist flexion. 9 - thumb flexion. 10 - detainee on the ground, supine. 11 - detainee on the ground, prone. 12 - restraint recovery position. More radically, the UK's four High Secure Hospitals (Ashworth, Broadmoor, Rampton and The State Hospital) have reduced their core breakaway skills to four, namely *'fix and move'*; *'bowling'*; *'lever principles'* and *'close proximity techniques'* and have reduced the number of core teamwork skills to seven, five of which comprise the principal syllabus.

But teaching too many skills is only part of the problem. The skills taught will need to be recalled, with a sufficient degree of accuracy, often under conditions of extreme stress. One solution, used by the UK's High Secure Hospitals, is instead of linking specific defensive techniques to particular attack scenarios (which is the method used by the majority of organisations), the core breakaway skills have been decoupled, so that they are effective against a wide range of attack scenarios and are designed to be adaptable to a wide range of circumstances. Teaching these skills this way removes the difficulty experienced by many staff

of remembering, often during a highly stressful incident, which technique to use in any given situation and encourages them to apply the technique that they feel most comfortable with.

5.3 The training syllabus

Not only is it important to decouple and reduce the number of skills taught during training but it is also important to remove from the training any techniques that are unnecessary. Many training courses still teach techniques that are of no use whatsoever to the staff but do so because they have always done it that way. This is a common problem with trainers following a one-size-fits-all approach to training.

The training curriculum must be informed by a training needs analysis which, as its label suggests, necessitates an analysis of an organisation's training requirements based on a review of accurate data. An example of techniques commonly taught but hardly ever used are known as *'internal rotation'* and *'external rotation'* techniques. These are techniques designed to take the subject to the floor, under control, by applying pressure and rotation to the subject's wrist, either internally or externally. There are two problems with these techniques. First, they attract a high injury rate during training and, second, they are rarely used operationally. The reason they are rarely applied operationally is that they are extremely difficult to apply. Moreover, as the emphasis should be on keeping the subject on their feet rather than taking them to the floor as a default manoeuvre, removing these techniques should be welcomed. Keeping the subject on their feet also helps facilitate more effective de-escalation strategies aimed at eliminating the more forceful, or any, uses of force. Where it proves necessary to take the subject to the floor, there are far safer and more efficacious ways of doing so. These alternatives are also much safer to practise during training.

Defences against hair grabs are also commonly taught to staff including those who are so follicly-challenged that the chances of them ever needing to defend themselves against such an attack are nil. Their time would be better spent learning skills that are relevant and likely to be of use.

Although the introduction of a standardised syllabus of skills might appear attractive it will not provide the panacea that some might envisage. The main advantage of operating under a standard syllabus is that each skill within the syllabus can be put through a rigorous process of review by medical, legal, ethical and biomechanical experts. But a standard syllabus implies a one-size-fits-all approach to PMVA which does not accord with best practice, nor will it

comply with the person-centred approach both in respect of the people being trained and in respect of those upon whom the techniques may be used. The *'gold-standard'* approach to curriculum design is to create a high-level syllabus of guidance containing the techniques identified by risk assessment and training needs analysis. These techniques must be reviewed by medical, legal, ethical, behaviour and biomechanical experts. The syllabus is a reference point for patient and staff safety procedures for all relevant personnel and should be used as guidance for organisations in carrying out their duty to provide appropriate training and policies as well as for staff who may be required to deal with conflict as part of their role.

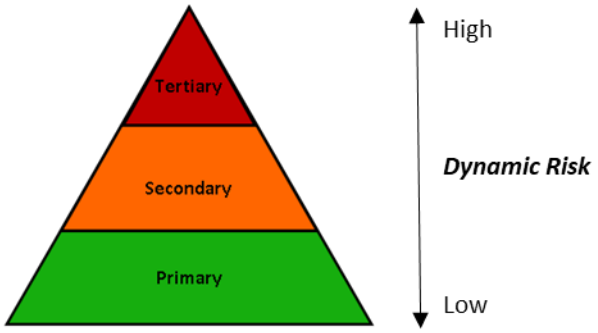
The high-level syllabus of guidance should be used when putting together the organisation's training manual which should also include guidance on use-of-force issues. Although it is not intended that staff should be trained in all of the techniques set out in the manual, only techniques that are contained in the manual may be taught to staff. This has the advantage of enabling personalised training so that managers will be able to select techniques from the manual that may be required for specific problems, specific patients or specialist roles. This approach enables flexibility, whilst at the same time, recognising that the understanding of the techniques and the standard by which competence is measured should be uniform. Staff should not use any of the techniques contained in the manual without first having received appropriate instruction from a qualified instructor who can advise on the correct application of the technique having appropriate regard to the likely medical implications and any legal or procedural responsibilities.

Once the manual has been put together, it must be kept under constant review. Such review should take place periodically (typically annually) or whenever changes are identified with either the population, specific individuals, or staff, or where specific risks have been identified.

In addition to techniques being selected by both risk assessment and training needs analysis, they should also be aligned to a hierarchical model whereby they can be ranked in terms of their relative risk and level of restriction. Based on the public health pyramid often seen in PMVA training, figure 4 illustrates an intervention hierarchy into which each intervention can be placed. This shows how the risks associated with an intervention increase as the user moves up the hierarchy from primary to tertiary. It is important for users to keep interventions, insofar as possible, in the primary section moving, where necessary, to secondary interventions. By contrast, a tertiary response should be considered as a medical/psychiatric or environmental/situational emergency. A tertiary response is the most-restrictive of

interventions and is designed to manage significant increases in risk in a subject's violence and aggression to themselves or others. Tertiary responses include restraining the subject on the ground and/or the use of pain compliance through the application of additional flexion or distraction/diversion. Such techniques may be justified when the subject cannot safely or reasonably be managed with less restrictive techniques or to prevent the dangers associated with prolonged restraint in any position. In all cases, the emphasis should remain on violence reduction and a consequent reduction in the use of any kind of restraint or coercive intervention. It must be recognised that there may be circumstances where there is no alternative to physical intervention and in such circumstances, it is important to provide staff with the best available options to keep them and those under their care and control as safe as possible in the circumstances. Any use of force must be a necessary and proportionate response within the boundaries of law and professional practice.

Figure 4. Intervention and risk hierarchy



5.4 A modular approach to PMVA training

Clearly, not all staff need to be trained in all physical intervention skills. To reflect the different needs of staff working in different settings and environments, with differing levels of risk, a flexible, modular approach to PMVA training is desirable and would include the following topics (British Self Defence Governing Body, 2018):

- Module A – Theories of personal safety. Prediction, prevention and management of aggression and violence. De-escalation strategies.

- Module B – Primary and secondary interventions. These include breakaway and low-level holding restraining techniques.
- Module C – Tertiary interventions. These consist of more restrictive physical interventions.
- Module D – Specialist skills.

The decision as to which staff should receive training, and the content of that training, needs to be taken locally and informed by an assessment of the risks and a consideration of any specific issues that might arise and any specialised roles undertaken by specific staff. This helps to ensure maximum flexibility whilst maintaining a uniform approach to the measurement of competence (British Self Defence Governing Body, 2018).

All staff who come into contact with the public should be trained in Module A. Given the substantial number of such staff, Module A could be delivered as a distance-learning module with appropriate safeguards to ensure satisfactory completion. Module B builds on the learning from Module A and covers the physical skills intended to help separate or break away from an aggressor in a safe manner. Module C covers the more restrictive physical intervention training, the specific content of which will depend on the particular setting, risk assessment and training needs analysis. Module D is restricted to high-risk settings, such as high-secure or high-risk settings, where additional skills are likely to be needed.

5.5 Proposal for new skills to be added, removed or modified

Matters concerning safety can change rapidly, and for a variety of reasons, including changes in the make-up of staff or changes in the detained or patient population where a single powerful and violent person could render ineffective the training provided. For these reasons, different skills may be needed to those initially included in a syllabus. Thus, staff, and especially instructors, may from time-to-time wish to propose amendments, additions or deletions to the techniques in the manual. Any changes to the approved syllabus must be managed carefully. Some organisations manage this process well but others quite poorly. The Author devised the form illustrated in Fig. 5 below which is used by a number of organisations.

Figure 5. Proposed changes to syllabus form

Part A

Proposer's institution

Proposer's name

Proposer's position

Date

Part B

This proposal relates to (please tick as appropriate):

a new skill to be added ☐

an existing skill to be removed ☐

an existing skill to be modified ☐

Part C

Describe the proposed new skill (please provide a video recording if this might be helpful)

Is the proposed new skill intended for general use or for a specific purpose/service user? If for a specific purpose/service user, set out the specific details

Explain in what circumstances it might be used

Explain what the current procedure is for dealing with these circumstances

Explain what is wrong with the current procedure

Explain why the proposed new skill is more appropriate

Explain how the proposed procedure fits within the hierarchy of responses and is the least restrictive intervention

Set out any implications for the proposed new skill (resources, equipment, safety, etc)

_____

This part of the Form is to be completed by [manager's name/position]

Checklist:

☐ Ethical approval given by …… on ……

☐ Legal approval given by …… on ……

☐ Medical approval given by …… on ……

Overall result

Approved ☐

Refused ☐

Signature

Date

5.6 How should training be carried out?

For training have any proper benefit, it needs to be carried out with a degree of chaos and realism, subject to the confines of safety. Otherwise, staff will not be adequately prepared for operational reality when faced with violence or aggression (Baskind, 2006). Put simply, most able-bodied people will be able to follow an instructor's movements with reasonable fidelity but not many will be able to carry them out with sufficient skill to keep themselves, and others, safe when faced with violence or aggression, especially at the higher end of a violent incident. This is because not many people have experienced the reality of violence and its associated panic and danger.

This presents a number of problems, the most important of which, for present purposes, relates to the physical ability of staff to complete the training. There is likely to be considerable variation in participants' levels of fitness and many older participants' physical capabilities will be in decline. Some participants may be carrying injuries of varying degrees of seriousness or may fear picking up an injury during the training. All these issues may lead to a reluctance in some participants to engage with the training, properly or at all. This often leads to instructors delivering their training in such a way that all participants can engage, typically at a much lower level than is ideal. As a consequence, courses are sometimes delivered in a highly choreographed manner, without the essential realism. The Author has coined the phrase *"choreographed dance"* to describe this defective method training. Related to this issue, some instructors, and organisations, are extremely risk-averse and dumb down the training so as to minimise the risk of training injury. Dumbing down the training also makes it easier to

complete for those staff who might struggle to complete the training if a reasonable degree of resistance is used.

Whilst it is undoubtedly correct to state that fewer staff will sustain injury if the training is merely choreographed, it is equally correct to acknowledge that training carried out this way provides very little, if any, benefit to staff in terms of equipping them with the skills needed to protect themselves and colleagues and deal with violence and aggression in a safe manner. Such training is also likely to give staff a false sense of security, as they may leave the course thinking they can deal safely with violence and aggression only to find that they cannot when facing the problem operationally (Baskind, 2006).

Conversely, training with the appropriate level of resistance and disruption (in a safe training environment) will help equip staff to appreciate the unpredictability of disruptive and violent behaviour before being exposed to it operationally. It is during this kind of training that instructors should introduce staff to the process of dynamically risk assessing incidents to assist their decision making and assist them to think on their feet. By instructors providing immediate feedback during these sessions, staff ought to be feel more prepared to deal with the uncertainty of events and use what they have been taught to make decisions effectively in challenging and often frightening circumstances.

Concern as to liability for training injury is largely misplaced. The question of providing realistic training has been the subject of a number of recent judgments of the courts which have emphasised the need for training to be delivered with a degree of realism. In the Scottish case of *Grant v Chief Constable of Grampian Police,* (2001), Lord Johnson stated:

> *"I am satisfied that considerable care was put into the formulation of the course. The issue of the volume of force was addressed as was the question of technique to a substantial, if not, total extent. I recognise that realism, so far as it could be reasonably achieved, was essential and that therefore what had to be balanced was a sufficient degree of force to create a realistic position against the risk that excessive force might cause an excessive injury."* (paragraph 17).

Similar reasoning was given in another Scottish case. Lord Morison stated that it was necessary to weigh the risk of injury to staff during training against the need to provide realistic training and held that there was no failure on the part of the prison service to exercise reasonable care when a prison officer was injured during a control and restraint training exercise carried out with a degree of realism (*Brisco v Secretary of State for Scotland,* (1997).

The dicta of Lord Johnson in *Grant* were approved by the English Court of Appeal in *Chief Constable of West Yorkshire Police v Hunter,* (2009) which added that:

> *"Both these Scottish judgments recognise that if a training exercise is to have any degree of realism, which it surely should, it cannot be demonstrated or structured in advance; a choreographed exercise would not be a useful one."* (paragraph 12).

Choreographing or substantially dumbing down the training is a mere tick-box approach to training which will have the likely effect of pushing the liability on to operational work where the risk will be greater.

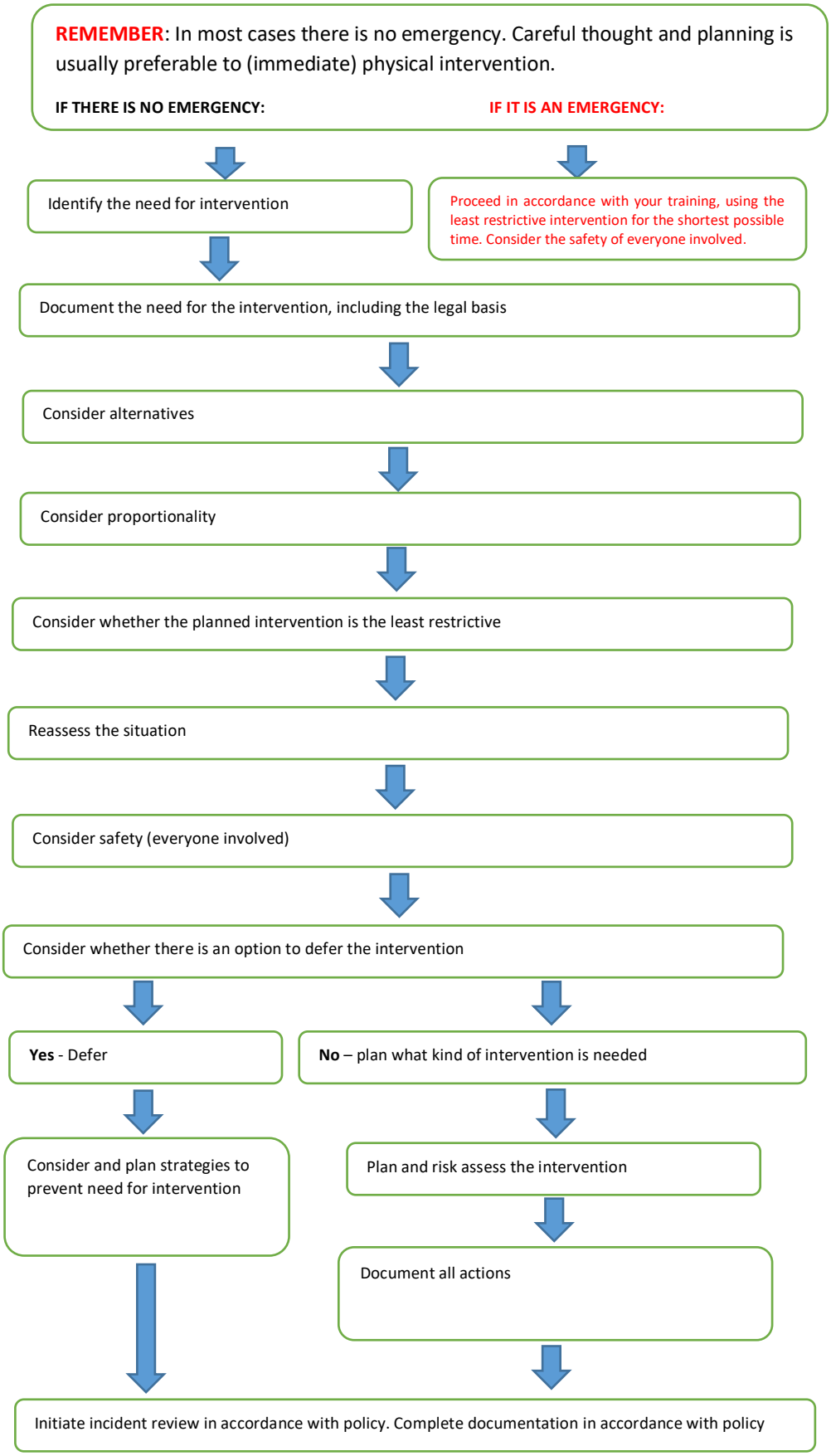
5.7 Planned and unplanned interventions

Many organisations distinguish between planned and unplanned interventions. A planned intervention is one that, although might be necessary, there is no urgency or immediate danger. An unplanned (or spontaneous) intervention is one where there is an immediate threat to someone's life/limb or to the security of an establishment and where staff need to intervene immediately.

Planned interventions are typically safer than ones that occur spontaneously. This is because there has been time to assemble the necessary staff, plan what is going to take place, and put in place all necessary safety procedures. It follows, therefore, that where possible, staff should plan an intervention (British Self Defence Governing Body, 2018). The additional time this takes also provides an opportunity to consider other options, short of the use of force.

The Planned Intervention Flowchart (see Fig. 6, below) was created by the Author to identify the various stages in a planned intervention that can be used in any setting. Staff should always consider whether any steps could be taken to convert what might initially appear to be a situation where unplanned intervention is necessary to one that fits into a planned intervention protocol. Doing so is likely to have a positive effect on safety and satisfies the requirement for restraint minimisation. It also demonstrates staff adherence to 'last resort' principles and a humane approach to the prevention and management of violence and aggression. Given the clear advantages of planned over unplanned interventions, it should feature prominently in policy documents and PMVA training.

Figure 6. Planned intervention flowchart (Baskind, 2011)



5.8 Periodic or refresher training

In addition to initial training, staff need to undergo regular refresher training that should include communication skills, de-escalation and non-physical behavioural management. Skills degrade over time, and this is a particularly important consideration given the widely acknowledged requirement to minimise the use of physical interventions. Table 5 shows a study by Whitmore (2017) which identified that a person's recall after 3 months is just 65% when they are *"told, shown and experienced"* the skill in question. This reduces to just 10% when the instruction is merely *"told"* (Whitmore, 2017). Carried out properly, physical skills training falls under the *"told, shown and experienced"* category. Recall continues to decline over time.

Table 5. Impact on recall (adapted from Whitmore, 2017)

	Told	Told and shown	Told, shown and experienced
Recall after 3 weeks	70%	72%	85%
Recall after 3 months	10%	32%	65%

Although the evidence supporting the appropriate frequency of refresher training is weak, most organisations provide this training on an annual basis although, from time-to-time, there will be a need to update staff outside of their routine training schedule. Such urgent updates will need to be brought to the attention of staff as promptly as possible. The evidence that does exist, however, suggests that refresher training should be provided more frequently than annually (Health and Safety Executive, 2006; Smallridge and Williamson, 2008). One study that considered whether the benefits of training were lost over time compared scores three months post training with those recorded immediately after training. These scores reflected the perceived capability of the individual to deal with a physical attack originating in a variety of situations and contexts. It observed that *"what is clear is that any benefit of training is largely lost within a matter of months"* (Health and Safety Executive, 2006; p. 22). Smallridge and Williamson (2008) recommended that *"there should be a requirement for more frequent refresher training [than 12 monthly] in restraint. Ideally this should be on a 6 monthly basis, to enable staff to ensure that their skills are refreshed and assured for safety by qualified instructors"* (Recommendation 52, p. 13). Although this Recommendation was accepted by Government (Ministry of Justice, 2008) which stated that *"six-monthly refresher training will help to ensure that high standards are maintained" (Ministry of Justice*, 2008; p. 22), it was

never put into practice. The legal requirement to provide periodic training is set out in Appendix 1.

This chapter provided an in-depth examination of staff training and curricula design paving the way for a detailed discussion about emotions and evidence and the part they play in affecting the efficacy and safety of managing VAAoCB.

CHAPTER SIX: EMOTIONS, SAFETY AND EVIDENCE

6.1 Emotions and Evidence affecting the efficacy and safety of managing VAAoCB

There is no shortage of literature exploring various topics within the management of VAAoCB but as we will shortly see, comparatively little in some aspects of PMVA practice, resulting in much of the discussion relying heavily on expert opinion (Allen 2000; Paterson, *et. al.*, 2003; NICE 2015; Lindon and Roe, 2017).

More recently, the Restraint Reduction Network (RRN) has published claims that their training standards *"evidence best practice"* and that whilst recognising the lack of research currently available on the subject, point out that *"existing research shows there is a lack of evidence that physical intervention training leads to meaningful or positive outcomes for people accessing services"* (Restraint Reduction Network, 2023). The RRN discourages the provision of physical intervention training and does not *"advocate for the use of any type of restraint"* (Restraint Reduction Network, 2023). The RRN's claims about the use of physical restraint are highly controversial and unsupported by many organisations including the highly respected and influential National Federation for Personal Safety (NFPS) (NFPS, 2020) and British Self Defence Governing Body (BSDGB) (of which the Author is Chair).

6.2 Emotions and Safety

Dietz (2021) explores two ways that emotions can, and often do, facilitate knowledge. First, emotions can play an evidential role with respect to belief formation and, secondly, emotions can be knowledge-conducive without being evidential by securing the safety of belief.

The positive epistemic contributions of emotion are often neglected within epistemology, perhaps owing to the persistence, in some measure, that *"when we feel ourselves moved by some passion we suspend our judgment until it is calmed, and do not let ourselves be easily deceived by the false appearance of goods in the world"* (Descartes, 1991; p. 267). Emotions can, and often do, play an evidential role with respect to belief formation and relatedly, for the idea that they can serve as good reasons for beliefs (Brady, 2013). Furthermore, emotions can be knowledge-conducive without being evidential. Thus, emotions may enhance the safety of various kinds of belief, referred to by Dietz (2021) as *"emotions-as-information"*. When thinking about the epistemic role of emotions vis-à-vis judgements, some theorists point to

cases that fall into the category of what they refer to as *"feelings-as-information"* or *"affect-as-information"* (Schwarz, 1990). This theory holds that one's judgements are directly guided by one's feelings towards a particular object, event, or even a particular theory (Goldie, 2004; Elgin, 2008; Helm, 2009). Thus, if one feels sufficiently strongly that certain things (such as physical restraint, mechanical restraint, pain-compliance interventions or prone restraints) should never happen, it will be difficult to change those views, even when faced with incontrovertible evidence to the contrary. Regrettably, as discussed throughout this thesis, this is clearly seen with managing VAAoCB.

6.3 Evidence

The use of evidence to support assertions goes back a long time. It is believed that Aristotle (384–322 BC) was the first person to *"really think out the problem of evidence"* (Hooker, 1888). When Aristotle approached a problem, he would examine (a) what people had previously written or said on the subject, (b) the general consensus of opinion on the subject, and (c) a systematic study of everything else that is part of or related to the subject (Hooker, 1888).

Unfortunately, there is a dearth of research in some aspects of PMVA practice which has meant that much of the discussion relies heavily on expert opinion (Allen, 2000; Paterson, *et. al*,. 2003; NICE, 2015; Lindon and Roe, 2017). The dearth of robust research in this area is due largely to the risks associated with severe violence (NICE, 2015). Ethical constraints prevent the full recreation of fatal events in laboratory studies using human participants (Sethi, *et. al.*, 2018). Nevertheless, the provision of PMVA training remains a practical necessity for staff to handle extremely disturbed and/or violent subjects in an organised and planned way (NICE, 2015) and those in the front line require clear guidance that is balanced, practical and reflects the complexity and uncertainty of the current state of knowledge. (Sethi, *et. al.,* 2018).

De Brún (2013) points out that in practice there are many situations where relevant research studies have not yet been carried out and, in such circumstances, it is a perfectly valid approach to base the information on the best available evidence, or on the experience and expertise of professionals, or the personal experiences of patients or service users. Within PMVA, despite the dearth of robust research into the physical skills, there is a plethora of evidence from practitioners, clinicians and other experts, including experts by experience (patients, service users and others with specific experience in matters relating to PMVA). There is also no shortage of PMVA policy and guidance documents.

Policy and guidance documents should assist practitioners and other interested parties to improve performance by setting out principles of best practice. But they are not law. The English High Court has recently held (in the context of NICE guidelines) that they are *"stronger than 'consider' but short of 'must' … But it is common ground that NICE Guidelines do not have the force of law, and that a clinician is not necessarily in breach of duty if s/he departs from them. The key question is whether the departure from the recommendation is sufficiently explained and justified in the context of [the] particular case".* (*Biggadike v El Farra & El Neil* [2024] EWHC 1688 (KB) [272]). Even though these documents do "*not have the binding effect which a statutory provision or a statutory instrument would have […] [they] should be given great weight. [Although they are] not instruction, [they are] much more than mere advice which an addressee is free to follow or not as it chooses. It is guidance which any [organisation] should consider with great care, and from which it should depart only if it has cogent reasons for doing so. […] In reviewing any challenge to a departure from the Code, the court should scrutinise the reasons given by the [organisation] for departure with the intensity which the importance and sensitivity of the subject matter requires. […] It is not, however, for the courts to resolve debatable issues of professional practice, but to rule on issues of law. If a practice is supported by cogent reasoned justification, the court is not entitled to condemn it as unlawful".* (*R v Ashworth Hospital Authority ex-parte Munjaz* [2005] UKHL 58, House of Lords; paras 21 - 24).

The *Munjaz* case concerned the Code of Practice to the Mental Health Act 1983 which contained 'guidance' for hospitals and medical staff on the use of seclusion for detained psychiatric patients. It was held that Ashworth High Secure Hospital had demonstrated *"clearly, logically and convincingly that it had cogent reasons for departing from the Code"* in favour of its own policy and its decision was not therefore unlawful (Munjaz, 2005; para 99). Any argument that a departure from the Code will lead to widespread variations in practice and undermine its status thereby lowering the protection offered by the law were given short shrift by Lord Hope who explained that the requirement that cogent reasons must be shown for any departure from it *"sets a high standard which is not easily satisfied"* (Munjaz, 2005; para 99). Moreover, the protection, which the law provides to ensure that any departures from the Code are compatible with Convention rights, is an additional safeguard. Lord Hope explained that it would be wrong to see the judgment as opening the door to substantial departures from the Code on the part of individual hospitals and that the decision of the majority of their

Lordships in Munjaz should not be seen as an invitation to other hospitals to do this and resort to their own policies. (Munjaz, 2005; para 99).

It should follow, therefore, that these documents should be the product of wide consultation and consensus not least because when reviewing any challenge to a departure from the guidance, a court should scrutinise the reasons given by the establishment for such departure even though *"it is not […] for the courts to resolve debatable issues of professional practice, but to rule on issues of law. If a practice is supported by cogent reasoned justification, the court is not entitled to condemn it as unlawful."* (Munjaz, 2005; para 24).

Throughout this thesis, the Author has referred to various guidance and policy documents as well as Codes of Practice. Having earlier observed that guidance documents are not law and do not have the binding effect which a statutory provision or a statutory instrument would have, it is important to note that policy documents are also not law although as just noted, both should be followed with any necessary departure carefully documenting. This helps us understand why, "*if a practice is supported by cogent reasoned justification, the court is not entitled to condemn it as unlawful".* (*R v Ashworth Hospital Authority ex-parte Munjaz* [2005] UKHL 58, House of Lords; paras 21 - 24). As to UK Codes of Practice, although they are not themselves laws, they are to be regarded as statutory instruments that provide detailed guidance on how to comply with the law. They are often used to regulate specific activities and ensure that laws are applied consistently. For example, the Mental Health Act Code of Practice is a statutory instrument, meaning it is legally binding guidance set out within the Mental Health Act, which provides instructions on how professionals should carry out their functions under the Act. Thus, while not directly part of the Act itself, it is statutory guidance that must be followed by relevant healthcare professionals.

Another significant concern relates to false legal assertions appearing, and being repeated, in peer-reviewed literature. By way of example, the assertion that the use of mechanical and physical restraint is against the law in Britain (*Steinart, et al*, 2009; p. 136) is completely false yet has been repeated in subsequent peer-reviewed publications (see, for exmaple*, Mantovani, et. al.*, 2010 and *Ziaei, et. al.,* 2019). The inclusion of this false assertion by *Ziaei et. al.,* (2019) is repeated amongst a narrative review of 200 related articles (*'Management of Violence and Aggression in Emergency Environments: A Narrative Review of 200 Related Articles')*, and its inclusion by *Steinart, et. al.*, (2009) also shows a degree of subjective confusion because the results of two out of 16 countries *"could not be included since the received answers from*

country experts remained contradictory (Norway) or we received no final version after expert discussion (Greece)" (*Steinart, et. al.,* 2009; p. 136). The false assertion, citing the above references, has also been cited in a number of court cases in which the Author has given expert evidence; two of which resulted in the trial judge ordering the Author and the expert witness called by the other side[6] to prepare a joint memorandum setting out whether or not mechanical and physical restraint was against the law and, if so, to cite the specific law that led to their prohibition. The other side's expert then agreed that neither mechanical nor physical restraint was in fact contrary to British law and cited the above literature as their sole source for initially claiming otherwise.

By way of further example, during an Inquest in which the Author was called by the Coroner to give expert evidence, another expert claimed that an acute hospital was at fault for allowing a security officer to work in its Emergency Department without adhering to the RRN Standards (2019). This was a significant point for the Inquest because, if the RRN standards had applied, the hospital would have been in breach of duty for failing to implement the standards. The Author explained to the Inquest that the RRN standards are not applicable to security personnel or acute hospitals but instead the relevant guidance was laid down by the Security Industry Authority, which the hospital had followed. Entirely different outcomes could have resulted in these cases had a competent expert not been instructed with far-reaching consequences had these false assertions been accepted by the court/tribunal and featured in the resulting judgment/determination.

Regrettably, politics and emotion continue to play a large part in the development of policies and guidance even where the evidence indicates that a different approach is needed. This is hardly the most attractive basis for the drafting of policies or laying down guidance on matters intending to reduce the use of coercive interventions and improve the safety of restraint and the overall outcome for all parties. The courts have long held that *"with the light before him, why should he shut his eyes and grope in the dark*?" (*Bwllfa*, 1903, approved by the UK Supreme Court in *Edwards*, 2019). The same principle ought to apply here.

Recent examples of the interplay between the emotion of politics and good practice can be seen with the reintroduction by the NHS of its previous unsuccessful and widely criticised zero tolerance policy; the way in which the Serious Case Review into Winterbourne View Hospital

[6] It was the same expert witness in both cases.

(2012) was used by certain private training providers and others to support their own agendas; and the ongoing objection and confusion into the use of mechanical restraining devices, even in circumstances where their use might constitute the least restrictive and safest form of intervention. This is particularly concerning given the requirement that, if a restrictive intervention has to be used, it must always represent the least restrictive option to meet the immediate need (Department of Health, 2014).

Furthermore, despite a wealth of experience from subject experts, including leading practitioners, two concerning themes emerge. First, policymakers have imposed policies without reference or discussion with these experts or practitioners who will need to implement them and, secondly, certain views are not canvassed if they are unlikely to support a pre-determined proposed policy under consideration. Examples of these concerns can be seen in some of the guidance and policy documents published by the Department of Health and the Security Industry Authority. Whilst there is no doubt that these policies and documents are well-meaning, some of their content has created concern. Examples of these concerns relate to the use of certain physical restraints: notably prone restraint positions and pain-compliance interventions, and the use of mechanical restraining devices. We should all be concerned when the evidence is ignored not least because bad science makes for bad policy, bad law and bad practice (Godwin, 2012). If misinformation is allowed to go unchallenged then the ultimate losers will be those who most need our support and the staff charged to look after them. With regard to the first two of the above concerns, at the opening of Broadmoor Hospital's new Violence Reduction Centre on 10 September 2014 the Rt. Hon. Norman Lamb MP, the then coalition government's Minister of State for Care and Support, applauded a demonstration of restraint put on for his benefit despite the demonstration clearly and intentionally showing both prone restraint and pain-compliance techniques. When this was pointed out to him, he didn't know that a prone restraint technique had been used, mistakenly believing that what had been banned was the kind of prone restraint where the subject's face was pushed into the floor. This is despite him being a major proponent on the ban of prone restraint and the leading force behind *Positive & Proactive Care* even advocating that its use should constitute a criminal offence. Sir Norman Lamb (as he now is) remains an advocate for the elimination of prone restraint positions.

Historically, mechanical restraining devices have consisted of various barbaric contraptions designed to secure or contain the subject to a surface, device or to themselves, where they were often left for considerable periods of time (Knutsen, *et. al.*, 2012), frequently for the

convenience of staff (Fluttert, *et. al.,* 2010). Although the resistance to these devices has to some extent softened in recent years (see, for example, Care Quality Commission, 2018) outside of policing, their use is still seen largely in a negative light.

6.4 Winterbourne View

Winterbourne View was a private hospital run by Castlebeck Care Ltd. Opened in December 2006, the hospital was registered to provide assessment and treatment and rehabilitation for people with a range of learning disabilities. The majority of the patients in Winterbourne View hospital had been placed at the hospital under the Mental Health Act.

On 31 May 2011, a BBC Panorama television programme showed people with challenging behaviour being abused by staff working at the hospital. The abuse that took place amounted to criminal behaviour, for which a number of staff were imprisoned. The hospital is now closed. The hospital's policies and procedures were good but they were not put into practice (Royal College of Psychiatrists, 2021). Despite this case not being about restraint *per se*, the case set in play a number of far-reaching policy changes, most notably, the guidance that sought to prohibit the use of prone restraint (Positive and Proactive Care (2014).

6.5 Cross-sector oversight

There are many examples of exemplary practice across all settings which are, unfortunately, marred by pockets of poor and dangerous practice. It is the Author's view that the importance of cross-sector oversight of all matters relating to VAAoCB should be self-evident yet there exists an absence of any meaningful joined-up approach to the subject. There are many good pockets of practice that could sensibly be adapted for, or adopted in, other sectors yet this does not happen. This lack of a joined-up approach also results in wasted resources, time and money as well as valuable wasted opportunities for cross-sector learning, aimed specifically at improving safety.

6.6 Reporting and data collection

The collection of accurate data and the way it is analysed and used is key to understanding what is happening both within a particular sector as well as across the different sectors. This is made more difficult due to the different methods used for data collection as well as significant inconsistencies in what is collected. For example, the police use of force data records how

many times force was used by police officers rather than how many individual incidents took place. Thus:

> *"In a situation where three police officers restrain an individual on the ground, and one of those officers then handcuffs the individual, there would be three separate use of force reports submitted (one by each officer). These would be counted […] as three 'incidents'. All three reports would include the details of the incident […] and subjects' details […]. The report would also include the tactics the reporting officer used (i.e. two reports would list ground restraint only, and one report would list both ground restraint and handcuffing)".* (Home Office, 2019; p.4).

This distorts the data considerably as well as the number of incidents in which force was used.

A further issue exits with the recent encouragement for more comprehensive and accurate reporting of data (Department of Health, 2014). Although it is essential for services to report accurately and honestly, this encouragement will show an increase in the use of coercive interventions which services are required to reduce. Claims that *"in 2018, the use of restraint on adults with learning disabilities rose by 50%"* (Restraint Reduction Network, 2019) are likely, at least in part, to result from better reporting.

A yet further problem lies with what some services require to be reported. The Author has encountered some services whose use-of-force reporting forms do not allow certain interventions to be recorded, including, no doubt due to the controversies surrounding them, pain-compliance and prone restraints. Some of these services claim that because their staff do not use these interventions there is nothing to record. Consequently, they are able to report that their use-of-force reporting data does not show any use of these interventions. More worryingly, the Author has also received complaints from staff who are told by management not to record pain-compliance or prone restraints, either at all or save in the most serious circumstances, thus distorting the true value of data collection.

Notwithstanding the need to reduce the number of coercive interventions, it is fallacious to treat this data on the basis that the services recording the lowest number of interventions are in some way 'better' than those whose numbers are higher. This is because it is not possible to treat different establishments as though they were the same. One might expect a higher number of interventions in a secure mental health facility than in a different facility catering for a population with a lower incidence of aggression and violence. Similarly, a unit housing a larger number of people should expect a higher number of incidents than an identical unit housing a smaller number of people. Another problem analysing data is that in many cases a small number of individuals (sometimes even one) will be responsible for a significant number of

interventions and thus adversely affect the data. It has been suggested that more meaningful data would exist if all organisations took account of the overall population in a unit, the makeup of the population, and the number of different persons who have been restrained. It is also important to define precisely what needs to be recorded so as to ensure a level playing field insofar as data is concerned. An example might assist. Some organisations require staff to record any situation where staff lay hands on a person (for example, holding an unsteady person's arm or 'coaxing' them to do or desist from doing something) whereas others only require incidents to be recorded where the laying of staff hands occurs against the individual's wishes. Another problem with reporting requirements is where more than one member of staff is involved in an intervention. Some organisations require this recording as multiple interventions (depending on the number of staff involved) whereas others will only record such an incident as one intervention. For any data to be meaningful, consistency is essential.

Having examined the issues around emotions and evidence in the management of VAAoCB the next chapter provides a critical examination of the safety issues involved: safety for the individual as well as the safety of staff. The chapter also provides a detailed analysis of the key medical issues that increases the risks of harm with restraint.

CHAPTER SEVEN: SAFETY ISSUES IN THE MANAGEMENT OF VIOLENCE, AGGRESSION, AGITATION, AND OTHER CHALLENGING BEHAVIOURS

7.1 The safety of whom?

From a legal perspective, the question of duty of care is paramount. Lord Atkin's famous *'neighbour principle'* (Donoghue v Stevenson, 1932) established when, and to whom, a legal duty of care might arise. The neighbour principle is that one must take reasonable care to avoid acts or omissions that could reasonably be foreseen as likely to injure one's *'neighbour'*; that is someone who is so closely and directly affected by the act that one ought to have them in contemplation as being so affected when directing one's mind to the acts or omissions in question. Lord Atkin stated:

> *"[I]n English law there must be, and is, some general conception of relations giving rise to a duty of care […]. The rule that you are to love your neighbour becomes in law, you must not injure your neighbour […]. You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour. Who, then, in law is my neighbour? The answer seems to be persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question."* (p. 580)

Although the principles underlying Lord Atkin's neighbour principle remain good law today and will therefore be applied by the courts (see, e.g., *GR v Greater Glasgow and Clyde Health Board, Johnson and Johnson Medical Ltd,* 2018), it is sometimes difficult to find its application being respected in the world of PMVA.

One of the most difficult questions concerns the balancing of competing considerations and to weigh different rights against each other, especially if the considerations are not commensurate with each other. This is particularly evident in cases of assault where it is often necessary to balance the rights of the assailant against the rights of the victim. At one time, staff were trained in personal safety and self-defence techniques to enable them to protect and defend themselves against assaults and other incidents of violence. In the early days, knowledge about the safety of these physical techniques was patchy and very little about this appeared in the literature (Ho, *et. al.,* 2010). But it can be stated with certainty that the safety of staff took priority over the safety of individuals (Hollins, 2010). That was wrong then in the same way that it is wrong

now that, in certain settings, the safety of individuals takes priority over that of staff. These settings include healthcare and juvenile detention settings.

How do we attempt to right this wrong? There is now a growing trend at involving those who have been affected by coercive measures in the design and delivery of training and to reflect on their experiences. This has led to some positive outcomes. Generally known as *'co-production'*, its aim is to maintain safety while reducing all forms of restrictive practice principally by reducing conflict and improving care. Cygnet Health Care (2019) has described co-production as *"combining our mutual strengths and capacities so that we can work with one another on an equal basis to achieve positive change"* (De Souza, 2017). Part of this approach is to emphasise the negative impact associated with coercive and restrictive practises and in particular restraint and is used to help engage and inspire change and innovation to minimise conflict and improve services (CQC, 2017). There are many good examples, such as the Recovery College peer tutoring course operated by Mersey Care NHS Foundation Trust to enable experts by experience to co-deliver personal safety service training to all staff. Repper and Breeze (2007) explain how service users' involvement in the teaching and learning process motivates students to show more sensitivity and empathy and to adopt a more individualised approach in practice. Russell (2014) and Speers and Lathlean (2015) discuss how the whole learning experience is deeper and more transformative which in turn could result in positive changes in attitudes and patient-orientated practice.

Another growing trend is to involve service users in the design of training programmes. With regard to their experience of being restrained or secluded this has the benefit of sharing first-hand experiences of these practices, how it affected them and the therapeutic relationship with staff, and how things might have been done differently. The Author has attended many of these sessions and it is hard not to be moved by their experiences and the valuable contributions they bring to the debate. But there is a limit to the value of this input. Some policy statements have relied heavily on the experience of service users (and/or their families) with the result that they have become determinative of policy rather than informing it. It is impossible not to have sympathy for a bereaved mother whose son died in 2010 shortly after being restrained by 11 police officers in Bethlem Royal Hospital, Beckenham, London (INQUEST, 2017). The restraint included the deceased being held for a prolonged period in the prone position and it is too easy to see why the deceased's mother would want to see an end to people being restrained in the prone position. The debate about the use of prone restraint positions and prolonged

periods of restraint are discussed in Chapter 8. Just as hard cases make bad law in the sense that an extreme case is never a good basis for a general law that would cover a wider range of less extreme cases (Davis and Stark, 2001) hard cases involving restraint which arouse widespread sympathy should not be used to determine policies that will affect a wider population and a wide range of situations.

All parties are owed a duty of care and it is wrong in law, and dangerous in practice, for the duty owed to one party to usurp that owed to the other. Where these duties collide, such as in a case where a member of staff or another in their care is attacked, staff must be allowed to use reasonable force to defend themselves and others. Training must reflect this. Regrettably, a number of organisations and individuals have successfully campaigned for the elimination of certain interventions that might be needed in certain high-risk situations. Where these interventions have been eliminated, it has led to staff being unable to deal with some incidents, adequately or safely. This problem will be addressed as it arises throughout this thesis.

7.2 Restraint can be an inherently unsafe and harmful practice

Although our understanding of the prevention and management of violence and aggression (PMVA) and the safer use of restraint has improved, the notion of anything approaching an entirely safe method remains unrealistic. Restraint is intrinsically unsafe, and even if it does not end in physical injury, the experience and the memory can be profoundly damaging psychologically (Smallridge and Williamson, 2008). The Care Quality Commission has noted that restraint often re-traumatises patients which can have a lasting impact on their mental health, adding that patients have reported feeling *"like they were at times not seen as human or equal because they were completely powerless"* (Care Quality Commission, 2020c). One study in Finland in 2013 suggested that seclusion or restraint does not materially influence a service user's quality of life at discharge and any influence that was found was short-lived (Soininen, 2013). These findings are not, however, widely supported by clinicians or practitioners.

Harm is not, of course, limited to patients or service users. When clinicians find themselves in positions where they are forced to make decisions and act in a manner which violates their moral or ethical code, they sustain a moral injury (Greenberg, *et al*, 2020). The use of restraint is one such example, yet the welfare of staff is too often overlooked.

The dangers and damage caused by restraint is not new. In 1998, it was noted that *"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"* (Milliken, 1998). This is as true today as it was more than two decades ago. It is also correct to state that any restraint that ends up on the ground can be especially dangerous. Where restraint leads to death, it is usually a multiplicity of factors that are in play rather than a single cause (Sethi, *et al.,* 2018).

The medical complications associated with physical restraint encompass two groups: exacerbations of underlying physical disease and those arising de novo due to the act of physical restraint. Psychiatric patients are more likely to experience comorbid physical health disorders. Pre-existing respiratory, cardiovascular or neurological system disorders can increase the risk of complications associated with restraint. Examples include chronic obstructive pulmonary disease, cardiomyopathy and epilepsy. Restraint itself has been associated with complications across all systems, including muscle, bone, biochemistry, breathing/respiration, and circulation. Examples of complications include muscle trauma, fractures/dislocations, metabolic acidosis, thromboembolism, and arrhythmia (Aiken, *et. al.,* 2011).

In physical restraint, a confluence of factors can lead to medical emergencies. Consider the scenario where physical restraint position may restrict ribcage movement and uplift the abdominal organs. Clinicians leaning into the patient's back may limit lung expansion, the patient's agitation will increase oxygen demand, and medical risk factors such as obesity, sedative medications and respiratory disorders may reduce respiratory effectiveness. It is conceivable that such a clinical scenario may lead to restraint asphyxia, a form of positional asphyxia in which body position results in insufficient oxygen intake. The risk of fatal asphyxia may be reduced by monitoring during restraint, and pulse oximetry has been used to supplement visual observation (Sheldon, 2006). That said, pulse oximetry primarily detects hypoxia and may not detect hypercapnia, the latter has been associated with restraint asphyxia and acidosis (Hick, *et. al.,* 2009; Alshayeb, 2010).

In comparison with physical complications, mental disorders receive little coverage as a complication in physical restraint. Psychotropic medications cause several side-effects (e.g.,

extrapyramidal side-effects, pro-arrhythmic states, sedation) that can seriously compromise safety.

The negative psychological complications of physical restraint and the compound effect of enforced medication can lead to powerful experiences which evoke shame, humiliation, rage and fear. Patients in the acute mental health system commonly have significant trauma histories and physical restraint even by well-meaning clinicians may be re-traumatising, replicating the unconscious dynamics of past abuse. Such scenarios can lead to a violent and vicious circle. Proposed strategies to mitigate the potential negative psychological effects of restrictive interventions on patients and staff include the practice of debriefing (NICE, 2015). Although the concept of debriefing has an intuitive appeal, its effectiveness has yet to be fully established and requires further research (Sethi *et. al.,* 2018).

To make physical interventions as safe as possible it is important that training includes all known risks both in relation to the specific interventions and in relation to the specific population upon whom they might be used so as to equip staff with the knowledge to manage the risks associated with restraint as safely as possible. Clear reference to the ABCDE model discussed in Chapter 9 is essential. Additionally, staff need to be trained to expect the unexpected in a dynamically evolving incident especially in identifying and dealing with a medical emergency where the health and well-being of the patient must take priority over the restraint.

A useful way of providing this training and helping staff make often complex rapid safety-critical decisions during a continually evolving incident, is to present pre-prepared medical complications to staff as part of the PMVA training package. The emphasis should be on encouraging staff to deal with the incident as a whole, paying particular attention to the safety and well-being of the patient within the context of the overall incident, rather than regarding specific techniques in isolation. This could take the form of briefing staff on the person's pre-existing medical conditions and any other factors known to increase the risk of harm during restraint. Staff would then be invited to participate in the training scenario and explain how the information provided could increase the risk to the patient and suggest possible alternative courses of action.

It is essential that all staff who may need to restrain or supervise the use of restraint are aware of the risks and are able to identify the circumstances when restraint should be avoided as well

as those circumstances where restraint should cease and the subject treated as a medical emergency. Without intending to minimise the importance of any of the many factors that can render an intervention unsafe or ill-advised, certain conditions deserve more detailed discussion: these are discussed below. Aiken *et. al.,* (2011) advises that all PMVA training programmes should include this guidance and it is the Author's experience that they do.

- Excited Delirium and Acute Behavioural Disturbance
- Positional and restraint asphyxia
- Acidosis
- Psychosis
- Sickle cell anaemia
- Epilepsy
- Cardiac issues
- Obesity/high body mass index

7.3 Excited Delirium and Acute Behavioural Disturbance

The issues concerning excited delirium (ExD) and Acute Behavioural Disturbance (ABD) are complex and controversial, which is not helped by some commentators querying whether the "conditions" really exist (Paquette, 2003; Peters, 2012; Gonin, *et. al.*, 2018) or are merely terms designed to obfuscate the inappropriate use of force, typically by police, from which the subject dies (Costello, 2003). Ruttenber, *et. al*., (1999) describes cocaine-associated rhabdomyolysis and excited delirium as different stages of the same syndrome. Rimmer (2021) opines that *"precisely what they are is a complicated question".* More recently, these complications have led the Royal College of Psychiatrists to withdraw a statement on ABD, published just 3 weeks earlier, "*pending further consideration of the matters to which it refers"* (Royal College of Psychiatrists, 2021).

In terms of a diagnosis, ExD has had its medical validity questioned in recent years. Irrespective of the controversy surrounding diagnosis, it is important for staff to be aware of the syndromal combination of delirium, psychomotor agitation and physiological excitation. This combination has been described as ExD or ABD (Gillings, *et. al.*, 2016). Unless otherwise indicated, given the similarities in the literature between ExD and ABD, this thesis will refer to them as ExD/ABD. There is an association with intoxication (drugs or alcohol) and/or

psychiatric illness with cocaine being specifically implicated in drug induced ExD/ABD (Royal College of Emergency Medicine, 2022).

Differentiating between a person who is in a state of ExD/ABD from someone who is simply otherwise violent/aggressive is often difficult. The following may indicate the presence of ExD/ABD:

- Exhibition of unexpected physical strength or endurance
- Exhibition of abnormal tolerance to pain
- Feeling hot to touch and profuse sweating
- Extreme agitation or hostility
- Acute paranoia
- Bizarre behaviour and speech
- Disorientation and impaired thinking
- Hallucinations
- Sudden tranquillity following a period of frenzied activity

(Royal College of Emergency Medicine, 2022).

The Royal College of Emergency Medicine (2022) notes that this list is not very specific, and the differential diagnoses will include psychiatric emergencies due to mental illness, drug intoxication, serotonin syndrome, neuroleptic malignant syndrome, and other medical issues (e.g. hypoglycaemia, thyrotoxicosis).

In many cases it is only apparent that a person is suffering with ExD/ABD when they suddenly collapse. It is for this reason that staff should be alert to a person's sudden tranquillity following a period of frenzied activity. This may be due to severe exhaustion, asphyxia or cardiorespiratory compromise, but they will be at risk of sudden death (Royal College of Emergency Medicine, 2022). The management of ExD/ABD can potentially include having to manage severe agitation, hyperthermia and acidosis which requires emergency medical and psychiatric input, and should be treated as both a medical and psychiatric emergency (Royal College of Emergency Medicine, 2022).

Gillings *et. al.,* (2016) describes ExD as an acute form of ABD. The Faculty of Forensic and Legal Medicine (2010) has observed that *"of all the forms of acute behavioural disturbance, excited delirium is the most extreme and potentially life-threatening"*. Vilke *et. al.,* (2012) observes that its history can be traced back to 1849 where cases of psychiatric patients developing acute onset of agitation, mania and fever, resulting in sudden collapse and death

were reported. Although the term ExD was not used, these cases discuss clinical behaviour and outcomes that were strikingly similar to the modern-day concept known as ExD or ABD (American College of Emergency Physicians, 2009).

ExD/ABD has been described by various authors. Paquette (2003) has described it as an *"extreme state"* with features including agitation, excitability, paranoia, aggression, great strength, and numbness to pain and when confronted or frightened, these delirious individuals can become oppositional, defiant, angry, paranoid, and aggressive. Di Maio and Di Maio (2006) have described a person experiencing a delirium as involving combative and/or violent behaviour where the acute onset of this condition helps to distinguish it from other types of delirium. Another common feature of ExD/ABD is often the failure at post-mortem examination to reveal evidence of sufficient trauma or natural disease to explain the death (Peters, 2012).

However, despite these dangers, ExD/ABD remains a controversial topic. In many cases of restraint-related sudden death, medical authorities have reported considerable difficulty in identifying the cause of death by post-mortem examination alone. This has led to claims that ExD/ABD are no more than syndromes used to describe unexplained deaths, usually from police restraint, where there was no apparent cause other than the arrest and restraint itself in cases where these individuals exhibited behavioural disturbance that appeared to go beyond the distress that police officers typically encounter when dealing with aggression (Connor, 2003). Costello (2003) observes that those who do not recognise ExD/ABD as a potentially fatal medical condition state that there is no evidence to support the theory that people can be "excited to death". Costello (2003) goes further and cites both the American Civil Liberties Union ("ACLU") and the National Association for the Advancement of Colored People ("NAACP") who fear that the condition is being used as a medical scapegoat for police abuse and believe that in the main these deaths result from confrontation, abuse and the inappropriate use of restraint during a violent encounter that should have been avoided. These organisations theorise that the cause of death is due to the "psychological stress of being confronted with aggression that results in further physiological reactions (e.g., adrenaline release, increased heart rate, temperature, strength) which in turn leads to death" (ACLU, 2014; NAACP, 2017).

Ruttenber *et. al.*, (1999) points to the many known causes of ExD/ABD, such as brain tumours, infection, heat exhaustion, thyroid disease, illegal drugs and psychiatric medications) although asserts that it is a largely unknown medical condition. Accordingly, some of those who die

from a restraint-related ExD/ABD are victims of their own, usually long-term, cocaine and amphetamine abuse which causes heart disease and can trigger this fatal syndrome (Ruttenber *et. al.*, 1999; Paquette, 2003). Costello (2003) notes that those who take large quantities of antipsychotic medications and who are susceptible to ExD/ABD may also have the same effects as those taking stimulants. These individuals can suddenly become manic and very aggressive resulting in death during or shortly after being restrained. Gillings *et. al.,* (2016) describes patients typically presenting with tachycardia, tachypnoea, hyperthermia (often with undressing), excessive physical strength with apparent lack of fatigue, insensitivity to pain (including that associated with incapacitant sprays), and acute psychosis often accompanied by paranoia. Common causes include use of stimulant drugs, such as cocaine and exacerbation of underlying mental health disorder.

Karch (2016) discusses the role of sudden cardiac death noting that its cause is not fully understood in the context of restraint-related death. What is known, however, is that death can occur during or following restraint although the infrequency and complex circumstances of these events hamper scientific investigation in the real world (Sethi, *et al*, 2018).

The College of Paramedics issued a Position Statement on ABD/ExD in October 2018. Describing the condition as a *"medical emergency"* and noting that there is no consensus on the question of definition, the College recognises the definition set out by the Royal College of Emergency Medicine: "*sudden onset of aggressive and violent behaviour and autonomic dysfunction*". (College of Paramedics, 2018).

Although ExD/ABD have been cited as significant factors in restraint-related deaths, it has to be asked why there still exists such controversy. The controversy stems from the fact that neither 'condition' is recognised by the World Health Organisation leading to some medical practitioners and coroners declining to record it as a cause of death. There remains, therefore, a great deal of controversy regarding the use of these terms to explain sudden death during or following restraint. This argument mainly centres on the fact that as well as the World Health Organisation, most medical associations around the world, including the American Medical Association, and medical coding reference materials including the International Classification of Disease (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM) do not recognise either term. These are the main resources for the classification of mental health conditions and disorders of various kinds yet do not recognise either term (Buck, 2009). The absence of formal classifications of ExD/ABD is not universally accepted: there are organised

medical associations, including the National Association of Medical Examiners and the American College of Emergency Physicians, that do recognise the existence of ExD/ABD. Additionally, as Table 6 shows, the ICD itself contains several codes that can be used to describe the same kind of behaviour as seen in ExD/ABD.

Table 6. ICD-11 Examples of Codes that describe the same behaviour as ExD/ABD (National Institutes of Health, 2022)

6C41.5	Cannabis-induced delirium
6C45.5	Cocaine-induced delirium
6D70.1	Delirium due to psychoactive substances including medications
6C4F.5	Delirium induced by multiple specified psychoactive substances including medications
MB23.M	Psychomotor agitation
6C45.70	Cocaine-induced mood disorder with manic symptoms
6A25.3	Manic mood symptoms in primary psychotic disorders
QE84	Acute reaction to stress, agitated state

Such controversy is unfortunate because notwithstanding the arguments as to the existence of these conditions the symptoms are recognised and included in the majority of PMVA training programmes where they are recognised as a medical emergency. The question should not, therefore, centre on whether the conditions exist on the WHO/ICD/DSM database but what it involves, how it can lead to death, and what can be done to improve the safety of restraint to prevent these deaths from occurring.

Paterson *et. al.,* (2003) emphasises that although restraint is often considered necessary in cases of ExD/ABD, it is important to recognise that continued resistance against such restraint increases the severity of the subject's metabolic acidosis which, combined with high catecholamine release, may lead to patients struggling to the point of collapse. Whatever the cause, we know from the cases that cardiac arrest can occur suddenly and without warning (Aiken *et. al.,* 2011). Vilke *et. al.,* (2012) has argued that the severe acidosis following a period of restraint is an important factor in cases that result in a fatal outcome; so, too, is the presence of hyperthermia indicating loss of autoregulation. Mortality and morbidity may be further

complicated by hyperkalaemia, rhabdomyolysis and disseminated intravascular coagulation, for which close in-hospital monitoring is advocated (Gillings *et. al.*, 2016).

Although there is currently a lack of complete understanding of the pathophysiology of ExD/ABD coupled with a poorly understood risk factor for death, Vilke *et. al.,* (2012) identifies as a key factor in improving subject outcomes the early recognition of potential causes. This lack of complete understanding is perhaps not helped by the fact that ExD/ABD is *"a diagnosis of exclusion"* (Royal College of Emergency Medicine, Best Practice Guideline, 2022) which is further complicated by the need to consider a number of other differential diagnoses, such as head injury, sepsis and hypoglycaemia (Vilke *et al,* 2012).

The more difficult question is how practitioners can recognise the symptoms associated with these conditions since, as already observed, many of them are seen in cases of serious violence. These symptoms include a state of high mental/physiological arousal; paranoia; hallucinations; breathing problems; agitation; high body temperature and/or sweating; violence, aggression, hostility, bizarre behaviour; insensitivity to pain and sudden tranquillity after a period of frenzied activity (Aiken *et. al.,* 2011).

It is because these symptoms are often difficult to detect and/or distinguish from episodes of non-medical-emergency violence that clear guidelines are provided and incorporated into PMVA training. Unfortunately, many current guidelines lack consistency and best cross-sector expertise which can create a risk of death through ignorance of a potentially life-threatening condition (Liddle, 2018).

Hall *et. al.*, (2013) described the frequency of signs of ExD/ABD in subjects having been restrained by a Canadian police department. The authors listed eleven signs suggestive of ExD/ABD which were then prospectively assessed by police officers: their frequencies are presented in Table 7. This group noted that approximately 15% of individuals subjected to restraint have three or more concomitant signs of ExD/ABD.

Table 7. Frequency of signs of excited delirium syndrome in subjects undergoing police use of force (Hall *et. al.,* 2013).

Clinical features	**Frequency**
Violent behaviour	66.0%

Constant or near constant physical activity	24.7%
Subject not responding to police presence	21.7%
Tolerance to pain	20.8%
'Superhuman' strength	10.8%
Rapid breathing	9.7%
Does not tyre despite heavy physical exertion	8.8%
Naked or inappropriately clothed for the environment	7.4%
Sweating profusely	4.9%
Hot to the touch	3.5%
Attraction to or destruction of glass or reflective surfaces	2.8%

As alluded to earlier, ExD/ABD are often discussed in connection with deaths in custody following a period of restraint and both terms been used by coroners' courts in England and Wales to classify cases of death following police contact (Baker, 2018). Problems continue to exist due to terminology. Inquest findings in deaths attributed to ExD/ABD have suggested that the terminology is confusing, not least because numerous terms are used in the literature, from ExD, ABD to autonomic hyperarousal state (Kutcher, *et. al.,* 2009). It can potentially impair communication between police and medical teams if different terms are used in training, thus hindering its recognition as a medical emergency and, from a research perspective, it is challenging comprehensively to capture the existing literature, when the same phenomenon is described using so many different terms (Aw-Yong, 2020).

Lipsedge (2016) argues that 'excited delirium' is an inappropriate term, and should be phased out of use in preference of 'acute behavioural disturbance'. Whereas 'excited' is used in psychiatry as a non-specific adjective referring to agitation and hyperactivity, 'delirium' is considered a specific technical term (Vilke, *et al.,* 2019). Vilke, *et al.,* (2019) observes that, in this context, 'delirium' by definition describes the neuropsychiatric manifestation of an underlying serious and identifiable medical cause and that, despite some overlapping

symptoms with delirium, primary psychiatric conditions have no underlying organic medical cause. Therefore, from a psychiatric perspective, if a patient dies following a form of delirium, there should be post-mortem evidence to confirm the organic cause. This is commonly not the case for deaths classified as due to 'excited delirium', making the term self-contradictory (Mash, 2016).

An example of a death that occurred in 2011 might assist. Following the death of Michael Sweeney on 11 April 2011, the London Ambulance Service stated that the term ABD is the most appropriate one to use. Mr Sweeney died after taking cocaine on a recreational basis. He was a sporadic user of the drug. At post mortem examination, ten times a typical recreational level was found in his blood. Following the cocaine ingestion, Mr Sweeney entered a public house with a knife. He was extremely agitated. The Metropolitan Police Service was called and officers attended shortly thereafter. Police officers almost immediately identified Mr Sweeney as being unwell, suspecting that he was suffering from what had then been described in their training as ExD. They correctly categorised his condition as a medical emergency and asked police control to arrange for an ambulance to be sent. Police control contacted ambulance control. London Ambulance Service categorised the call as C1 Amber, rather than Red One or Red Two. At the time, there were no paramedics located in the ambulance control room who could have recognised the seriousness of the condition and upgraded the call. The combination of the categorisation of the call and the demand upon the service meant that an ambulance was not sent within the target time. Twenty minutes after police first asked for an ambulance, they took the decision to transport Mr Sweeney to the Royal London Hospital in a police van. Once at hospital, police officers, medical and nursing staff were very challenged by the situation. Mr Sweeney remained violently agitated and demonstrated extraordinary strength in trying to hurt himself and resisting efforts to help him. He was restrained prone until sedation was effective and was then turned over, supine. He arrested within a minute and died less than two hours later. In its response to the outcome of the inquest, London Ambulance Service highlighted that the shift to using ABD (rather than ExD) is to recognise that this is not a definite condition but a spectrum of behaviours, for which there can be several causes (Radmore, 2013). It was noted that differential diagnosis of these causes is not practically possible in a prehospital context, making ABD the more appropriate term. Furthermore, the word "acute" signals that it is a medical emergency, for which a rapid response is needed.

The Author disagrees that the term ABD is the most appropriate and concurs with the view of the Coroner in *Sweeney*. The Coroner pointed out that although the training given to police officers covers ExD (now referred to as ABD) this term is not widely used in this country, and neither ambulance, nursing nor even some of the medical staff had heard of it. Although more medical staff are now aware of ABD, understanding of the term, and its significance remains patchy. Although it would certainly be possible to provide ambulance and hospital personnel with a better understanding of the term, given that it describes a medical condition, it seems more logical for the police to follow health services in this, rather than the other way round. Moreover, there are situations where a person exhibits extreme agitation that is not related to an acute drug psychosis. There is the potential for an organic cause to be missed because of reliance on the terms ExD or ABD as an apparent diagnosis. Extreme agitation can be caused by conditions such as a bleed on the brain, sepsis from infection (e.g. meningitis), or a diabetic coma (Hassell, 2013). As the Coroner opined in Sweeney, the safest and most effective way to deal with a person exhibiting such an acute behavioural disturbance seems to be simply to use the term "extreme agitation". This describes the constellation of symptoms without purporting to diagnose the cause. This then leaves the investigation into the cause of the agitation to the medical professionals. If such an approach were to be followed, it would simply mean that staff training would move away from using terms such as ExD or ABD, to describe the condition as 'extreme agitation'. Nothing in this suggestion would move away from treating the condition as a medical emergency as it is now. Further, the same terminology, and training, would be provided in some form to police control staff so that they recognise the importance of the term when an officer uses it, and pass this on to the ambulance service. It would also require the ambulance service to amend its protocols and training to recognise extreme agitation as a medical emergency and prioritise calls appropriately.

'Agitation' was the key focus of a recent study by Humphries, *et. al.*, (2023) who sought to find a consensus on ABD in the UK. The key findings of the study are that ABD is not considered a diagnosis or syndrome, but refers to the presentation of an individual in a state of severe agitation. The authors point out that there are clear differences in expectations between law enforcement and emergency care providers regarding use of ABD terminology, either focusing on physical health management prioritisation or recognition of the severity of ABD. Humphries, *et. al's* (2023) study provides a clear consensus that ABD is not a separate entity to agitation, but there are criteria which can be used to identify agitated patients at greatest risk of poor outcomes. Specific terminology should be used to identify this group and provide a

common language regarding prioritisation and management strategies. Consideration should be given to using new terminology such as ‘red-flag agitation’ to describe the most severely agitated patients at the greatest risk of physical health emergency. The Author presented the findings of Humphries, *et. al.,* (2023) at a meeting of police use-of-force trainers at the College of Policing in 2023 and the term *‘red-flag agitation’* was considered to be more helpful than ABD in ensuring the most appropriate support is provided to the person.

7.4 Positional and restraint asphyxia

Ventilation in a healthy person involves two main factors: movement of the ribs by the intercostal muscles and movement of the diaphragm (Parkes, 2000; Reay, 1992). In this context, the lungs serve two purposes: to get oxygen into the body (inhaling) and to get rid of carbon dioxide (exhaling). The chest can be likened to a set of bellows. Working properly, this helps keep the organs functioning correctly and gives the pink colour to the person’s skin and lips. Conversely, a lack of oxygen prevents organs from functioning properly resulting in the person becoming confused, agitated, or sleepy. If oxygen levels are significantly depleted, the skin, lips and nail beds can turn a blueish colour. Although turning a blueish colour is a reasonable indicator of low oxygen levels, this is not always easy to identify since many restraints take place in the dark or reduced lighting, and in cold weather the person’s skin, lips and nail beds might appear blueish anyway.

Positional asphyxia occurs where there is an insufficient intake of oxygen as a result of a person’s body position that interferes with their ability to breathe. Restraint asphyxia is a form of positional asphyxia and occurs during the process of restraining a resistive individual in a way that causes ventilation compromise. Respiration is compromised causing insufficient oxygen in the blood to meet the body’s oxygen needs (hypoxia) resulting in a disturbed heart rhythm (cardiac arrhythmia). Certain people will be more vulnerable than others when restrained, especially those who are overweight, drug or alcohol intoxicated, on certain medications, uses of certain substances, have breathing difficulties, and those who, perhaps due to severe exertion, need to breathe hard to inhale sufficient oxygen and those struggling to exhale sufficiently to get rid of carbon dioxide. Others who might be more vulnerable under restraint include those with a medical condition that causes low levels of oxygen (e.g., pneumonia), or acid blood (e.g., brought about by kidney failure or high blood sugar commonly seen in people with diabetes). When restrained, the person’s already low oxygen levels can be depleted further, and their carbon dioxide levels raised. This can lead to the person becoming

more agitated and aggressive leading to increased amounts of restraint. As a result, their oxygen levels drop and/or their carbon dioxide levels rise to dangerous levels often resulting in them struggling less and becoming quieter. This then becomes a medical emergency as death can occur quickly. Other warning signs of a medical emergency include the subject making gurgling or gasping sounds, panicking, or calling out that they cannot breathe. A person might stop breathing as a result of the position they are being held in. Positional asphyxia is likely to occur when a subject is in a position that interferes with inhalation and/or exhalation and cannot escape from that position. There is a common misconception that if a person can talk, then they are able to breathe and are therefore not in danger. This is not the case. A person may be dying as a result of positional asphyxia yet may well be able to speak or shout prior to them collapsing. Much of the debate on positional asphyxia has focussed on prone restraint but as we will shortly see this has led to some commentators concluding, wrongly, that prone restraint is wrong and dangerous, and should not be permitted. This is despite other commentators explaining that there is no evidence to ban prone restraint (Smallridge and Williamson 2008; para 6.35) and that the suggestion that restraint in the prone position contributed to deaths "has not been supported by recent research" (Royal College of Emergency Medicine, Best Practice Guideline, 2022).

Nevertheless, the use of prone restraint positions has been the subject of much criticism. When an individual is restrained or contained in a prone position, three things might happen that could compromise the body's ability to breathe satisfactorily:

1. There is possible occlusion of the respiratory orifices (Belviso, 2003)
2. There is a compression by weights or restriction to movement of the ribs limiting their ability to expand the chest cavity and breathe (Parkes, 2000; Stratton, *et. al*., 2001)
3. The abdominal organs may be pushed up, restricting movement of the diaphragm and further limiting the available space for the lungs to expand (Parkes, 2000; Reay, 1992).

Accordingly, even without any other contributing factors, simply restraining an individual in a prone position may be seen as restricting the ability to breathe, so lessening the supply of oxygen to meet the body's demands. Whilst acknowledging that this is true, any impairment of oxygen or the ability to breathe satisfactorily was considered not to be statistically significant (Parkes and Carson, 2008).

In the prone maximal restraint position (observed mostly in the USA) the individual is placed in a prone position on the floor with their hands secured behind them with handcuffs and their legs either cuffed or otherwise secured by way of ties at the ankles with the ankles secured to the wrists with their legs bent and shoulders pulled back in order to accomplish this. This position is known as the *'hogtie'* or *'hobble'* restraint. It has been suggested that this prevents adequate chest wall, abdominal, and diaphragmatic movement, leading to hypoventilatory respiratory compromise and risk of death from positional asphyxia (Stratton, 2001). Significant changes were found after this restraint: vital capacity was reduced, and a decrease observed in expiratory volume, heart rate, blood pressure and cardiac output (Roeggia, 1999). This form of restraint is not used in the UK by any of the state agencies nor is it taught by any of the main PMVA training providers.

It is wrong and only adds to the confusion to hold that prone holding, irrespective of other factors, results in chest compression and that this compression directly or indirectly produces cardiac events that will eventually lead to death in some people. It is clear that applying the full weight of an adult to the back (or front) of a person lying on the ground can result in chest compression but that is not the way prone restraint is taught or should be applied. Correctly taught, a prone hold should avoid all significant contact with the torso therefore eliminating any additional weight to compress the chest. But there are some who argue that even without putting additional weight on the torso, a person in a prone position is in significant danger of positional asphyxia because of an alleged decrease in oxygenation levels of the blood (see, *e.g.*, Winston, *et. al.*, 2009, RRN, 2019). The evidence showed that there is virtually no change in oxygenation in a prone position even while struggling during a restraint (Masters and Wandless, 2005). Masters and Wandless (2005) used a pulse oximeter to measure oxygenation levels during restraint on 12 adolescents ages 12 to 18 years. A pulse oximeter is a device that attaches to the finger with a clip and measures oxygenation of the blood in a non-invasive manner. The authors found that baseline rates of oxygenation were at 96% or greater and the rates of oxygenation during restraint were 95% or greater for all individuals. Seven of the twelve individuals were held in a prone position, the rest were standing. No incidents of respiratory distress were noted.

The Author has investigated a number of restraint-related deaths in connection with his professional practice. Table 7 shows the position in which the deceased was held and the key points which were significant causes of death.

Table 8. Position in which the deceased was held during the restraint.

	Death (D) / Serious injury (S)	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
Olaseni Lewis (2010)	D	Prone	1, 2, 3, 4, 5(a)
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)
Paul Reynolds (2017)	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

Although the majority of the deaths followed prone restraint, in each case there were other significant factors that were causative of death. First, in all of the above cases, the restraint lasted for a long time. The dangers of prolonged restraint are discussed in Chapter 8. Secondly, in all cases there was evidence of a lack of appropriate training. It is unrealistic to expect staff to perform an intervention safely unless they have received appropriate training. Thirdly, the restraints applied in all of the cases were poorly performed. This is likely to be attributable, at least in part, to the lack of appropriate training. Fourthly, in all of the cases there was no effective monitoring of the person during the restraint. The importance of effective monitoring is considered in Section 8 below.

It is also important to appreciate that there is no such thing as a single prone restraint and a failure to investigate the specific holds used in each case in which there was a serious injury or death has added to confusion as it has led to those who wish to ban the use of prone restraints to conflate all prone holding positions as if they are all the same. There is, in fact, a myriad of ways to hold a person in a prone position and they involve different body mechanics, different limb position of the subject, different numbers of staff and different positions of the staff involved. Thus, it would be misleading to say, simply because of the orientation of the individual that, in the absence of any other information, a prone procedure is safe or unsafe. Paterson (2010) confirms this observation and states that the prone position is actually a range of procedures incurring possible risks:

> *"These multiple versions of prone actually share only one variable, which is that the individual is held against resistance face down either by being physically held, via control of the limbs, the approach most commonly used in the UK."*

What we can say, however, is that prone holding, *per se,* is not inherently dangerous, any more than sleeping on one's front.

Further examples have been cited by Nunno *et. al.,* (2006) who listed 45 child and adolescent fatalities that occurred over a span of 10 years. Of those fatalities, 27 happened in a prone position. Many of the opponents of prone holds would consider this to be sufficient proof that the prone position is dangerous. However, although the individuals were, in fact, in prone holds, no formal procedures were ever described. The descriptions of the holds are quite revealing and help to underscore the Author's contention that prone alone does not equal dangerous. Of the 27 fatalities cited by Nunno *et. al.,* (2006), 7 had multiple staff lying on the person (across the torso), 6 had the person's arms crossed in front of their chest in the form of a prone basket hold, 4 involved staff who were sitting directly on the individual and 2 fatalities were the result of a choke hold whilst the person was being held in a prone position. Thus, in 19 out of 27 cases of prone holding, holds were performed in such a way as to render them extremely dangerous. It wouldn't matter if the person was face-down or face-up if they had multiple adult staff lying across their torso or were being choked by staff. Such procedures are dangerous *per se* and the element of position is meaningless. In the Nunno study, 62% of the holds involved dangerous practices that went beyond a simple prone/supine distinction. Furthermore, in 74% of the cases, signs of distress, such as turning blue, vomiting and telling staff *"I can't breathe"* (p. 1338) were completely ignored by staff. This is not a problem of

prone holding *per se*, but a problem of poorly trained and/or poorly supervised staff. Finally, in many of the cases, there were no clear criteria for the implementation of any restraint at all.

Some organisations, including the Security Industry Authority, argue that if you don't teach a prone hold, then staff won't be able to do it incorrectly. But this misses the point. Simply prohibiting the teaching of all prone holds, which of course prevents teaching safe prone holds, will not prevent spontaneous interventions where staff will do what they believe to be safe, although such a ban will almost certainly result in some staff failing to record their use of such holds. The greatest hedge against this sort of improvisation is to teach staff procedures that are safe and effective, and part of a certification program that holds people accountable to perform procedures as taught.

Another problem with focussing too much on prone restraint positions is that it removes the attention of other restraint techniques that are dangerous. For example, Gareth Myatt was held in a seated position and bent forward at the waist causing hyperflexion which severely restricted his breathing. Research by Parkes (2011) found that seated restraint positions with the person leant forward may increase the risk of harm or death during prolonged restraint and the risk will be further increased where the person exhibits higher body mass index. A further problematic restraint is a *'basket hold'* in which the individual is restrained by a member of staff standing or sitting behind them who then crosses the subject's own arms in front of them and secures them at the wrist or forearm. In Gareth Myatt's case, staff modified the restraint procedures without supervision but also as the organisation had made a policy decision not to use prone restraint as it was perceived as dangerous. This procedure has in the past been used in the secure juvenile estate but following the Inquest into Gareth Myatt's death the double basket hold has been removed by the Ministry of Justice.

Parkes (2002) postulated that breathing can be reduced by 15% in a face down position and by 23% if the person is bent in a face down position.

Typical signs of asphyxia are cyanosis, congestion and petechial haemorrhages (O'Halloran, 2002). O'Halloran (2002) observed that more than half of the cases considered at Inquest had petechial haemorrhages. However, in cases of restraint-related deaths, these have not always been noted during post-mortem examinations (Shepherd, 2005). Petechiae found at post-mortem examinations are simply markers of increased cephalic venous pressure such as found

in chest crushing injuries or status epilepticus. In and of themselves, they should not be regarded as supportive evidence of asphyxia (Ely, 2000).

Another study measured hypoventilatory respiratory function in prone healthy subjects when weights were placed on them and after they were exercising. Michalewicz (2007) found that results were within normal range and function concluded that:

> *"Factors other than ventilatory failure associated with the restraining process may be responsible for the sudden unexpected deaths of restrained individuals".*

During a violent struggle, the subject may use their arms to brace themselves in order to improve the quality and depth of their breathing. Any restriction of this 'bracing' during the restraint may also disable effective breathing in an aroused physiological state.

Chan (1997) observed that on healthy volunteers there was a small statistically significant decline in lung volume in restraint positions after exercise but no clinically relevant changes in oxygenation or ventilation. However, Day (2002) points out that there is limited relevance in Chan's study to the real physical restraint situation as healthy volunteers are not representative of restraint subjects. The objectivity of these findings may also be questionable as the research grant awarded to Chan was in relation to a civil court case and the findings were used by the defence (Parkes, 2002).

Restraint alone is unlikely to account for sudden death without other underlying conditions (Gulino, 2000; Glatter, 2004; Ross, 2010). Glatter (2004) observes that the mere act of restraining an agitated individual would not lead to considerable hypoxia and death unless there was some pre-existing problem with central cardiac output, peripheral oxygen extraction, or oxygen utilisation. Reay (1992) had previously postulated that post mortem changes could not differentiate between sudden cardiac death as a result of respiratory restriction as in restraint, or as a result of psychological events, (e.g., bio-behavioural stress, causing malignant ventricular arrhythmias unrelated to the position of the individual).

NICE guidelines (2005) on the management of violence and aggression noted that the evidence base surrounding the dangers of positional restraint is weak and it is not possible to give a specific time frame for keeping someone restrained. However, NICE guidelines (2015) expressed a preference for supine restraint over prone and cautioned against the use of manual restraint for more than 10 minutes, after which time staff should consider rapid tranquillisation or seclusion as alternatives. It is the Author's opinion that ten minutes is far too long and is in

any event impracticable. This is because in a violent incident there is usually no one available to time the incident. Further, although NICE (2015) suggests that 10 minutes of restraint is the maximum that should be used, the individual is almost certain to have been involved in an earlier struggle before staff have managed to secure the restraint. This means that he will likely be out of breath before the restraint starts indicating that the 10 minute 'rule' should in fact start much earlier in the incident. Finally, what are staff meant to do after 10 minutes has elapsed? Rapid tranquilisation might not be available and even if it is, it might not be appropriate. O'Halloran (2000) analysed 21 case reports and found that the time before collapse ranged from 2 to 12 minutes. Miller (2004) observes that the average time between first application of restraint and when full cardiopulmonary arrest was noticed is only 5.6 minutes. Parkes (2002) found that immediate death did not occur after positional restraint but there was more likely to be prolonged, severe struggle before collapse under restraint. Laboured breathing and cessation of resistance may demonstrate this collapse and indicate a medical emergency rather than cooperation from the individual.

7.5 Acidosis

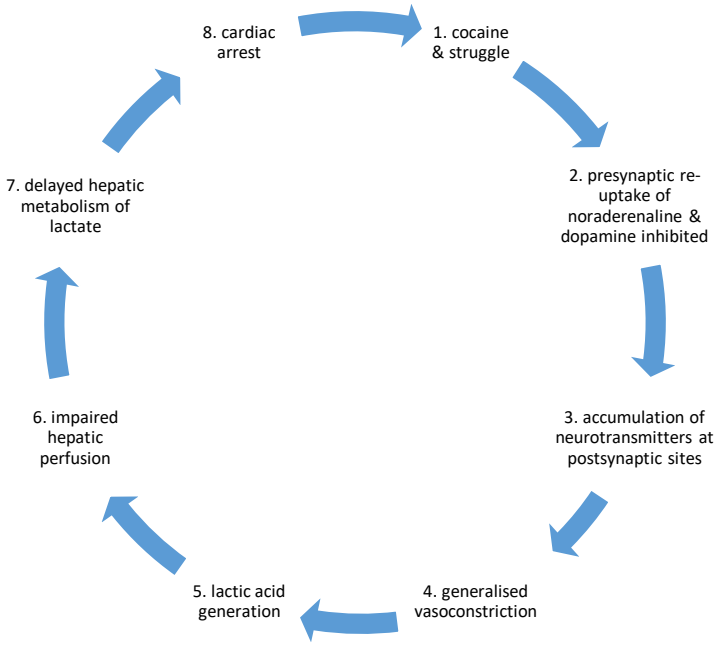
Persons under restraint frequently struggle against the restraint. This often leads to the staff increasing the level of force and restriction used. This vicious cycle is dangerous. In a study of five cases of sudden death, Hick (1999) found that there may have been exacerbation of exercise-induced lactic acidosis by sympathetic-induced vasoconstriction, enhanced by the actions of cocaine in at least some of the cases. Furthermore, the case descriptions raise the suspicion of ExD/ABD in three of the cases. All five developed a pronounced acidosis with pH ranging from 6.25 to 6.81, which was interpreted as lactate acidosis. All were positive for cocaine in urine or blood, and one survived (he had an initial pH of 6.46). Hick (1999) concluded that the lactate level documented in one case (>24 mmol/L) was much higher than what has been reported as the top levels in sprinting athletes (17 mmol/L).

With regard to respiratory function being impeded in hobble restraint position, Hick (1999) observed that:

> *"The controversy continues over whether this positional decrease in ventilatory ability has any clinical effect. A healthy patient model who does not continue to struggle against restraints apparently suffers no ill-effects from moderate reductions in ventilatory capacity. The detriment to a struggling, profoundly acidotic patient whose life may depend on the ability to develop a respiratory alkalosis has not been studied".*

Alshayeb (2010) also noted that people exercising intensely, who are highly aggressive and then restrained, and have taken cocaine, may develop lactic acidosis and subsequently suffer cardiac arrest. In this process, cocaine toxicity prevents the re-uptake of noradrenaline, serotonin, and dopamine at presynaptic nerve terminals and increases the release of calcium from the cerebral vascular smooth muscle cells, resulting in accumulation of neurotransmitters at postsynaptic sites and generalised vasoconstriction (Farooq, 2009). This will lead to increasingly impaired tissue perfusion resulting in impaired cardiac contractility, cardiac arrhythmias, and cardiac arrest. Alshayeb (2010) points to these dangers and observes that the process is typically not responsive even to advanced cardiac life support. Figure 7 describes the process of profound lactic acidosis leading to cardiac arrest.

Figure 7. The process of profound lactic acidosis leading to cardiac arrest. (Alshayeb, 2010)



However, Chan (1999) does not support these findings arguing that a significant portion of the metabolic acidosis may have simply been due to cardiopulmonary arrest. Chan further points out that the generation of a portion of the observed metabolic acidosis was from high oxygen consumption and anaerobic metabolism due to physical exertion from the 'fight or flight' syndrome occurring immediately prior to the restraint rather than the restraint itself. It is the Author's view that the true position is likely to be a mixture of both pre-restraint and restraint phenomena.

Tamsen *et. al.,* (2014) observes that the relationship between acidosis and ExD/ABD is unclear although a possible role for metabolic acidosis is not always considered in the case reports of ExD/ABD-related deaths, and often measurements of pH and lactate are missing.

Ho *et. al.,* (2010) performed an experimental study on the response in test subjects to different situations that simulated use of force by law enforcement personnel. These situations included both intense physical activity and exposure to an electronic control device and oleoresin capsicum (commonly known as 'pepper spray'). The lowest recorded pH was in the group who did heavy bag resistance for 45 seconds; the median pH was 7.01 and the minimum was 6.91 both 2 and 4 minutes post-exposure. The same group also experienced the highest lactate levels with a median of 18.26 mmol/L at 8 minutes post-exposure. Evidently, even short periods of intense physical activity can lead to low pH values, which makes the profound acidosis attained in cocaine-intoxicated people with ExD/ABD after an intense struggle more understandable. It is also interesting to note that the pH minimum and lactate maximum in Ho *et. al.*'s (2010) study was obtained some minutes after the physical activity ceased, comparable to the minutes after a struggling person has been apprehended and finally calmed down.

Hick *et. al.,* 1999 concluded that the pH values in their cases were considerably lower than what have been reported in ordinary out-of-hospital cardiac arrests (pH 7.20–7.26). The authors speculate that the effects of cocaine and the intense struggle contributed to the severe acidosis through different mechanisms. Central stimulant drugs could increase catecholamine-induced vasoconstriction, thereby increasing lactate levels. Psychosis and delirium can elevate the pain threshold, which could make it possible for the person to exert an abnormal amount of muscular effort. Furthermore, sympathetic output might suddenly be reduced due to catecholamine depletion in the suprarenal glands or because of cessation of struggle. This would result in dilatation of the vessels, and large amounts of lactate would stream to the heart with possible arrhythmias as a consequence. Other than a study of burn patients that showed partial or complete depletion of adrenaline and noradrenaline in the adrenal medulla at autopsy (Goodall, 1967), Tamsen *et, al.,* (2014) did not find any other references concerning catecholamine depletion in humans.

But what of the possible role of positional asphyxia in the development of acidosis? Tamsen *et. al.,* (2014) reminds us that since it is impossible to create realistic human experiments to determine how death might occur during apprehensions of agitated people, we are left with the possibility of separately investigating different aspects and then trying to integrate these into

scenarios that make pathophysiological sense. One of the key questions that cannot be satisfactorily examined in human experiments is whether the effects on respiration demonstrated in some studies of restraint techniques have any part in the development of the profound acidosis described in case reports. In some sports, a training method that includes breathing at a reduced frequency during exercise is used in order to induce periods of tissue hypoxia, with the aim of improving lactic acid tolerance. As a consequence, there are several studies of this method in the sports science literature. Although breathing in these studies is reduced by frequency of breaths in contrast with the restrictive respiratory impairment in restrained people, the results may be interesting in the discussion of positional asphyxia and acidosis.

Yamamoto *et. al.,* (1987) studied the effects of reduced frequency breathing ("RFB") on arterial hypoxemia during exercise. The subjects alternated 30 seconds of exercise (bicycle ergometer at 210 W) with 30 seconds of rest for ten rounds. This was done both during continuous breathing (CB) and during RFB consisting of breathing cycles with 4 seconds of breath holding at functional residual capacity ("FRC") followed by 2 seconds of CB. During rest periods, breathing was uncontrolled. The mean pulmonary ventilation during exercise was reduced by 35–45% with RFB compared to CB, while almost the inverse relationship was observed during rest, thereby compensating for the reduced ventilation in RFB. The mean oxygen saturation dropped to 89% during part of the exercise with RFB, while it was above 96% at all times with CB. A drop in mean pH to a lowest value of 7.26 was also noted with RFB. However, lactate was not statistically significantly altered with RFB compared to CB. To investigate this finding further, Yamamoto *et. al.,* (1988) conducted another study in which they measured lactate during both exercise and recovery phases. They concluded that exercise with RFB probably enhances muscle lactate production, but that there is a delay in the appearance of lactate in blood due to an accumulation of lactate in the muscles. Whether Yamamoto's results have any relevance for the relationship between positional asphyxia and metabolic acidosis in deaths during apprehension is unclear. However, it is interesting to note that a reduction of less than half of the pulmonary ventilation had clinically significant effects on oxygenation and pH (Tamsen *et. al.,* 2014).

7.6 Psychosis

Psychosis is a general term that describes mental illnesses where the subject loses contact with reality (Johannessen, 2021). It can manifest in a loss of insight and make the person extremely

suspicious. Many people suffering from psychosis believe that their personal safety is under threat and that others are going to harm them; even that their life is under threat. Persons suffering from psychosis are to be regarded as seriously ill and in urgent need of medical attention (Johannessen, 2021).

They may become frightened, agitated, aggressive or violent. A psychotic person's response to pain may also be abnormal. As a result, these individuals may struggle violently during restraint, resulting in them becoming extremely exhausted during the struggle leaving them with insufficient strength to support their vital respiratory movements of their chest and result in them collapsing either during the struggle or after they have been brought under control. Death may result. (Johannessen, 2021).

It may, therefore, be dangerous to restrain such a person and appropriate medical support should be summoned as soon as possible.

7.7 Sickle cell anaemia

Sickle cell anaemia is an inherited blood disorder that occurs primarily in Black, African, Middle Eastern and Asian people (Dyson and Boswell, 2006). It also occurs albeit less commonly in other people, for example, people of Mediterranean origin (Chouhan, 2003).

In sickle cell the red cells are abnormal resulting in a chronic, severe form of anaemia which is reduced oxygen-carrying capacity of the blood. Oxygen is carried by haemoglobin from the lungs to the rest of the person's body. In sickle cell anaemia, this haemoglobin is abnormal and can become sticky and clump together, blocking blood flow through small vessels. When a person becomes ill, for example, with an infection, or when their oxygen levels fall, haemoglobin can crystallise. The red cells become stiff and misshapen and block up blood vessels, reducing oxygen delivery further. This is referred to as a 'sickle crisis'.

One relevance to restraint is that a sickle crisis can cause severe pain and hence agitation. Furthermore, a sickle crisis can damage a person's organs causing them to work abnormally. Most importantly, this can include the lungs leading to breathlessness which can worsen the sickle crisis through lack of oxygen. It can also affect the person's brain leading to confusion and agitation. Consequently, if the person's breathing is impaired and oxygen levels are reduced, the act of restraint could itself precipitate a sickle crisis.

Exercise-related collapse in individuals with sickle cell anaemia is a rare but serious complication (Aiken *et. al.,* 2011). Local hypoxia causes intravascular sickling, in turn causing vascular occlusion and organ and tissue damage. This can result in rhabdomyolysis (the breakdown of muscle fibres resulting in the release of muscle fibre contents into the bloodstream), myocardial ischemia, arrhythmias and sudden death (Scheinen, 2009). Incidence of restraint-related deaths of individuals with sickle cell anaemia is extremely rare but Dyson (2006) found that:

> *"Statistically, sickle cell could not possibly explain the highly raised over-representation of deaths of African-Caribbean males in custody."* (p. 24).

This over-representation of Afro-Caribbean males is also evident in mental health settings. Afro-Caribbean males are three times more likely to be admitted to hospital and 44% more likely to be sectioned under mental health legislation (NICE, 2017).

Dyson (2006) argues that citing sickle cell disease as a cause of death in custody is a useful tool used by some organisations to avoid having to deal with institutional racism. He states that claiming sickle cell anaemia is a cause of restraint-related deaths is out of proportion to the issue as sickle cell anaemia only affects 1 in 300 people of Afro-Caribbean descent in the UK.

7.8 Epilepsy

Aiken *et. al.,* (2011) observes that epilepsy is another risk factor with restraint. Post-ictal aggression (i.e. the period that begins when a seizure subsides and ends when the patient returns to baseline) in epilepsy can occur when physical restraint is applied to a delirious or confused person. In particular, this can lead to a vicious circle of attempts to restrain and resulting resistive violence with fatal results (Devinsky, 2003).

Sudden unexpected deaths in epilepsy (SUDEP) may be caused by respiratory events, including airway obstruction. In addition, cardiac arrhythmia, during both the ictal and interictal periods, leading to arrest and acute cardiac failure, play an important role (Harrison, 2007). The additional factor of extreme exercise as in struggling in restraint is therefore still unknown although in the UK one service user (Godfrey Mayo) died after being restrained during a seizure (Aiken *et. al.,* 2011).

It is currently unknown whether or not epileptics are more vulnerable to SUDEP if they choose to engage in vigorous physical activity. However, one could postulate that as physical exertion

can lead to dehydration, electrolyte imbalances, hyperventilation secondary to increased oxygen demand, and hyperthermia - all of which are well known to decrease the seizure threshold in an epileptic (Harrison, 2007).

7.9 Cardiac issues

Two studies have reported an abnormally enlarged heart as being one of the predisposing factors that can lead to restraint-related death (Laposata, 2006; Southall, 2008). This abnormality has been linked to chronic stimulant drug abuse (Schmidt, 1999). In a larger study examining the post-mortem reports of 21 cases of restraint-related deaths, 15 had heart disease including an enlarged heart (O'Halloran, 2000) and in a recent Inquest where the Author gave evidence the cause of death was recorded as:

Medical Opinion as to the Cause of Death

1a. Cardiorespiratory arrest

1b. Myocardial ischaemia

1c. The adverse physiological effects associated with recent physical restraint and multiple injuries to the surface of his body, in a man with coronary artery atheroma.

(Inquest into the death of Christopher Pearson, a serving prisoner at HMP Leeds. Mr Pearson collapsed and died less than two hours following an episode in which he was subject to restraint having been forcibly removed from his prison cell (2023)).

The Author told the Inquest that save for the limited circumstances where the subject is known to staff, such that they might be expected to have knowledge of any underlying medical condition, it is unrealistic to expect those carrying out restraint to be aware of the additional hidden dangers that restraint might exacerbate. This 'hidden danger' is further evidenced by Aquaro (2011), who noted chronic cocaine misuse resulting in cardiac structural involvement which could lead to cardiac damage and become evident later in life. Aquaro (2011) observed that 83% of people using cocaine over long periods have suffered major structural damage to their hearts. The risks associated with restraint are self-evident.

7.10 Obesity/high body mass index

Another risk factor noted by Aiken *et. al.,* (2011) relates to individuals who are obese or have a high body mass index (BMI). Obesity is known to increase the work of breathing (Hough, 2001) and reduce diaphragm movement in the prone position (Hollins, 2010). Atypical anti-

psychotic drugs can increase the risk of obesity thus making those with serious mental illness more vulnerable.

Obesity was also one of the predisposing risk factors to police custody deaths in studies by Hick (1999), O'Halloran (1993) and Southall (2008). In a study into fatal outcomes where ExD/ABD was reported, 56% of the cases were obese (obesity being defined in the study as having a BMI greater than 29 (Stratton, 2001). Comparisons can be made to O'Halloran's study (2002) where the cases of obesity (BMI greater than 25) were 75%.

Reay (1996) explained the risk this way:

> *"A large, bulbous abdomen (a beer belly) presents significant risks because it forces the contents of the abdomen upward within the abdominal cavity when the body is in a prone position. This puts pressure on the diaphragm, a critical muscle responsible for respiration, and restricts its movement. If the diaphragm cannot move properly, the person cannot breathe."* (p. 17).

Unlike many of the other risks which cannot be seen, obesity is often visible, enabling staff to recognise a higher-than-normal risk factor and alter their approach accordingly.

7.11 The supervisor and safety person

Many restraint-related deaths could have been prevented had a competent safety person been present whose sole responsibility was the safety and well-being of those involved with the restraint, and in particular the person being restrained. The safety person does not get physically involved in the restraint.

There are considerable advantages of having an independent person assume the role of safety supervisor. Although all staff involved in the restraint should, insofar as is practicable, monitor the subject and react to any signs of distress throughout the duration of the restraint, and possibly for a time following the restraint, a dedicated safety supervisor's task is to ensure the safety of the subject and staff. This involves ensuring that the restraint is, and remains, necessary and is performed as safely as possible in the circumstances. This is assisted by the fact that an independent safety supervisor is likely to be less emotionally involved in the restraint compared to those directly involved in the restraint.

An analogy to surgery might assist. Surgeons are all too aware that the lives of their patients are often in their hands during surgery and that mistakes can lead to death. It is likely that they are busy concentrating on doing a good job for their patients rather than reflecting on the

enormity of their actions. By contrast, anaesthetists have a unique position in providing perioperative patient-focused care, monitoring their wellbeing throughout their surgical experience. But where is the 'anaesthetist' during restraint? A supervisor and a medically trained safety officer should be present during all planned interventions, and as soon as possible during spontaneous and unexpectedly complex interventions. The supervisor should be in overall charge of the intervention but should not participate in it.

7.12 Investigating untoward incidents and improving safety: extending the coronial approach

In the Author's professional practice as an expert witness, he has dealt with more than 3,000 cases. By definition, the Author is only instructed in these cases when something has gone wrong, sometimes catastrophically, and one party is seeking redress from another(s). These cases generally follow the same pattern. An incident occurs, someone (generally) gets harmed, lawyers become involved, the lawyers decide that they need to instruct an expert, the Author reviews the papers, sometimes visit the site where the incident took place, and then prepares a report. In a civil case, the experts on either side are required to discuss the issues and to prepare a joint report, setting out the areas upon which they agree and those upon which they disagree. Often, in a civil case, the case settles and in other cases the matter proceeds to trial. The trial judge hands down a judgment while in a criminal matter, a jury has to decide whether or not the accused is guilty of the offence(s) charged. There may be an appeal but that is generally the end of the matter. In a civil matter, the remedy is one of monetary damages. This brings to an end the litigation but does nothing to improve safety.

The following case, in which the Author was instructed as an expert witness, is typical of expert evidence assisting the Court but doing nothing to improve safety. *Middleton v The Office* (2003) concerned a claim for damages for injuries sustained by a prison officer during his routine control & restraint training provided by the prison service. The officers were practising a breakaway technique designed to free themselves from a prisoner who was on top of them on the ground and attempting to strangle them with their hands. The technique was taught in accordance with the prison service training manual. At the time Mr Middleton was injured he was role playing a prison officer, was lying on the ground, and another officer, playing the role of a prisoner, was straddling him simulating a strangle hold. The technique involved Mr Middleton twisting his body to one side and thereby propelling the prisoner from on top of him. The Author gave evidence that the technique included in the manual was inherently dangerous

and inefficacious although could easily have been modified to render it safer and more efficacious. This was accepted by the Court. At paragraphs 26 and 27 of the judgment, the trial judge explained:

> *"Mr Baskind goes on […] to explain a simple alteration to that technique which increases control by the addition of the armlock, the effect of that increased control, as [the Defendant's expert] says, being to reduce the risk […] which I find clearly shows a relatively simple alteration to the Home Office approved technique of 1993 to 2000 which, however substantially, reduces the exposure of the person playing the assailant, as Mr Middleton was, to the kind of impact to the tip of his right shoulder which he clearly suffered on this day.*
>
> *Weighing the expert evidence before me today, I conclude that there was in 1998 available a technique that would have reduced the risk to Mr Middleton of the very kind of injury which he sustained in the course of this training and that the failure by the defendant to employ that technique was a failure on their part to fulfil their duty to take reasonable care in the circumstances to reduce the risk of this inherently risky training exercise to a minimum. For this reason the claim succeeds."*

Mr Middleton won his case and that was the end of the matter. The same technique that the judge found to be defective and unsafe continues to be taught by the prison service. Had this case resulted in death, the Coroner might have been minded, after the Inquest, to take action to prevent other deaths occurring in similar circumstances. In any case where information is revealed as part of the coroner's investigation, including during the course of the evidence given at the Inquest, *"anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist in the future"* (paragraph 7(1)(b), Schedule 5 of the Coroners and Justice Act 2009), and *"in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances"* (paragraph 7(1)(c)), the Coroner has a duty to act if he is of the opinion that action needs to be taken to prevent other deaths occurring in similar circumstances. In such circumstances, the Coroner is required to issue a report to a person, organisation, local authority or government department or agency who the Coroner believes has power to take such action. This is known as a Coroner's Regulation 28 Report (more commonly referred to as a Report on Action to Prevent Future Deaths, or a PFD Report) and sets out the concerns and requests that remedial action is taken. The person, body or organisation in receipt of this report then has 56 days to provide the Coroner with their response (Regulation 29), to include details of the actions taken and to reassure the Coroner that their concerns have been addressed to prevent future deaths. Regulation 28 Reports, and the responses to them, are sent to the Chief Coroner who will, in

most cases, publish the reports and responses on the judiciary.gov.uk website. It is noteworthy that successive governments' responses to investigating these deaths tend largely to utilise Coroners to report and investigate such deaths by way of their PFD reports (Matthews, 2014). Despite the advantages of the FPD system, more needs to be done. The system has recently been described by the Justice Committee (2024) as *"not fit for purpose"* (Castro, 2024) due to inconsistencies in Coroners issuing PFD reports. Coles (2024) told the Justice Committee that *"one of the values of PFDs should be the learning at a national level"* which rarely happens (Castro, 2024). It is the Author's experience, that save in the most high-profile cases (such as Lewis, 2017) little if anything happens once the report has been issued and the responses returned by those named in the PFD. This is extremely disappointing because PFDs are potentially life-saving reports which are not being used in a way that can help save lives. We are seeing similar deaths occurring and little is being done to prevent them. The Justice Committee was told that lessons learnt in one region could not easily be found by another region which has experienced the same death and there was no way to share learning across organisations (Castro, 2024).

Causation is a central feature in law. Thus, in a civil claim, unless the breach caused the harm complained about it is said to lack causative potency and damages will not result. This is because it is necessary for the claimant to establish the necessary causal link between the defendant's conduct and his loss (see, e.g., *Barnett v Chelsea & Kensington Hospital Management Committee*, 1969). Helpfully, a Coroner's PFD report need not be restricted to matters that are causative, or even potentially causative, of the death under investigation. This is because paragraph 7(1)(b) refers to "*anything*" revealed by the investigation which gives rise to concern that circumstances creating a risk of other deaths will occur. There is also no requirement for the PFD report to restrict itself to reporting on issues to prevent the recurrence of fatalities similar to that in respect of which the inquest is being held, as used to be the case under the original Rule 43 regime. Consequently, as the PFD report does not have to relate to a death in similar circumstances, Coroners may now report issues that may be peripheral to a particular case but nevertheless will prevent deaths in the future. As the following example illustrates, this can be extremely important in PMVA cases.

A patient dies during physical restraint. Unauthorised and dangerous mechanical restraining devices are found at the scene but there is no evidence that these were used during the incident. Questions were raised during the course of the investigation about the hospital's process for risk assessing and authorising mechanical restraints for use by staff and the training such staff

would receive in their use. There was also evidence that senior managers had expressed concern about these unauthorised devices and in particular two recent incidents where patients had to be revived following their use. These questions raise sufficient concern with the Coroner that action should be taken to prevent future deaths, notwithstanding that any such future deaths might not be in circumstances similar to the deceased's death, but relating to other possible deaths where the issue and use of mechanical restraining devices are shown to be inadequate. The coroner is required to set out in Box 5 of the PFD report clearly, simply and *"in neutral and non-contentious terms"* the factual basis for each concern (*R v Shrewsbury Coroner's Court, ex parte British Parachute Association* (1988) 152 JP 123). In many cases, the action to be taken following the Coroner's concern will be obvious. But it is not a matter for the Coroner to express precisely what action should be taken. A PFD report is a recommendation that action should be taken, but should not lay down what that action this should be, as that is properly a matter for the person or organisation to whom the PFD report is directed.

Hallett (2011) explains:

> *"... it is neither necessary, nor appropriate, for a coroner making a report under rule 43 to identify the necessary remedial action. As is apparent from the final words of rule 43(1), the coroner's function is to identify points of concern, not to prescribe solutions."*

Prior to the introduction of PFD reports (paragraph 7, Schedule 5 of the Coroners and Justice Act 2009; Regulations 28 and 29 of the Coroners' (Investigations) Regulations 2013), Coroners could, in similar situations, issue 'Rule 43' reports (under rule 43 of the Coroners Rules 1984). But there is one important difference between the two reports: with the previous regime of Rule 43 reports, the Coroner had a discretion whether or not to issue a report whereas under the PFD regime this discretion has been upgraded to a duty to do so in any case where it appears there is a risk of other deaths occurring in similar circumstances.

Of course, coronial hearings relate only to deaths and there is no corresponding procedure in non-death cases. This is regrettable. Deaths are only the tip of the iceberg and, although impossible to quantify, a considerably larger number of people are injured during PMVA-related matters than those who die. It is also correct to note that the same intervention, omission or incident, could end without injury in one case but could seriously injure or cause the death of a person in another. Often the end result is a matter of pure chance. The Coroner's PFD report is an important step forward in cases of death. Urgent action is now needed to deal with similar concerns in non-death cases. This is not the function of a court of law and no other

process exists to deal with such investigations. Such a process could, and should, be created by parliament. Accreditation is currently a hot topic in healthcare PMVA training for which those seeking to become accredited pay a fee. There is no reason why this fee should not include a levy which would fund a system based on the Coroner's PFD report for cases that although do not result in death, give rise to a concern that circumstances creating a risk of other injuries (or deaths) will occur, or will continue to exist in the future and action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of injury or death created by such circumstances.

Based on the PFD report, the Author has devised a specimen *'prevention of future harm'* report (PFH), the template of which is intended to be incorporated into the wider learning from PMVA-related injuries and deaths (see Fig. 8 below). It is intended that this report is completed alongside any existing use-of-force forms for all cases where harm has been caused to any party during an intervention. For these purposes, harm should include psychological as well as physical harm. By reviewing these reports, it would be possible to see what common themes emerge and what steps can be taken to eliminate or minimise the harm caused. It is anticipated that clear patterns will emerge of recurring similar issues. By asking, on the PFH report, for a timely response (Q7) which must contain details of action taken or proposed to be taken, setting out the timetable for action, or an explanation as to why no action is proposed, a database of actions/proposed actions can be created. This will greatly improve lessons learned and ensure that actions taken are properly evidenced. It will also allay any oversight panel's concerns that any potential failings have been properly investigated and evidenced. This data can also be used to ensure that organisations make good on their proposals and that findings and recommendations have been incorporated into their organisation's practice.

It will also be useful for organisations to be able to demonstrate to regulators and other investigators and stakeholders that they have incorporated findings and recommendations into their own organisation's practice as well as taken on board the national learning from the proposed PFH database.

Completed PFH forms can then be used for further investigation as part of a new Author-proposed *'National Learning From PMVA Harm Framework'*. It is intended that cases selected for investigation as part of the Framework will be made according to their potential for national/systemic learning as well as those based on a scale of risk and harm, the impact on those involved, and on public confidence in the way in which matters relating to PMVA are

managed. The Framework will establish and maintain a database of incidents investigated with recommendations for improvement. This way, the potential for learning to prevent future harm will be hugely enhanced.

Figure 8. Example Report to Prevent Future Harm from PMVA

	REPORT TO PREVENT FUTURE HARM FROM PMVA THIS REPORT IS BEING SENT TO: 1. Chief Executive, ABC Mental Health Trust 2. Chief Executive, DEF Training Limited 3. Chief Executive, GHI Training Equipment Limited 4. Care Quality Commission 5. Secretary of State for Health and Social Care, Department of Health & Social Care
1	**INVESTIGATOR** I am ERIC BASKIND, senior investigator, for [organisation name].
2	**INVESTIGATOR'S POWERS/DUTIES** I make this report under [set out any powers/duties that exist].
3	**INVESTIGATION [note: the details below are fictional]** On 23 August 2023, I commenced an investigation into serious harm sustained by AAB123, a then 29-year-old female, who was a patient in ABC Hospital, run by the ABC Mental Health Trust. The investigation concluded on 24 April 2024. The conclusion of the investigation was that her injuries were caused by excessive force being used on her in order to make her comply with a verbal instruction to tidy her room. No force should have been used. A restraint belt was also placed and secured across her mouth to stop her from spitting and screaming. This should not have happened. Hospital staff had access to restraint belts provided by GHI Training Equipment Limited although had not been trained in their use. Staff relied on a written training guide, provided by their external training provider, DEF Training Limited, which had obtained the written guides from GHI. This supported the use of the belts in any way staff thought appropriate, including placing it across a patient's mouth. None of this was appropriate. No staff had received any PMVA training. The harm caused to AAB123 was entirely foreseeable and preventable.
4	**CIRCUMSTANCES OF THE HARM SUFFERED** (1) AAB123 has a long history of psychiatric illness. Prior to this incident, she was living with her mother. She had not previously been an inpatient in a mental health facility. (2) She was being treated satisfactorily in the community with Olanzapine prescribed by her GP. (3) Her father had recently died and AAB123's mental health deteriorated. She was admitted to ABC Hospital. After 2 days, her medication was changed to Aripiprazole although she was not given any reason for this. She had difficulty tolerating this new medication and became uncharacteristically aggressive and untidy. (4) She was told to tidy her room but refused. (5) Without warning, 3 members of staff entered her room and dragged her off her bed and to the floor where she was restrained. Her left elbow was fractured by the application of an arm hold by staff member XYZ. She started crying and screaming

	out in pain. This was possibly mistaken for her spitting at staff and a restraint belt was applied and secured across her mouth. Staff made no attempts to calm her down or talk to her. The only things said were that if she refused to cooperate, she would be restrained. (6) In addition to the fractured left elbow, her mental health has deteriorated considerably.
5	**INVESTIGATOR'S CONCERNS** During the course of the investigation the evidence revealed matters giving rise to concern. In my opinion, there is a risk that future harm will occur unless action is taken. In the circumstances it is my duty to report to you. The **MATTERS OF CONCERN** are as follows. (1) The ABC Mental Health Trust did not liaise with the patient's GP or refer to her medical notes before changing her medication. This should have been a priority. The Trust should also have collated all medications she had been prescribed historically and if there were any medications that did not work so well nor had adverse effects on her mental well-being. (2) Aripiprazole has been shown to increase aggression, especially if it is titrated too quickly. This is a common failure by staff who think it will work quicker although it only increases side effects and increases risk. (3) Staff noticed the change to her behaviour but did not consider possible causes. Staff ought to have explored with her the reasons for her change in behaviour, querying whether this might have been due to a physical decline were baseline observations completed including a urine and drug screen dip. There is no evidence that staff explored with her concerns about her father's death and how she was feeling regarding being brought into hospital. Might she have been better at home following bereavement to recover rather than in a hospital? It is unclear why she was she admitted: could there have been a less restrictive way of managing her needs? It is also unclear precisely what risk was being managed. It is possible that aggression could have been caused by the fact of admission. There was no rationale for the restraint. (4) The ABC Mental Health Trust did not have its own policies on PMVA. Instead, it relied on old policies from a number of other Trusts, some dating back more than 15 years, and which contained numerous contradictory statements and was, in any event, out of line with current best practice. (5) None of the Trust's staff had received any PMVA training despite this having been raised as a concern in the past. As a result, staff had to do the best they could, often resorting to inappropriate and dangerous interventions. Injuries to patients and staff were high. The Trust's explanation that they had contracted with DEF Training Limited but this training was still awaiting Board approval is unacceptable. (6) Mechanical restraint devices should only be provided with Board approval. The Board was unaware that the Hospital had any such devices. (7) The written guide to the use of the restraining belts was wholly inappropriate.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future harm and I believe each of you, respectively, have the power to take such action.
7	**YOUR RESPONSE** You are required to respond to this report within 56 days of the date of this report, namely by [DATE]. As the investigator, I may extend this period if requested to do so with reasons for such a request.

	Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the following Interested Persons [NAMES]. I have also sent it to [NAMED PERSON] who may find it useful or of interest.
9	**[DATE]** **[SIGNED BY INVESTIGATOR]**

FOR INVESTIGATION USE ONLY

10	□ A1. No force should have been used □ A2. De-escalation strategies were not used and would likely have had a positive outcome had they been used □ A3. Some force was necessary but at a lower level than was used □ A4. The intervention used was inappropriate □ A5. The intervention used was dangerous □ A6. The intervention went on for too long when it was not necessary □ A7. The intervention could have led to serious harm □ A8. The intervention could have led to death □ A9. No evidence of staff self-reflection

CHAPTER EIGHT: CONTROVERSIAL PHYSICAL INTERVENTIONS

8.1 Why are some interventions more controversial than others?

The use of force is in itself controversial and one which will always require justification within the context of deployment. Three interventions engender the greatest amount of controversy, with repeated calls for them to be banned. These are: restraints in the prone position; pain-compliance techniques; and mechanical restraining devices. The first two have been described by Allen (2000) as *"the most controversial type of physical intervention used in human care services"* and by Leadbetter (2004) as *"high risk"*. Cunningham *et. al.,* (2003) described prone restraint as *"socially invalid"* and *"oppressive"* while the Millfields Charter (2005) *"deplores"* its use describing it as *"degrading and dehumanising"*. But for every person who is against the use of prone restraint positions, there are others who accept them, in appropriate circumstances, as a legitimate and necessary part of the restraint process (Baskind, 2014). In any event, as Hollins (2010) correctly observes, a ban on the use of prone restraint *"would be impossible to achieve"*. It is with this obvious impossibility in mind, that it was surprising to learn that the Rt. Hon. Sir Norman Lamb MP, who served as Minister of State for Care and Support in the Department of Health in the Coalition Government advocated that its use should constitute a criminal offence.

The reasons why these interventions are so controversial will be discussed throughout this chapter.

Calls for the banning of these kinds of intervention are not new. The opposing views can generally be split between the views of practitioners and those of academics and commentators. Practitioners, especially those working in areas with the most challenging episodes of violence, tend to agree that it would not be safe or practicable to ban these kinds of intervention, while some academics and medical professionals often take the opposite view. (Restraint Reduction Network, 2019).

The Author gave expert evidence in a civil case (C v D, 2023) in which the central issue was whether or not it was negligent for an organisation to prohibit its staff from using prone restraint or pain-compliance techniques. This case is discussed below.

An analysis of these techniques follows.

8.2 Prone restraint positions

There is no universally accepted single definition of prone restraint: it refers to a position in which the subject is held, chest down, against a surface that serves to restrict their movement. That surface is generally the floor, although other surfaces may be used, such as a bed. When applied, staff generally apply some pressure to parts of the subject's body to ensure they are held in this position until it is deemed safe to get them into another position, ideally to their feet. Although some of the literature and indeed some researchers, refer to prone restraint as a single specific kind of restraint (see, e.g., Morrison *et. al.,* 2001; Chan, 2004; Holden, *et. al.,* 2011), the term merely describes an intervention where the subject is restrained on their front. It is also commonly referred to as *'face-down'* restraint, notwithstanding that the subject's face is turned to one side (MIND, 2013). The Author will return to the face-down label later as this term has added confusion to an already complex situation.

There are many reasons why a prone restraint position might be used and these include a deliberate action by staff to take the person to the floor for their own safety or the safety of others including staff, or where the staff and/or the subject lose their balance, slip or trip, during the initial struggle and end up on the floor, with the subject facing towards the floor. Other reasons include the person deliberately dropping to the floor and either adopting the foetal position and/or pulling staff down with them.

Restraining a violent person, or a person who is out of control, on the floor has one important advantage in that the floor serves to limit the person's movement thus enabling staff to bring the person under control more quickly than if they attempted the restraint in the standing position. Once the person is held in the prone position, their ability to attack staff (e.g., by punching, kicking, head-butting, or spitting) is significantly limited. So will be their ability to resist as, properly applied, they will not be able to generate the force needed to push themselves up as they would if they were held supine. Supine restraint positions are discussed below. One suggestion advanced by those against the use of prone restraint is to instruct staff to abandon the intervention if it goes to the floor. However, as Hollins (2010) correctly points out this *"would be legally and morally indefensible if it allowed an individual the opportunity then to hurt themselves or others as a result"*.

8.2.1 Risks associated with prone restraint positions

Concerns about the risks associated with prone restraint are not new. Awareness of the dangers of *'hog tie'* and *'hobble'* restraints, previously in widespread use in American policing, was

publicised by (Reay, 1988). Four prone restraint-related deaths in the prison service between 1991 and 1995 led to a comprehensive review of the control and restraint techniques used by prison officers to control violence in His Majesty's Prisons (Safety in Custody Statistics, 2023). Staff were advised that prisoners must not be left in the prone position with their hands secured behind their backs although there was no prohibition on restraining prisoners in the prone position (Safety in Custody Statistics, 2023).

The most significant risk associated with the use of prone restraint positions is restraint asphyxia (Hollins, 2010). Restraint asphyxia is a type of positional asphyxia. Miller (2004) describes positional asphyxia as "*death that occurs because the position of a person's body interferes with breathing, and the person is unable get out of that position*". The difference between positional and restraint asphyxia is that with the latter, the person is unable to escape from the position because of the restraint applied by staff. A number of commentators have explained the dangers often ascribed to prone restraint not on the position itself but on a range of other factors. These other factors include antecedent and other impact factors (Lancaster *et.al.,* 2008), pre-existing health conditions such as heart or lung disease, prolonged exertion, psychoactive drugs, and obesity (Mohr *et.al.,* 2003). Hough (2001) explains the link of death to obesity as the increased difficulty in breathing in obese individuals. Stubbs (2009) points to the widespread use of atypical antipsychotic medication and its prominence in psychiatric populations. The proper functioning of the heart is an additional factor as it can be critically impeded by the occlusion of carotid blood flow (Reay *et.al.,* 1982), lactic acidosis, potassium ion accumulation (Ball, 2005) and blunt trauma to the chest (Mohr *et.al.,* 2003). Sharp (2004) notes the additional risk of prone restraint when applied to adolescents. This enhanced risk is due to adolescents' incomplete physical maturation which can place them bio-mechanically at a disadvantage together with a higher ventilatory requirement, an altered perception of exertion, an ineffective anaerobic warning system and poor thermos-regulation, especially in cases where exertion levels are high and prolonged (Sharp, 2004).

A number of restraint deaths brought the dangers of prone restraint into the public focus. One of most high profile of these cases is that of David *'Rocky'* Bennett who died during his detention at the medium secure Norvic Clinic on 30 October 1998. A far-reaching public inquiry followed (Bennett Inquiry, 2003). The Bennett Inquiry criticised the use of prone restraint and recommended strict time limits should be imposed when restraining a person in this position expressing particular concerns about positional asphyxia. Given that many of the

points highlighted in the Inquiry Report are identical to those being discussed today it is worth setting them out here:

> *"The Inquiry was convinced that it was always dangerous to place a person in a face-down prone position, but accepted that there were occasions when it was necessary to do so. We heard powerful evidence that the longer a person was held in a face-down prone position the more dangerous it became.*
>
> *We accepted the evidence that there should be a time limit to restraint in a prone position. We recognised that it was arbitrary to impose a specific time limit, but we concluded that the imposition of a time limit was essential in order to minimise the risk. We therefore recommend that a person should not be restrained in a prone position for more than three minutes. Dr Ball said that restraint in the prone position was particularly dangerous. He was sympathetic to the view that prone restraint should not happen or, if it did, for it to be ended almost instantaneously or changed to restraint with the person lying on their back.*
>
> *The RCN considered that face-down positions were more dangerous than face-up, but said that it must not be forgotten that face-up positions could still be dangerous. They said that there was a need to articulate the legitimate concerns of nurses as well as patients. It was necessary to get the balance right between safety of the mental health patients and the safety of staff.*
>
> *Mr Tucker said that progressive trainers would say you never put people in a face-down position. Dr Shepherd said that the safest way of dealing with violence was a rapid episode of initial restraint by people who have had proper training. This should always be treated as an acute medical emergency. He would hope that control could be gained within seconds. It might be necessary to place the person being violent on the floor to start with, in order to gain control, but one had to be aware of the risks to the patient in keeping them face-down. If they were kept face-down, there was a risk of causing death. One could construct a timescale of two or three minutes for a patient to be face-down but any time limit was entirely arbitrary. While they were face-down it was a very difficult and dangerous phase for the patient. There was no risk-free option. Dr Cary pointed out that if a patient was struggling while being restrained, that person ran out of oxygen incredibly fast particularly if his chest was squeezed and his lungs were empty. You should never restrain to exhaustion. He was not totally against using face-down restraint in order to gain initial control in what otherwise might be a dangerous situation, but it was not satisfactory where the only obvious escape from face-down restraint was when the person either became limp or was unable to go on struggling."*

The Bennett Inquiry also noted that "*INQUEST drew our attention to the current prison service's control and restraint manual, which sets out their procedures for the applications of control and restraint. That manual stated: "Whenever an inmate is held face-down on the floor the maximum period of continuous restraint should not exceed five minutes". Professor Appleby said that if you had people in the prone position on the floor it should be for the shortest possible time and he would support a recommendation for a time limit, even if it were*

arbitrary. Dr Shepherd favoured a time limit of, say, two or three minutes, but added that any limit was likely to be entirely arbitrary. Mr Tucker said that there was no harm in imposing an arbitrary limit and even an arbitrary limit would be better than no limit at all. Finally, Dr Pereira said that the Royal College of Psychiatrists did not have a policy regarding the prone position." (pp 52 – 53).

In its publication 'Policing Acute Behavioural Disturbance', the Police Complaints Authority (2002) cited with approval Dr Cary's view that: *"The prone position should be avoided if at all possible and the period that someone is restrained in the prone position needs to be minimised".*

There has never been a consensus of agreement about the safety of prone restraint positions. Allen (2000) has explained that prone restraint can cause significant effects on a subject's breathing which in extreme cases could prove fatal. Perry (2008) considered that if properly used for short periods of time, prone restraint may be the only practicable way of managing a violent situation without exposing staff or carers to undue risk of injury themselves, although it should only be considered after other techniques have failed.

Dr John Parkes has conducted some of the best-known research into the dangers associated with prone restraint positions (Parkes, 2011). Parkes' research carried out at Coventry University examined the effect of certain restraint positions on lung function. He explains that:

> *"Our conclusion is that some, but not all, prone restraint positions have a significant effect on breathing […]. It is clear that recommendations given previously, either to consider all prone restraint as dangerous or to consider prone restraint as presenting no additional risk, are not supported by empirical results."*

Parkes' 2011 study into lung function associated with prone restraint is discussed below.

Dr Heather Payne gave oral evidence to the Howard League Carlile Group (2005). She called for the use of prone restraint to be discontinued until it could be shown to be safe. But that is an impossible proposition because we know that there is no such thing as an entirely safe restraint, including prone positions (Sethi, *et. al*., 2018). The better approach is to consider whether there are any safer, effective alternatives to restraining a person in the prone position. If there are, they should be used. If no safer effective alternatives exist, the debate should consider whether not restraining the person is a safer option than not restraining them. Dr Payne is not alone in calling for the discontinuance of prone restraints. At one time, the Department

of Health sought to prohibit their use (*Positive and Proactive Care*, Department of Health (2014; para. 70), the Welsh Assembly Government which has gone further and banned prone restraints in health, education, and social care settings (Welsh Assembly Government, *'Framework for Restrictive Physical Intervention Policy and Practice'*, 2005), and the Security Industry Authority prohibits the teaching of any ground restraint techniques, irrespective of the subject's orientation, during its mandatory licence-linked training courses.

Despite the unequivocal wording of the Welsh Assembly Government's ban on prone restraint that states: *"Under no circumstances, should any individual ever be restrained in a face down position"*, (Welsh Government, 2005) it is the Author's experience that prone restraint was still used in Wales provided that a risk assessment determines its use is safer than the alternatives. This left practitioners in an unacceptably confused position. The 2005 ban was reversed in 2009 when the Welsh Assembly withdrew its earlier prohibition by advising practitioners that they should *"continue to use their professional judgement to determine whether use of a particular restraint technique is an appropriate response to a given situation.*" (Welsh Assembly, 2009).

It is the Author's experience that the majority of organisations now recognise the risks associated with all types of restraint as well as the importance of proper risk assessments and training needs analysis, and are increasingly aware of the need to minimise the use of all kinds of restraint and coercive and restrictive practices. The better organisations also recognise the difference between eliminating an intervention and eliminating the *need* for an intervention, and the importance of concentrating on safety within a human rights framework.

Dr John Parkes summed up the problem thus: *"The scientific evidence on safety during restraint is weak. Guidance is often based on the opinions of individuals deemed to be 'experts' but little empirical evidence supports the recommendations made"* (Smallridge and Williamson Inquiry, 2008; para 6.15, p. 34).

In an attempt to clarify and draw together the available evidence, a number of leading experts, including the Author, published an article in the British Journal of Psychiatry, *'Restraint in mental health settings: is it time to declare a position?'* (Sethi, *et. al.*, 2018) which advanced the argument in this way:

> *"Although deaths have occurred during prone restraints, it is not clearly demonstrated that death is associated specifically with this position and the number*

> *of deaths directly associated to it is small. Hall et. al., (2015) studied 3.25 million police/public interactions which resulted in 2,015 restraints in a prone position and 2,358 in a non-prone position. One fatality occurred following restraint, which translates to a rate of 0.02%, and this was in a non-prone position. There is no randomised controlled trial examining this issue and the challenges associated with such a trial are self-evident."* (Sethi, *et. al.,* 2018; p. 3).

There are many good examples of organisations maintaining the use of prone restraints where deemed necessary, one example being Hampshire County Council Children's Services Department which, in evidence to the Smallridge and Williamson Inquiry (2008) explained that *"the presenting behaviours were of such a high risk that [prone restraint] was the safest way of containing that behaviour"* (para. 6.28; p. 36). Confirming the relative safety of prone restraint positions, Matthews told the Smallridge and Williamson Inquiry (2008) that data collected by services that have used the '*Team Teach'* training programme demonstrates that prone restraints can be safely used, explaining that only three out of 3,000 instances of prone restraint resulted in hospital attention (Smallridge and Williamson, 2008; para 6.28, p. 36). Dr Perry explained that if properly used for short periods of time, prone restraint may be the only practicable way of managing a violent situation without exposing staff or carers to undue risk of injury, although he felt that prone restraint should only be considered after other techniques have failed (Smallridge and Williamson Inquiry, 2008; para. 6.30, p. 36). The importance of the Smallridge and Williamson Inquiry (2008) is that they were commissioned by the Government to conduct an independent review and to provide, *inter alia*, guidance on prone restraint positions. They concluded their advice by stating that:

> *"We are aware that the secure estate is looking to us for guidance on prone restraint. But there are no simple answers. We are wary of over-simplification over prone restraint and are cautious on the issue. Where a young person is held face down with pressure only on the limbs the evidence is that there is likely to be only a small effect on lung function, and in these cases prone may be quite safe for most young people, for most of the time. However, more 'forced' prone restraint, when body weight is applied to the back or hips may be unsafe for almost everyone.*
>
> *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. There should be procedures in place to ensure that a senior member of staff responds to the incident, assesses the situation, evaluates the competing risks and implements an alternative to prone if safety demands. Against this background, it is critical that further research is undertaken into effect of lung function and restraint. We support the Youth Justice Board's recent commissioning of Dr John Parkes to research the effect of different restraint positions on lung function."* (paras. 6.34 and 6.35, p. 37).

It ought to be obvious that calls for any intervention to be discontinued must be evidence-based and supported by guidance as to what might reasonably fill the gap that has been left by the withdrawal of the intervention. Despite numerous attempts by the Author, and others, enquiring as to what might fill this gap should they be required to discontinue the use of prone restraint, to date, the response has been consistent: this is not a matter for the policy makers or regulators. These enquiries have been directed to the NHS, CQC, BILD and the RRN. If it is not a matter for regulators, then it ought to be. It's all very well removing options from a syllabus, but what replaces them? Questions of safety mean that staff in these circumstances need to be taught how to implement alternative tactical options that either does not involve physical restraint at all or which involves tactics that are acceptable to the regulator and proven to keep people safe. A regulator requiring an employer to follow its regulations or guidance does not absolve from liability the employer, or its employees, from matters relating to health and safety. The majority of the practitioners working with persons at the higher end of the violence spectrum agree that although the use of prone restraint can and must be reduced, it is neither safe nor possible to discontinue its use in all cases and in such cases there is no viable safe alternative.

8.2.2 Laboratory research

Given the significant disagreement as to the safety of restraining a person in the prone position, it is interesting to review a study by Parkes *et. al.,* (2008) into the physiological effects of restraint positions and in particular lung function when held in different positions. The research by Parkes *et. al.,* (2008) is referred to widely in the literature as well as by the majority of those operating in the various sectors where restraint is used (police, prison service, hospital settings, security companies, etc).

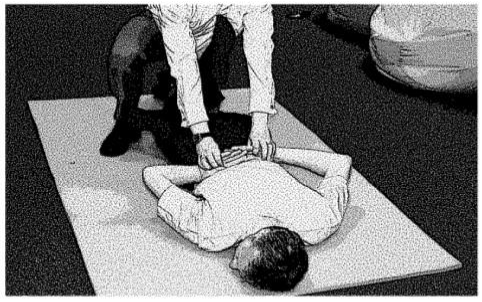
Parkes, *et. al.*, (2008) compared a person's lung function when held in different positions on the ground. The positions compared by Parkes can be seen in Fig. 9 below.

Figure 9. Restraint positions used in Parkes' study

Position 2. Flat on floor, supine.

Position 3. Flat on floor, prone.

Position 4. Prone, restraining staff apply body weight to torso ('Chicken wing').



Position 5. Prone, arms and legs restrained in flexed position ('Figure four leg lock')

The results of this study are shown in Table 9 below. The result in bold are noted in the article as being statistically significant.

Table 9. *'Comparison of lung function: prone vs supine'*, Parkes *et. al.*, Med Sci Law, 2008, 48(2); pp. 137-141.

	Forced Vital Capacity (FVC) mean lung function	Forced Expiratory Volume in 1st second (FEV_1)
Position 1 Standing control position	100%	100%
Position 2 Supine (held by arms in 'chicken wing')	-3.56%	-3%
Position 3 Prone (held by arms in 'chicken wing')	-7.8%	-7.87%
Position 4 Forced prone (leaning into subject with arms held in 'chicken wing')	**-23.83%**	**-27.39%**
Position 5	**-30.46%**	**-29.87%**

Forced prone (with fig. 4 leg lock and arms restrained)		**(one participant showing -57%)**

It can be seen from the above that merely holding the subject in a prone position does not materially affect their lung function, even when their arms are being restrained. The danger arises when pressure is applied to their body which can be seen from Positions 4 and 5. This accords with the Author's research noted in Table 8 above. These results are hardly surprising because the mere placing of a person in the prone position is not in itself dangerous. Some people sleep on their fronts without coming to harm and, during the height of the Covid pandemic, some Covid patients with severe hypoxia were intubated in the prone position leading to a reduced rate of mortality (Gulart, *et. al.,* 2020). There is, of course, a material difference between *lying* on one's front and being *restrained* in such a position. That is, with the former, the person can simply move into a different position should they experience any kind of respiratory distress whereas with the latter, the person is being restrained in such a position against their will with their movement substantially reduced. This is compounded by the fact that the person will often be resisting the efforts of staff to hold them in a particular position.

Barnett *et. al*., (2013) conducted a similar study to that carried out by Parkes, reporting that small reductions in lung function in the prone position could be ameliorated by a modified arms placement. This is where the subject's arms are placed in such a way that their chest is slightly raised from the floor (Reay, 1988).

Although attention in the UK has mainly focused on the prone position, fatalities have occurred in other positions (Park *et. al.,* 2001). The focus on restraint positions, and especially the prone position, was described by Sethi *et. al.,* (2018) as *"an unhelpful and confusing distraction"*, not least because *"any restraint intervention delivered poorly has the potential to lead to serious negative outcomes"*. Hollins (2010) explains that such a narrowed focus on one type of intervention leads to a misunderstanding around the wider risks associated managing restraints as this reduces the understanding and knowledge of the range of risks that are present during any period of restraint. The danger in this lack of understanding is that it can lead to a perception that certain risks are linked exclusively with prone restraints, *"leading staff to develop a situational blindness to other risks"* (Hollins 2010) associated with other restraint positions or types of intervention. The danger is obvious. Laboratory testing of seated positions have demonstrated reductions in lung function that are substantially greater than those from

prone restraint (Parkes, *et. al.,* 2011). The death of Gareth Myatt in a seated hold led to a multi-agency review of seated restraints (Youth Rights UK, 2007). Karch (2016) discussed the role of sudden cardiac death, the causation of which is not fully understood in the context of death following restraint. We know that death can occur during or following restraint; the infrequency and complex circumstances of these events hamper scientific investigation in the real world. Laboratory simulations point to some, but not all, positions inhibiting lung function. Ethical and practical constraints prevent the full recreation of fatal events in laboratory studies using human participants, yet front-line staff, irrespective of sector, require guidance. Such guidance needs to be balanced, practical and reflect the complexity and uncertainty of the current state of knowledge.

Some organisations have removed the teaching of prone restraints from their training. This is problematic as it increases the risk to both staff and service user. First, removing any intervention will mean that staff will need to use a different technique, and this is likely to lead to an increase in the time it takes to bring an incident under control. We have already discussed the increase in risk the longer a restraint is applied. Second, it is entirely foreseeable that removing prone restraints will lead to an increase in the use of pain-compliance techniques to bring the subject under control. Third, anecdotal evidence informs us that more staff are requesting permission to use mechanical restraint and seclusion. Removing prone holds from training cannot prevent the common occurrence of an incident going to the ground with the subject going into a prone position. Therefore, the biggest risk if prone restraint is not taught, is that staff may still (have to) use a prone hold but without the training or knowledge to safeguard the subject and reduce risk.

It is the Author's view that the prone-supine dichotomy is best summarised in this way: Intentionally taking a person to the floor during restraint should always be considered an exceptional intervention although many interventions will end up on the floor due either to one or more of those involved losing their balance resulting in everyone going to the floor or the subject taking themselves to the ground, typically in a protective foetal position. Even where the intervention goes to the floor unintentionally, the subject will often put themselves into a protective foetal position. This explains why so many interventions end up with the subject in the prone, or semi-prone, position without this being a deliberate choice of those restraining them. Staff then need to restrain the subject as safely as possible. Where it is possible to turn the subject off their font, it may be desirable to do so although there will be circumstances

where this could introduce fresh trauma into an already traumatised incident. A typical situation where this is likely to increase the subject's trauma is with a person who has previously been sexually assaulted. Any attempt to turn such a person onto their back is likely to be met with resistance and hostility. This same example also explains why it may not be desirable to take such a person onto their back so as to restrain them in the supine position.

Accepting, as we must, that restraining a person on the ground carries an enhanced risk of harm, the real question is can ground restraint (in any position) be eliminated? Not least because of the concept of gravity, this question can only be answered in the negative. The ground (as well as any other solid surface) presents a stable and solid barrier which can greatly assist the initial stage of any restraint thereby enabling staff to gain control quickly.

Despite the evidence, what happens where an organisation proscribes the use of a certain intervention, and this leads to harm? This is what happened in C v D (2019) in which the Author was called to provide expert evidence. This case is described below (the case name has been anonymised and is currently the subject of an appeal).

C v D (2023)

Factual background

The Claimant (C) was a nurse employed by the Defendant (D) working in D's psychiatric intensive care unit (PICU). He had been employed by D for more than 25 years. In addition, C was also a PMVA trainer with more than 20 years' experience, experienced across a number of PMVA training packages. Since 2011, he was D's lead trainer. He had been trained, and had trained others, in the use of prone restraint positions and pain-compliance techniques and gave evidence to the Court that during his career he had not encountered a case where prone restraint had been used in which, other than minor bruising and the like, harm had resulted, either to patients or staff. In 2018, D introduced a ban on the use of prone restraint positions and pain-compliance techniques. C was not consulted on these changes although he did express grave concerns about such a ban.

The incident

On 14 March 2019, there was an incident in the PICU during which a patient (P) started damaging furniture and attacking other patients as well as staff who came to assist. P was a large male and extremely powerfully built. An alarm was sounded and C attended and took

control of the incident. A manager (M) also attended but did not get physically involved. When C arrived at the scene, P was fighting with another member of staff (E), had his forearm around E's neck and was attempting to choke her from behind. C, together with another staff member (F), managed to release P's hold of E. P was screaming and behaving with extreme violence. C's evidence was that during his 25 years' experience working for D this incident was amongst the most violent he had encountered. C told the Court that he was concerned that P might be suffering from excited delirium although accepted that there was no evidence that this was the case. As a result, it was C's wish to bring P under control as quickly as possible. During the intervention, P, C and F all ended up on the floor with P landing on top of F where he started to gouge at F's eyes. C pulled P off F using a pain-compliance wrist/thumb flexion technique and P curled up in a semi-foetal position on the floor, still screaming and issuing threats to staff. At one point, P was in a semi-prone position and C's evidence was that, but for D's prohibition, he would have initially restrained P in the prone position as he deemed this to be the most appropriate and safe position in the specific circumstances of the case. He told the Court that he was aware of the dangers of restraint, including those pertaining to prone restraint, and would have ordinarily restrained P in prone for the shortest possible time and ensured that the restraint followed the usual safety protocols. At the precise moment C was about to turn P onto his side with the intention of restraining him in the supine position, M shouted a warning to him to "get him off his front now!". During the transition to supine, P broke free and punched C to his face, breaking his nose and dislocating his jaw. C abandoned his intention to turn P onto his back and successfully restrained him in the prone position for approximately 2 minutes from which time further staff arrived and P was brought incrementally to his feet. The Court noted that during the time P was being restrained in the prone position M was shouting to C to reposition him off his front which for reasons of safety C admitted to ignoring.

The claim

C's claim against D was for damages for the serious injuries he sustained during the incident and told the Court that from his experience he would not have sustained injury had he restrained P in the prone position from the outset. C also told the Court that in his view P would not have come to any harm had he done so.

The expert evidence

The Author was called by C's legal team to give expert evidence. The Author set out the history of the controversy of ground restraints and explained that although caution is needed whenever

any incident goes to the ground, and that prone restraint should not be the default intervention, it was wrong and dangerous to prevent properly trained staff from using appropriate prone restraints in certain high-risk situations, including the situation that arose in this case. The Author explained that the use of both the pain compliance wrist/thumb flexion and prone restraint techniques were entirely appropriate and that without them the likelihood of greater harm to all parties was extremely high, and probably inevitable.

D called their own expert witness who told the Court that in his view D was correct to proscribe both pain compliance techniques and prone restraint positions, adding that in his experience, there were no circumstances at all in which either kind of intervention had a place in modern-day PMVA practice.

Judgment

The trial judge accepted the factual basis of the incident. He queried the legal basis upon which any organisation could ban these kinds of intervention, noting that it was a matter of what would be deemed reasonable in the circumstances of each case. He held that in his judgment, both interventions were necessary in this case, for the safety of staff and patient. He was concerned that any organisation should attempt to ban an intervention without engaging with managers, practitioners and trainers and, further, that nothing appears to have been introduced to fill the gap created by the ban or any risk assessment carried out. The judge observed that these interventions have not been banned by other organisations, notably, the police and prison service. Judgment was entered for C.

So, what is wrong with prone restraint positions and why is there such controversy over their use? The principal argument put forward by those who wish to see this intervention banned is that people can die suddenly when held prone. There are two fundamental problems with this argument. First, as noted above, the term merely describes an intervention where the subject is restrained on their front and not a single kind of restraint. In practice, it merely describes the anatomical positioning and fails to take account of critical factors such as number of staff involved in applying the restraint, how and where pressure is being applied to the person, the nature and degree of any force used to achieve stability, whether any other techniques are being used simultaneously, the total time of the force application as well as any known pathologies or injuries that may be present within the individual (Hollins (2010). Furthermore, prone restraint positions are (or ought to be) merely transitory and maintained for only as long as necessary to bring the incident under control (Baskind, 2006).

8.3 Time in restraint

We know from a large number of cases that the longer the person is held in restraint the greater is the risk of death and this is particularly the case in connection with positions where the individual's breathing is compromised (Paterson *et. al.,* 2003; Davison, 2005). Individuals who are restrained have almost universally been restrained to terminate a violent episode. They are likely to be exhausted and their physiology deranged. Such a subject may also be dehydrated, be physiologically aroused, akin to an athlete after a prolonged period of running or exercise. To recover from a period of exertion, an individual needs to compensate the likely oxygen deficit but hyperventilating, replenishing fluids and correct the lactic acidosis. Any intervention that may compromise this recovery mechanism is likely to be dangerous and may lead to cardiovascular collapse and even death.

A number of important questions arise:

8.3.1 How long is too long?

Although there is no period of time for which it can be said it will be safe to restrain, several attempts have been made to set a maximum period of time or at least provide some other guidance on the matter. However, before discussing the question of time, it is important to recognise that, if restraint is needed, *"the safest way of dealing with violence was a rapid episode of initial restraint by people who have had proper training"* (Shepherd 2003).

It can be seen from the following comments that were provided in evidence to the Bennett Inquiry (2003) that there was no consensus of opinion as to the question of time:

- Dr Nathaniel Cary stated that *"the prone position should be avoided if at all possible and the period that someone is restrained in the prone position needs to be minimised".* This was subsequently cited with approval by The Police Complaints Authority in Policing Acute Behavioural Disturbance (2002).
- The then current Prison Service's Control & Restraint manual stated that *"Whenever an inmate is held face-down on the floor the maximum period of continuous restraint should not exceed five minutes".*
- Professor Appleby told the Inquiry that if individuals were being held in the prone position on the floor it should be for the shortest possible time and he would support a recommendation for a time limit, even if it were arbitrary.

- Dr Shepherd explained that one could construct a timescale of, say, two or three minutes for a patient to be restrained in prone, but acknowledged that any time limit was entirely arbitrary and that there was no risk-free option.
- Mr Tucker explained that there was no harm in imposing an arbitrary limit and even an arbitrary limit would be better than no limit at all.
- In the Author's evidence to the Inquiry, he stated that we know from cases from around the world that a minority of people can die within an extremely short period of time when restrained in certain positions whilst others (the majority) will come to no lasting physical harm even when restrained in such positions for an hour or more. The Author expressed a preference for there to be no time limit because that might imply that anything shorter than such a limit was safe. Instead, the Author said that ground restraint (in any position) should be kept to an absolute minimum with the subject's health and wellbeing closely monitored.

The Inquiry preferred the evidence that there should be a time limit for restraint in a prone position. They recognised that it was arbitrary to impose a specific time limit but concluded that the imposition of a time limit was essential in order to minimise the risk. They therefore recommended that a person should not be restrained in a prone position for more than three minutes.

NICE (2015) took a similar approach despite the Bennett Inquiry recommendation being rejected by the profession as misleading and unworkable. In NG10, NICE (2015) advised practitioners that manual restraint should not routinely be used for more than ten minutes (para 6.6.3.13) and that they should consider rapid tranquillisation or seclusion as alternatives to prolonged manual restraint lasting longer than ten minutes (para 6.6.3.14).

The problems with Bennett (2003) and NICE (2015) were not so much related to the number of minutes set out in their respective publications but the practicality of applying the recommendation in practice. That said, the NICE ten-minute guideline was considered to be too long, whilst concerns were expressed about both the three and ten minute recommendations that they might be interpreted as being formal endorsements that restraining someone for these periods of time was deemed to be safe.

Smallridge and Williamson (2008) were asked to provide guidelines on the maximum period for which a young person should be restrained which they described as *"understandable"* given

the *"strong evidence that as the duration of restraint increases, particularly when face-down restraint is used, then the risk of adverse consequences, including death, increases"* (Smallridge and Williamson 2008, para 6.47). They declined to specify any such time limits noting that *"there are dangers about being prescriptive in this way. There is no agreement about what the limits should be – the 3 minute limit on prone restraint proposed by the Bennett Inquiry, for example, was not supported by the National Institute for Health and Clinical Excellence on analysis of the scientific literature"* (para. 6.48; p. 38). Moreover, Smallridge and Williamson pointed out that *"fixing time-limits runs the risk of confusing the primary responsibility of staff to monitor risk closely in all restraint incidents, to respond to warning signs whenever they arise and to end all restraints as soon as possible"* (para 6.49; p. 39). The approach not to set maximum time limits for restraint was supported by the PCC Medical Panel which opined that *"continual observation of holds is required to determine when the young person must be released, rather than stating that particular holds should be applied for no longer than a specified period of time"* (para. 6.49; p. 39).

An analysis by O'Halloran (2000) of 21 restraint cases noted that the period during which a person was restrained in the prone position before collapse ranged from two to twelve minutes. Miller (2004) reported that the average time between the initial application of forceful prone restraint and when full cardiopulmonary arrest was noticed is 5.6 minutes. Although Miller (2004) refers to *"forceful"* prone restraint, it is submitted that the entirety of the debate is concerned with forceful restraint since merely holding a person on the ground in the prone position in circumstances where he can freely alter his position if breathing becomes laboured or restricted is relatively unharmful. Furthermore, in the majority of cases, a prolonged violent struggle preceded the subject's collapse under restraint Parkes (2002).

8.3.2 When does the time start?

The practicality of applying any timescale to prone (or indeed any) restraint becomes apparent when one considers the build-up to the restraint as well as the restraint itself.

The struggle to secure a restraint as well as the restraint itself will almost certainly mean that the subject will be out of breath and his increased demands for oxygen may not be met if his ribcage movement is restricted. Parkes (2002) observed that the risk of death was elevated in cases where there was a prolonged, severe struggle before collapse under restraint. Staff are also likely to be out of breath, but they can be 'retired' and replaced by others during the restraint. This becomes more serious the longer the initial struggle and the restraint itself goes

on. This might suggest, therefore, that the 'clock' should start the moment staff lay hands on him but this will not take account of what transpired beforehand. The justification for the restraint is typically an outbreak of violence involving the subject which itself may have gone on for some time and will have itself increased his demands for oxygen. Accordingly, the 'clock' would need to start towards the start of this violence if any arbitrary timescale is to have meaning. But this is not the case: no one has suggested that this earlier period of violence should be taken into account for the purpose of timing the subsequent restraint and it is submitted that the practicality of taking this into account would be virtually impossible in practice.

8.3.3 If a maximum time is mandated, what happens at the end of the allotted time?

This question exposes the principal fallacy with the timescale argument. If the restraint can be ended upon the expiry of the allotted time, then presumably it could (and should) have been brought to an end sooner. Similarly, what happens if, at the expiry of the allotted time, the subject is still not properly under control or, if he is, it is deemed unsafe for the staff to discontinue (or even slacken) the restraint?

The NICE (2015) recommendation that staff should consider rapid tranquillisation or seclusion as alternatives to prolonged manual restraint lasting longer than ten minutes (para. 6.6.3.14) is helpful, although is not applicable in non-medical settings. Also, drugs used in rapid tranquillisation may take up to 30 minutes (sometimes longer) to overcome violent activity.

The safety of those restrained in non-medical settings would be enhanced considerably by the presence, or rapid availability, of suitably experienced medical personnel whose function would be to monitor the subject during restraint and have the ability to administer rapid tranquillisation should the need arise. Doing so would align non-medical settings to hospital and similar settings where the monitoring of patients under restraint is the normal standard.

8.4 Alternatives to restraint in the prone position

If any intervention is to banned or even discouraged alternatives are needed. But policymakers and regulators have consistently stated that finding alternatives are not matters for them and have not been dissuaded from this view when told that in certain situations, no viable alternatives are available.

There are, of course, several ways in which to hold a person in restraint and the many calls for the banning of prone restraint has led to the quest to find other more socially valid positions (Hollins, 2010). But social validity or acceptability is not the same as safety as evidenced by a number of tragic cases. For example, the death of 13-year-old Gareth Myatt who died in 2004 after being restrained by staff in a hyperflexed *'seated double-embrace'* position at Rainsbrook Secure Training Centre, Warwickshire. *Myatt* was held in a seated position and bent forward at the waist causing hyperflexion which severely restricted his breathing. Research by Parkes (2011) found that seated restraint positions with the person leant forward may increase the risk of harm or death during prolonged restraint and the risk will be further increased where the person exhibits higher body mass index. Another dangerous restraint is a *'basket hold'* in which the individual is restrained by a member of staff standing or sitting behind them who then crosses the subject's own arms in front of them and secures them at the wrist or forearm. In Gareth Myatt's case, staff modified the restraint procedures without supervision but also as the organisation had made a policy decision not to use prone restraint as it was perceived as dangerous. This procedure has in the past been used in the secure juvenile estate but following the Inquest into Gareth Myatt's death the double basket hold was removed by the Ministry of Justice (Aiken, *et. al.* (2011). It should not have taken a fatality before removing this technique because it is one that was known for some time to be dangerous (Chan, *et. al.,* 1997; Chan, *et. al.,* 2004; Parkes, *et. al.,* 2011; Vilke, *et. al.,* 2011), yet it didn't evoke the wrath of commentators because the person was restrained in the seated position rather than on the floor. The case of *Myatt* exposes another problem with focussing too much on prone restraint positions because it removes the attention of other restraint techniques that are known to be dangerous.

The natural alternative to restraining a person in prone is to do so in supine or in the recovery position. Both positions carry risks: they are just different. Supine restraint can interfere with a person's ability to protect their own airway and carries the additional risk of choking or inhaling vomit (Morrison *et. al.,* 2001). Moreover, there is no data that suggests that the supine position is safer than restraining a person in the prone position (Mohr *et. al.,* (2003). One of the risks associated more with supine restraint relates to that position being less secure that prone. It is far easier for the subject to sit up when on their back as well as being more easily able to punch, kick, head-butt or spit. In order to keep the subject restrained on their back, staff will often need to apply force across their upper body. As the photograph below demonstrates the risk of asphyxiation is obvious.

8.5 Pain-compliance interventions

The natural opposition to the intentional infliction of pain during physical restraint is easy to understand and can be stated thus: *'that the deliberate infliction of pain on anyone cannot be justified'*. In short, it is the function of the state and in particular the criminal justice system to punish wrongdoers and therefore the infliction of pain as punishment during physical restraint must be wrong. The argument is perhaps stronger when the subject of the restraint is unwell and not responsible for their actions.

8.5.1 arguments against the use of pain-compliance techniques

The Bennett Inquiry *"formed a firm view that it was not appropriate to inflict deliberate pain during any form of restraint of a patient, whatever the circumstances might be. Any patient who required physical restraint was by definition in a medical emergency.*". Professor Appleby was against deliberately causing pain to prevent damage by the patient to himself or others. Professor Gournay saw a potential for terrible abuse of patients if the application of pain was allowed. But he added that it was very difficult to provide specific guidance about particular types of restraint and to attempt to make them universal because the situations in each case were so different from each other. Professor Sheehan expressed his personal view was that one should not inflict pain as a necessary part of controlling violence. The RCN said that in this country many systems for controlling violence were based on pain, which was not acceptable.

The above views are almost identical to those expressed today from those opposed to the use of pain-compliance techniques.

8.5.2 arguments in favour of the exceptional use of pain-compliance techniques

Dr Cary considered that sometimes a very carefully applied painful hold could be the most humane way of dealing with a person. It was distasteful to think of someone having to be controlled through the use of pain but, from the point of view of safety to life, it was sometimes safer to use a painful hold than to restrain by other methods.

There can be no serious case that advocates the routine use of pain-compliance techniques during physical restraint. Consequently, the argument is whether or not pain-compliance techniques during physical restraint should ever be used and, if so, when and upon whom? Even those who might tolerate the use of these techniques in exceptional circumstances argue that there are no circumstances where they could be justified on children, the elderly or those suffering from a medical condition including mental ill-health.

In the vast majority of cases, it is the author's opinion that the use of pain-compliance techniques during restraint is wholly unnecessary and the question as to their use shouldn't even arise. However, in certain high-risk situations the use of a painful stimulus *might* present a safer option, for both subject and staff. It would be impossible to provide an exhaustive list of such situations, but they would include to force the subject to release a serious grip (bite, choke, etc.) on another person and to prevent an otherwise lengthy period of restraint which is known to be extremely risky. A number of documents have provided the following guidance:

The Department of Health (2014) provides the following guidance on the use of pain-compliance techniques:

> *"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, in accordance with NICE guidelines, 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. These techniques should only be used by trained staff having due regard for the safety and dignity of patients. The use of these techniques must be embedded in local policies"* (para. 69).

A commonly used pain-compliance intervention is the *'wrist flexion'* technique or *'wrist lock'*. These techniques operate by the member of staff taking hold of the subject's wrist and flexing

it inwards. Variations of the technique involve incorporating the subject's thumb into the hold. The more the wrist is flexed, the greater the pain that may be experienced by the subject. The author uses the word 'may' because some individuals will not experience pain, for example, those under the influence of alcohol or drugs. Nevertheless, the intention of the member of staff is to inflict a sharp pain so as to distract or deter the subject from the behaviour. In any event, wrist flexion can be applied in such a way that minimal discomfort will be experienced with nothing more needed provided this controls the subject appropriately. This represents the least restrictive intervention required by most PMVA programmes and guidance. That said, even if the member of staff only intended to hold the subject's wrist any struggling by the subject may well cause pain, however unintended this might be.

Barnett *et. al.,* (2018) challenges the assertion that wrist flexion techniques can exist as non-pain-inducing interventions since the margin of error is too small especially when applied during a real-life struggle. He argues that due to this small margin of error between an intention to inflict pain and one where pain might result accidently, organisations authorising their use should be transparent and acknowledge that these techniques are likely to bring about discomfort, pain or distress, perhaps through *"intentional application or misapplication"* or as a result of *"staff inability to understand the individual's physical limitations and/or perception of pain, and the inability to finely control the use of [wrist flexion techniques] whilst under stress managing individuals who are struggling against their restraint"*. Barnett concludes that the research *"would indicate that all [wrist flexion techniques] should be considered as pain inducing with increased risk of injury, with individual [techniques] only varying in the degree of pain they induce. Organisations using [these techniques] should re-consider whether such techniques are acceptable professionally and ethically and should review whether [they] should be authorised and approved for practice"*. It is precisely because of this small margin of error that better alternatives in the form of isolating arm holds have been developed whereby the member of staff holds the subject towards the end of their arm. This does not use flexion, is not a pain-inducing hold, and will not accidentally cause pain if the subject struggles. This kind of isolating hold is secure and is entirely sufficient in many cases. Another advantage of this kind of isolating hold is that should it be necessary, the member of staff can convert it to a pain-inducing technique by sliding their hands down the subject's forearm to apply wrist flexion.

People's views on the use of certain kinds of intervention appear to change over time, sometimes without any obvious reason. In the *'Review of International Evidence and Practice on Non-Pain Inducing Techniques and Systems of Restraint'*, Dale and Duxbury (2016) concluded that it was *"not possible, based on the evidence available, to identify a safe, more effective system of restraint readily available to specifically manage volatile and serious situations within the youth secure estate in England and Wales"*. The principal purpose of this review was to identify, review and assess alternatives to pain-compliance techniques across the youth secure estate which are used effectively to bring volatile and serious situations under control. Those who work in these establishments will concur with this conclusion. It is perhaps surprising, therefore, to learn that the 2019 Restraint Reduction Network standards (chaired by Professor Duxbury) *"does not support the use of pain to gain compliance"*. (Restraint Reduction Network, 2019). Training providers must not include the teaching of any restrictive intervention that uses pain to force an individual to comply (RRN Training Standard 1.3.7). Appendix 21A of the RRN Standards goes on to confirm that *"the cross sector RRN steering group does not endorse the use of pain based techniques"*. The Author is aware from his discussions with members of the RRN steering group that this view is not shared by all members of the group. Appendix 21B, however, acknowledges the argument that pain-compliance techniques may be needed *"for escape or rescue purposes"* and that *"where there is an immediate risk to life, the NICE Guidelines (NG10) refer to the use of techniques which may cause pain-based stimulus to mitigate the risk to life"*. Although the expression *'immediate risk to life'* is open to quite wide interpretation, the proper use of pain-compliance techniques should only be considered as an exceptional intervention. It is difficult to reconcile Training Standard 1.3.7 and Appendix 21A with what is stated in Appendix 21B.

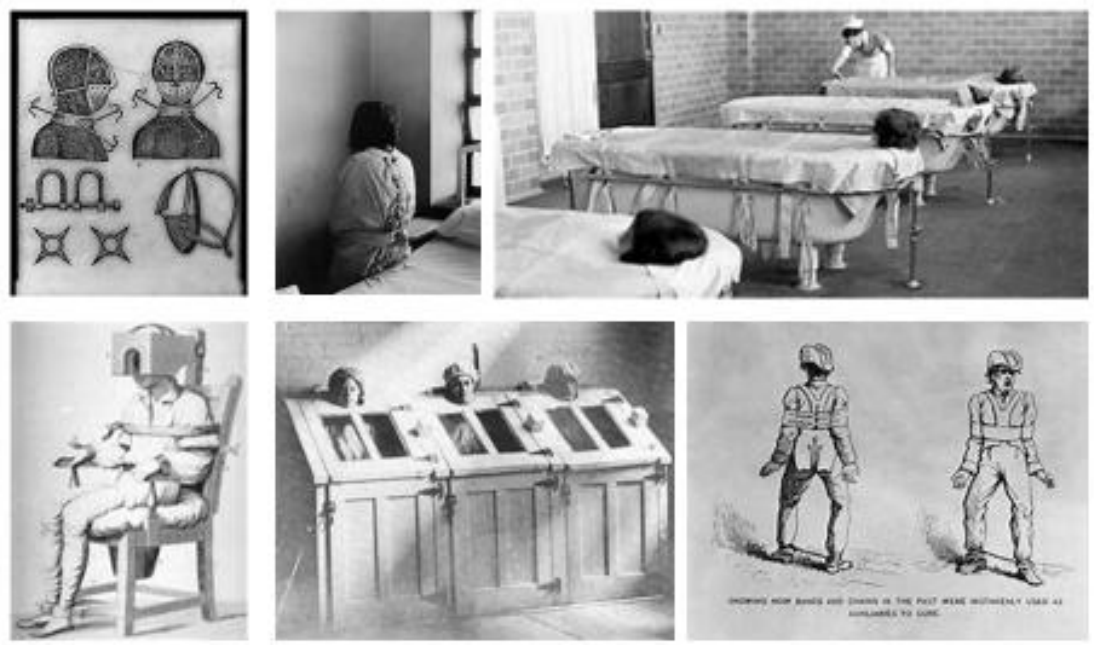
8.6 Mechanical restraint

Mechanical restraint refers to *"the use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control"* (Department of Health, 2014, para. 78).

Historically, as Figure 10 shows, mechanical restraints have been barbaric and have consisted of various contraptions designed to secure or contain the patient to a surface, device or to themselves. Once this had been achieved it was all too easy for staff to ignore them resulting in patients being contained by these devices for considerable periods of time, frequently for the convenience of staff. Outside of mental healthcare, these devices were relatively unknown. The

first mainstream appearance of mechanical restraint outside of mental healthcare were devices to secure a person's hands and feet used by police. Before metal handcuffs came into being, these tended to be made from vine, rope, or animal hide.

Figure 10. Collage showing various mechanical restraining devices from a previous era



The principal objections to the use of mechanical devices for restraint appear to be that they restrict the subject's freedom of movement and are applied against their will (Georgieva *et. al.,* 2012). Applying mechanical restraint is not, however, always applied against a person's will as some people agree (or even request) for such devices to be applied when experiencing episodes of crisis. Even where these devices are applied against the person's will, they should only be used if it is in their best interests.

Compared to many other countries, the use of mechanical restraint in healthcare settings in the UK is relatively uncommon (Stewart *et. al.,* 2009). In a 2009 survey of student psychiatric nurses in the UK, the use of mechanical restraint attracted the highest levels of disapproval out of all other methods of patient containment (Whittington *et. al.,* 2009). One notorious case from 1814 describes how a patient detained at Bethlem Hospital in London was restrained in chains for 14 years. This, together with other similar cases, is believed to have been the catalyst for caring for detained mentally ill patients without routinely restraining them. This humane method of caring for such patients was expanded by Dr Robert Gardiner Hill (1811-1878), who was best known as a surgeon specialising in the treatment of lunacy. He was superintendent of

the Lincoln Lunatic Asylum and sometimes credited[7] with developing a method of treatment in which reliance on mechanical restraint and coercion were totally eliminated (Longman, 1857).

The controversy around the use of mechanical restraint deserves further discussion not least because they are widely used in mental health services throughout the USA and Europe, and in many other parts of the world. What we might consider humane in the UK is often looked at with differently elsewhere. Professor Gournay reports on staff feelings in the US where *"they react with horror at being told their UK counterparts restrain patients by holding them down and injecting them"* (Batty, 2005). One advantage of mechanical restraint is that staff could more effectively communicate with patients who were mechanically restrained than those, for example, under sedation, and no doubt physical restraint. Restraint devices could also prevent disturbed patients from harming themselves (Batty, 2005). From the patient's perspective, it has been reported that some had expressed that they would rather be strapped down than physically restrained by nurses or heavily sedated (Batty, 2005).

Policies on the use of mechanical restraint lack consistency both nationally and internationally and depend to a large extent on the prevailing culture and legal framework (Steinert *et. al.,* 2009). Moreover, as noted above, people's views on the use of certain kinds of intervention appear to change over time, sometimes without any obvious reason, and this can also be seen in respect of mechanical restraint. In an interview with The Guardian (published on 2 February 2005), Joy Duxbury, then divisional lead for mental health at the University of Central Lancashire backed calls for the NHS to reconsider the use of mechanical restraint. Speaking after the death of David Bennett, she said that the need to explore alternatives to physical restraint had never been greater. Commenting specifically about mechanical restraint, she added that *"demonic images of patients tied to beds"* did not reflect the reality of modern-day mechanical restraint (O'Hara, 2005). Yet the Restraint Reduction Network's minimum standards (chaired by Professor Duxbury) sets down a requirement that *"there must be clear documentation as to how [mechanical restraint] has been deemed the least restrictive option [for the particular person] and why alternative approaches would not be suitable for them"* (RRN, 2019, training standard 2.8.A.1). The key emphasis should be on safety and the requirement for the intervention to be the least restrictive, as important as this is, should be subsidiary to that. There are many kinds of intervention, including mechanical restraint, where

[7] Although others have attributed the development to others: see, for example, *Bulletin in the History of Medicine*, Vol. 41, No. 2, March-April, 1967, pp. 140-160, Johns Hopkins University Press.

the requirements of safety will be enhanced, sometimes even significantly enhanced, by not adopting the least restrictive option. It would have been preferable had training standard 2.8.A.1 been drafted to reflect this. It is submitted that the following proposed amendment, devised by the author, to this Standard achieves this: *"there must be clear documentation as to how [mechanical restraint] has been deemed the least restrictive appropriate option [for the particular person] that safety would permit and why alternative approaches would not be safer or suitable for them."*

As with the use of any kind of physical intervention, which should be used only where necessary, mechanical restraint, being part of the intervention mix, is no exception. Examples given in the RRN Training Standards of the *"very limited number of very clearly delineated situations"* where mechanical restraint might be permissible are *"attempting to remove catheters, arterial lines and breathing tubes"* (RRN Training Standards, 2019; p. 100). The explanation given for the very limited support for this exceptional intervention is that the *"removal of an arterial line is potentially life threatening in a very short period of time, hence why such an extreme form of restraint may be advocated"*. Whilst this is undeniably correct, it is equally true that there are many other kinds of potentially life-threatening behaviours where the use of mechanical restraint could serve to improve the safety. In many, but not all cases, this would involve the use of the least restrictive option. The requirement for the use of physical intervention to be 'necessary' covers all situations although it has particular importance with regard to mechanical restraint. Left unmonitored and unchallenged it would be too easy for mechanical restraint to become part of the general mix in dealing with challenging behaviour or a convenient way of tacking staff shortages or training deficiencies: '*necessary'* must never be conflated with '*convenient'* or '*desirable'*.

Mechanical restraints have evolved enormously in recent years and need to be considered as part of the overall safe approach to the managing of VAAoCB. Modern mechanical restraining devices help to secure the subject safely while allowing a degree of movement, depending on the assessment of risk and planned activity. (see Fig. 11).

Figure 11. An example of modern day soft mechanical restraint

It is important to note, however, that mechanical restraint is not a complete alternative to physical restraining as they cannot be applied unless the subject is under some degree of control. In practice, this means that in most cases staff will need physically to restrain the subject before applying mechanical restraints.

Mechanical restraint was discussed during the Bennett Inquiry (2003). The Inquiry noted that they *"were not satisfied that these were effective and considered that they were degrading and that if permitted, their use could easily be abused.*" (p. 53). But this totally ignores the fact that had appropriate mechanical restraint being applied to Mr Bennett there would not have been the need to physical restrain him for a prolonged period. Other criticisms of mechanical restraint were also expressed by the Inquiry. June Tweedie said that the Mental Health Act Commission was against mechanical restraint absolutely because there was so much potential for abuse. Ms Tweedie was the Legal member of the Mental Health Act Commission and a non-executive director on the Board. She was the Chair of the Equality and Diversity Committee and one of a small team from the Commission which looked into the circumstances of deaths in psychiatric institutions. Within a health care setting the Commission would want to stress the importance of de-escalation techniques, of looking at the ward environment, patient care and treatment as a whole. If it were to be recommended that on isolated occasions mechanical restraint would be acceptable, the Commission would suggest very strongly that there should be outside monitoring to ensure that there was someone present after every

incident to check and make appropriate enquiries to ensure that it was absolutely the last possible resort. Demonstrating Ms Tweedie's unmoving opposition to the use of mechanical restraint she told the Inquiry that the Commission *"would support some form of national research and debate on this but would not be supporting the use of mechanical restraint as a proposal."* (page 53).

Dr David Ndegwa, Consultant Forensic Psychiatrist and Clinical Director of Forensic Psychiatry for the Borough of Lambeth within South London and Maudsley NHS Trust, was not in favour of mechanical restraints in a clinical setting although no reasons were published in the Report. Dr Richard Shepherd, Consultant Forensic Pathologist, Home Office Pathologist, Senior Lecturer in Forensic Medicine, talked in terms of there being *"political difficulties"* with mechanical restraints.

Dr Carey expressed doubts about the use of mechanical restraints but told the Inquiry that in America nurses were more ready to use them. He noted that Velcro wrapped round the patient's legs was sometimes effective at stopping a person from kicking out. He explained that one had to be extremely careful that mechanical restraints did not create *"a horrendous image of humiliation or control."* Using a chair into which a patient could be strapped might sometimes be an alternative, but Dr Carey pointed out that he had objections to this as well (page 53).

Professor Gournay pointed out that in America it was quite common to use mechanical restraint. He said that there they had four-point restraint and the job of the nursing staff was to get people into that four-point restraint so that their hands and legs were mechanically restrained. The American view was that that way of restraint was humane and safe, whereas in England, instead, you piled two, three, four or five nurses on some poor individual at a time. But he stressed that mechanical restraint should not be used, except possibly on very rare occasions (page 53).

NICE (2015) provides the following guidance on mechanical restraint:

- Health and social care provider organisations should ensure that mechanical restraint in adults is used only in high-secure settings (except when transferring service users between medium- and high-secure settings as in para 6.6.3.20), and its use reported to the trust board (para 6.6.3.18).
- Use mechanical restraint only as a last resort and for the purpose of:
    - managing extreme violence directed at other people or

• limiting self-injurious behaviour of extremely high frequency or intensity (para 6.6.3.19).

- Consider mechanical restraint, such as handcuffs, when transferring service users who are at high risk of violence and aggression between medium- and high-secure settings. In this context, restraint should be clearly planned as part of overall risk management (para 6.6.3.20).

Whilst acknowledging that the use of any form of mechanical restraint is generally unnecessary, this aspect of the guidance is illogical and ill-advised. First, it fails to have any regard to the Manual Handling Operations Regulations 1992 (as amended by the Health and Safety (Miscellaneous Amendments) Regulations 2002). Secondly, there is no logical basis for restricting the use of mechanical restraint to high-secure settings or when transferring service users between medium and high-secure settings. If, which is correct, the mischief to be prevented by the use of these devices is to manage extreme violence directed at other people or to limit self-injurious behaviour of extremely high frequency or intensity (as set out in NICE, 2015; para. 6.6.3.19) then why should the setting in which the service user is placed matter? The same person might be detained in one of the high-secure hospitals one day but transferred to a lower-secure hospital, prison or acute hospital the next. It is illogical, and potentially unsafe, for mechanical restraint to be permitted in one setting but not another when considering the same patient with the same dangerous behaviour that needs to be controlled in as safe a manner as possible. This is well illustrated by the 2021-2022 patient admission data published by The State Hospital[8] which shows that of the 38 admissions during the period, 16 were transferred from prisons, 15 directly from the courts, and 6 from other NHS hospitals. Similarly, of the 34 discharges during the period, 16 patients were transferred to other NHS hospitals, nine to prisons, and seven discharged under the direction of the courts. This aspect of the NICE guidance (2015) would have been more helpful had it specifically set out the kind of circumstances where mechanical restraint might be appropriate, such as to prevent an otherwise prolonged period of restraint or an otherwise risky intervention. Finally, the guideline fails to recognise best practice.

[8] One of the UK's four High Secure Hospitals (the others being Ashworth, Broadmoor and Rampton). The principal aim of the hospital is to rehabilitate patients, ensuring safe transfer to appropriate lower levels of security.

Despite the limited circumstances envisaged in NICE NG10 (2015) where the use of mechanical restraint might be appropriate, there is a reluctance to sanction its use in these and often in any circumstances.

The case of Nottinghamshire Healthcare NHS Trust v RC (2014) illustrates the problems with the restrictive guidance for the use of mechanical restraint set out in NICE NG10 (2015).

8.6.1 Nottinghamshire Healthcare NHS Trust v RC [2014] EWCOP 1136.

This case concerned a young male adult, then aged 23 and compulsorily detained in a psychiatric hospital operated by Nottinghamshire Healthcare NHS Trust. He suffered from a severe personality disorder although not from any kind of delusions or delusional disorder. His intelligence was within the range of normal and he appeared to have capacity both to make decisions with regard to his medical treatment and also to instruct lawyers to conduct litigation on his behalf. As a result of his medical disorder he had a history of compulsory detention under the Mental Health Act. Unfortunately, in 2012 whilst detained he committed an offence upon a staff member, as a result of which he was convicted and sentenced to five years' imprisonment. He once again began seriously self-harming whilst in prison serving that sentence. His self-harm included self-strangulation with ligatures and plastic bags, burning himself, and self-injury, including head-butting and self-laceration. He frequently re-opened wounds to aggravate an existing injury and cause further damage and blood loss. Another aspect of the case is that, because of a history of thrombosis, he was prescribed the anti-coagulant, Warfarin, which has the effect that when he did bleed, he bled more profusely than he might otherwise have done. Another aspect of the case is that he recently embraced the Jehovah's Witness faith, a tenet of which is a prohibition on receiving by transfusion blood or blood products. Whilst in prison on 1 February 2014 he seriously cut his right arm, opening his brachial artery at the antecubital fossa with a razor blade. He had significant blood loss and his haemoglobin fell to an extremely life-threatening level. He was admitted to intensive care and a blood transfusion was advised. He refused blood products on the basis of his Jehovah's Witness faith. The treating hospital abided by his expressed wish, believing it to be capably stated. He survived that event without any blood being transfused. There were further incidents of self-harm and attempting to tear open his earlier wounds during the course of February 2014 and on 12 March 2014 he was transferred from the prison to the psychiatric hospital in which he was compulsorily detained by virtue of the provisions of sections 47-49 of the Mental Health Act (1983). Between 13 and 18 March 2014, at that hospital, he was placed in a mechanical

restraint effectively pinning his arms to the sides of his body so as to prevent him from using his hands to self-harm. When that restraint was loosened on 18 March 2014, he once again began tampering with his wound, although only in a relatively minor way. He again re-opened his healing wound on 31 March 2014 and was again placed in a restraint belt for 24 hours. On 8 April 2014, he stated that he wanted to get his artery to bleed and began picking again at his wound, despite being under constant observation by staff.

This case clearly falls within the second limb of paragraph 6.6.3.19 of the NICE NG10 guidelines (2015) for the use of mechanical restraint to be used as a last resort and for the purpose of limiting self-injurious behaviour of extremely high frequency or intensity and demonstrates the danger in limiting the use of mechanical restraint to high-secure settings. Had this patient's injurious and life-threatening behaviour occurred whilst detained in a medium or low secure unit or continued while he was detained in prison, for example, in the prison's hospital wing, staff would have been in breach of paragraph 6.6.3.18 of the NICE guidelines (2015) had they restrained him with any form of mechanical restraint. Staff could, of course, have restrained this patient with hands-on manual restraint to prevent his self-harming behaviour but this would invariably have led to a considerable period of restraint which is likely to have fallen foul of paragraph 6.6.3.13 of the NICE (2015) guidelines which state that manual restraint should not routinely be used for more than ten minutes and that staff should consider rapid tranquillisation or seclusion as alternatives to prolonged manual restraint lasting longer than ten minutes (para 6.6.3.14). Clearly, in a case such as this, seclusion would not have been appropriate and it has to be asked whether forced rapid tranquillisation would have provided a better outcome for the patient or was even appropriate in the circumstances.

The Care Quality Commission ("CQC") appears not to have taken such a restrictive approach to mechanical restraint. In its 2018 publication "Brief guide: restraint (physical and mechanical)" it states:

> *"We recognise that the use of mechanical restraint may be considered to be the least restrictive intervention in some specific cases, and may present less risk to the individual than the alternative of prolonged manual restraint or transfer to a more restrictive setting. This could provide a valid reason for using mechanical restraint in an emergency or 'unplanned' interventions, as well as planned interventions. However, providers should clearly document that any mechanical and physical interventions were considered by a group wider than just the service to assess whether this was the least restrictive option which was in the best interests of the person, and that there were no less restrictive alternatives which were appropriate and proportionate to the risks posed."*

Whichever way one views mechanical restraint, there is as much need for a sensible national debate on the subject as there was in 2005 (Batty, 2005). The debate cannot be avoided if safety is to be taken seriously. There is also a significant legal consideration which is often overlooked: restraint is a manual handling activity to which the Manual Handling Operations Regulations (1992) applies. A manual handling operation is *"any transporting or supporting of a load (including the lifting, putting down, pushing, pulling, carrying or moving thereof) by hand or by bodily force"* (Manual Handling Operations Regulations 1992, reg. 2(1)). A load may be either inanimate, for example a box or a trolley, or animate, for example a person or an animal (Guidance on the Manual Handling Regulations, Health & Safety Executive, 4th edition, 2016, para. 3). A *"patient being lifted"* is one example of a load described in the regulations (para. 22). Physical restraint is a manual handling activity to which the Manual Handling Operations Regulations 1992, as amended by the Health and Safety (Miscellaneous Amendments) Regulations 2002, applies (*Fleming v Stirling Council,* 2000).

Employers are required to fulfil a number of criteria to reduce the risk of manual handling accidents at work. This includes a requirement that employers *"shall so far as is reasonably practicable avoid the need for his employees to undertake any manual handling operations at work which involve a risk of their being injured"* (Manual Handling Operations Regulations 1992, reg. 4(1)(a)). Where it is not reasonably practicable to avoid the need for employees to undertake any manual handling operations at work which involve a risk of being injured, employers are required to *"make a suitable and sufficient assessment of all such manual handling operations to be undertaken by them"* (reg 4(1)(b)(i) and *"take appropriate steps to reduce the risk of injury to those employees arising out of their undertaking any such manual handling operations to the lowest level reasonably practicable"* (reg. 4(1)(b)(ii)).

In order for employers to fulfil their risk assessment obligations noted above, they are required to have regard to a number of factors which are specified in Schedule 1 to the 1992 Regulations. These include questions as to "*holding or manipulating loads at distance from trunk"* and *"unsatisfactory bodily movement or posture, especially twisting the trunk, stooping, reaching upwards, excessive movement of loads, especially excessive pushing or pulling of loads, risk of sudden movement of loads, frequent or prolonged physical effort, insufficient rest or recovery periods and a rate of work imposed by a process*" (Manual Handling Operations Regulations 1992, schedule 1). Insofar as the loads (in this context, persons) are concerned, are they heavy, bulky or unwieldy, difficult to grasp, unstable, sharp, hot or otherwise potentially damaging? Schedule 1 also requires an assessment of the working environment and asks whether there are space constraints preventing good posture, uneven, slippery, or unstable

floors, variations in level of floors or work surfaces and poor lighting conditions? The Schedule also enquires whether the task requires unusual strength, or height or creates a hazard to those who might reasonably be considered to be pregnant or to have a health problem or does it require special information or training for its safe performance? Finally, the Schedule asks whether or not movement or posture is hindered by personal protective equipment or by clothing.

Any assessment such as is referred to above (reg 4(1)(b)(i)) must be reviewed by the employer who made it if there is reason to suspect that it is no longer valid or there has been a significant change in the manual handling operations to which it relates (reg 4(2)). This latter point is particularly important as it covers situations where the use of (manual) physical restraint has proven to be dangerous for any reason, including where staff have been unable safely to restrain a person or where circumstances have changed, such as where persons with a history of extreme violence and resistance to manual restraint are newly detained. Other options, such as segregation, also need considering but are beyond the ambit of this work.

A hierarchy of measures must be followed to reduce the risks from manual handling activities (Guidance on the Manual Handling Regulations, Health & Safety Executive, 4th edition, 2016, para. 31). First, to avoid hazardous manual handling operations 'so far as is reasonably practicable', by redesigning the task to avoid moving the 'load' or by automating or mechanising the process. The words *'so far as is reasonably practicable*' are used throughout the 1992 Regulations and indeed generally throughout UK health and safety legislation. Second, to make a suitable and sufficient assessment of the risk of injury from any hazardous manual handling operations that cannot be avoided. Third, to reduce the risk of injury from those operations 'so far as is reasonably practicable'. This will involve, where possible, the provision of mechanical assistance, for example, mechanical means of restraint or where this is not reasonably practicable, to explore changes to the task, the load and the working environment. Care needs to be taken when any new process is introduced that may itself introduce other risks.

The above approach is equally applicable to the work of the emergency services (Guidance on the Manual Handling Regulations, Health & Safety Executive, 4th edition, 2016, para. 33) and by necessary implication to the work of staff whose employment brings them into contact with persons who may exhibit violent behaviour, sometimes giving rise to an emergency situation where what amounts to 'reasonably practicable' may not be easy to ascertain. It is submitted,

therefore, that what is ‘reasonably practicable’ must consider the wider context in which such workers operate, especially where further preventive steps would make emergency functions extremely difficult to perform. However, this does not mean that employees can be exposed to unacceptable risk of injury.

Despite physical restraint clearly falling within the meaning of manual handling, many employers and organisations remain against the use of any form of mechanical restraining devices.

This chapter examines the key controversies associated with restraint and provides a detailed analysis as to why some interventions are more controversial than others. This provides a sound foundation for the next chapter which examines the need for a common set of guidelines and considers whether this is achievable.

CHAPTER NINE: THE NEED FOR A COMMON SET OF GUIDELINES

9.1 The relevance of policies and guidance

Policies and guidance are of little use unless they are acted upon and embedded into staff training. In this context, organisations must ensure that all relevant staff receive appropriate training in PMVA. This training should be integrated into staff induction training so as to ensure that all staff are appropriately trained before being exposed to an operational environment.

The content and duration of this training should be based on the role each member of staff undertakes and the risk assessment associated with that role. Staff must also undertake refresher training with such frequency as necessary to maintain competence as well as developing further skills and knowledge relevant to their roles.

9.2 Common cross-sector guidance on PMVA

There are significant differences in the approaches taken to PMVA by different sectors and this is most notable in the physical skills used. Although there are some excellent examples of good practice there are other examples which fall far short of an acceptable or safe standard. An example of the lack of consistency in PMVA can be seen in Table 10.

Table 10. Typical breakdown of skills taught in different sectors

	Police	Prison	Security (SIA)	High Secure Hospitals	Healthcare (excl. HSH)	Juvenile detention	Airlines	Cruise ships
De-escalation	✓	✓	✓	✓	✓	✓	✓	✓
Mechanical	✓	✓	×	✓	×	✓*	✓	✓
Prone	✓	✓	×	✓	×	✓	✓	✓
Pain-compliance	✓	✓	×	✓	×	✓*	✓	✓
Rapid tranquilisation	×	×	×	✓	✓	×	×	×
PPE	✓	✓	×	✓	×	✓	✓	✓

* Dependent on specific setting

There are no universally accepted standards for the use of physical restraint (see, e.g., Department of Health 2014, para. 127) despite calls for standardisation being around for at

least 40 years. One such call for standardisation came in the form of Recommendations by the Coroner to the Bennett Inquiry (2003):

1. *The need to formulate, adopt and apply national standards for the prevention and management of aggression by psychiatric in-patients and to apply regular monitoring. The Department of Health should liaise with the Home Office over this issue because of the knowledge and expertise possessed by the Prison Service and the Police Service in control and restraint techniques and policies.*

2. *The need for the Norfolk Mental Health Care NHS Trust to revisit and revise its current manual on the 'Prevention and Management of Aggression' to take into account all available expertise and the evidence presented at the inquest.*

The call for the regulating and accrediting of the use of physical interventions is not new and in recent years has become more vocal. At the Royal College of Nursing Annual Congress held in Liverpool in 2013 a resolution was passed "*that this meeting of RCN Congress asks Council to lobby UK governments to review, accredit and then regulate national guidelines of approved models of physical restraint".* (Royal College of Nursing, 2013). The Resolution was passed with 99.8% voting in favour (470 votes) and only 0.2% voting against (1 vote). There was 1 abstention.

The CQC has also highlighted ongoing concerns about the use of physical restraint, and in particular the wide variation in the number of incidents of use of physical restraint reported by providers (Care Quality Commission, 2017-2018, p. 88). They advised NHS England that proper regulation of this practice can only happen if there are *"better definitions of types and levels of restraint, more complete and consistent reporting, and better and more consistent training for provider staff in how to manage challenging behaviour"*. (CQC, 2017-2018). In response to the CQC's advice, NHS England established a programme aimed at addressing these issues. From April 2020, NHS Digital introduced new definitions that commissioners will require providers to follow. Further, the United Kingdom Accreditation Service ("UKAS") introduced an accreditation scheme for training provider staff which is operated through the British Institute for Learning Disabilities ("BILD Association of Certified Training, 2019"). Paterson *et. al.,* (2014) has criticised the BILD scheme on the ground that it *"actually explicitly eschews any judgments on the physical intervention procedures a given accredited training provider may use. Hence accreditation may offer little real assurance regarding the content of training, its appropriateness in relation to meeting the relevant sectoral or occupational*

standards or ultimately even its safety" (p. 103). Given that patients can be seriously harmed by the use of inappropriate restraint techniques, or even appropriate restraint techniques applied inappropriately, this criticism must be addressed. Hollins (2010) proposes that in addition to managing the risks arising from the use of force, the training should enable staff to learn how to stabilise a violent individual. This is essential.

The UKAS-BILD scheme is now part of the training in many healthcare settings as well as in some other settings and is mandatory for inpatient mental health units in England (Mental Health Units (Use of Force) Act (2018). This is a good start, but regrettably it does not go far enough. The biggest criticism of the scheme is that it fails to accredit the actual physical skills taught meaning that a provider can become accredited under the programme whilst teaching outdated, inefficacious, and dangerous physical skills. The author explored this defect with the chief executive of BILD in April 2023 and was told that as the RRN do not wish to see physical interventions used in practice it would not be in the scheme's interest to accredit such skills. In the author's view, this renders the scheme, which is expensive and significantly time-consuming, largely pointless. Moreover, it is a significant wasted opportunity to improve the safety of everyone involved in the management of VAAoCB.

Establishing a standardised approach to managing VAAoCB also needs to include security staff whose training depends on whether they are directly employed by the organisation or by a private security company engaged by the organisation. If they are directly employed by the organisation, their training will be determined by that organisation's policies and procedures whereas if they are employed by a private security company engaged by the organisation, then their training must conform to the licence-linked training mandated by the Security Industry Authority ("SIA"). This training is aimed at a very basic level and does not include any higher-level skills, such as pain compliance techniques, take-downs, or restraining techniques on the ground. The SIA's expectation is that where the security operative is deployed to a workplace with even moderate levels of violence or aggression, they should top up their training privately. It is the author's experience, that this rarely happens. Further problems arise where security staff are made up from both direct employees and private contractors since, without additional training, both 'teams' will be trained to different standards using different skills.

Another advantage of adopting a standardised approach managing VAAoCB is that staff will be able to work seamlessly in other parts of the country. In 2004, the Welsh Assembly Government introduced the *'All Wales NHS Violence and Aggression Training Passport and*

Information Scheme', the aims and objectives of which were *"to ensure consistency in violence and aggression training/assessment within participating Trusts and Local Health Boards; to develop a mechanism whereby skills can be transferred between participating Trusts and Local Health Boards; and to ensure the sharing of resource to minimise duplication within participating Trusts and Local Health Boards"* (All Wales NHS Violence and Aggression Training Passport and Information Scheme, 2004; p. 38). The introduction of this scheme followed the success of the '*All Wales NHS Manual Handling Training Passport and Information Scheme*' (2003). Launched in January 2003 this scheme represented the culmination of work that had been undertaken by manual handling professionals within Welsh NHS Trusts. It was the success of this Scheme that prompted a call to develop a similar scheme for violence and aggression. Like manual handling, violence and aggression presents a significant risk to the NHS. Similar schemes were already well established in the construction industry where there is a core workforce moving from employer-to-employer (All Wales NHS Violence and Aggression Training Passport and Information Scheme, 2004; p. 3).

9.3 Common approaches

VAAoCB never present themselves in a vacuum yet this is typically the way policymakers approach the subject, its prevention, and its management. Although guidelines exist in different sectors, apart from a few common messages, too often little or no consideration is given to many of the wider issues in play.

For any common guidelines to be beneficial they need to be universally adopted and this requires the broad support of those who will be affected by them, both staff and the users of the services. They also need to take account of the best available evidence. There are many examples where the evidence has not been followed and which has led to confusion and uncertainty and these have been discussed throughout this thesis.

A good example of this confusion concerns the so-called 'banning' of prone restraint and pain-inducing interventions as well as the curious antipathy towards mechanical restraining devices, even in circumstances where these kinds of intervention might be the safest, and least restrictive, in all the circumstances of an incident. The *Winterbourne View* scandal (discussed in Chapter 6) brought the question of prone restraint into the public focus. Despite *Winterbourne* being principally about the abuse of its vulnerable residents rather than restraint *per se* the subsequent Serious Case Review made the following recommendation in relation to restraint positions:

> *"The Department of Health, Department for Education and the Care Quality Commission should consider banning the t-supine restraint of adults with learning disabilities and autism in hospitals and assessment and treatment units."*
>
> (Winterbourne View Serious Case Review, 2012; p. 135).

'T-supine restraint' is a face-up position and defined in the report as *"restraint that results in people being placed on the ground with staff using their body weight to subdue them"* (Winterbourne View Serious Case Review, 2012; p. xi).

Just how a recommendation to *consider* banning a kind of supine restraint led to an attempt to ban prone restraint remains baffling yet provides further evidence of the confusion by policymakers. Yet further confusion can be seen in the backtracking of the policy to ban positions of prone restraint in subsequent guidelines, policies and announcements with the Department of Health stating that what people considered to be a ban was no more than guidance. Widespread - but by no means universal - concern was expressed by practitioners as to this so-called ban pointing out that in many cases, especially those involving extreme levels of violence, trying to restrain the subject in a position other than prone is often unsafe, unpredictable and in many cases impossible.

To some extent, NHS Protect clarified the position on prone restraints following a consultation with the Department of Health and the Health & Safety Executive in 2014. It concluded that it was *"not acceptable for restrictive interventions, such as face down restraint, to have become normalised"* but there *"may be exceptional circumstances where prone restraint will happen"*. It acknowledged that *"on rare occasions, face down restraint may be the safest option for staff and service users, with few, if any, viable alternatives"* and concluded by pointing out that *"if Boards decide that they need staff to be trained in prone restraints it is vital that they are trained in the risks and appropriate techniques"*. Until it was replaced by the NHS Counter Fraud Authority in April 2017, NHS Protect had responsibility in England for tackling (amongst other things) violence against staff. Regrettably, nothing has replaced this vital part of the NHS's work.

Although these clarifications met with the approval of many practitioners, those against the use of prone restraints were unmoved in their views that it should be banned. Furthermore, in a 2009 clarification, the Welsh Assembly Government clarified their position on the use of prone restraints by advising practitioners that they should *"continue to use their professional judgement to determine whether use of a particular restraint technique is an appropriate*

response to a given situation." With the above in mind, it is hardly surprising that there is so much confusion.

Another example where the evidence has not been followed concerns the issue commonly referred to as *'prolonged restraint'*. This is discussed in section 8.3 but for present purposes, the longer a person is held in restraint the greater is the risk of harm, including the risk of death. A question that is often asked is whether there is a period of time that is considered safe to apply restraint. Since it is known that death can occur extremely quickly this question must be answered in the negative. Despite this, several attempts have been made to prescribe such a time limit, the latest being NICE Guideline NG10 (NICE, 2015). NICE 2015 advises practitioners that manual restraint should not routinely be used for more than ten minutes (para 6.6.3.13), despite the earlier Bennett Inquiry recommendation that that a person should not be restrained in a prone position for more than three minutes (Bennett Inquiry, 2003) being rejected by the profession as misleading and unworkable.

The confusion around these issues is manifest. It is also damaging for the very reason stated above: that violence and aggression never present themselves in a vacuum. The reluctance of staff to intervene in an incident is understandable when there is so much confusion about how they should intervene with the real prospect of sanctions if their response fails to follow policy, yet at the same time, adhering to policy could place themselves and patients at risk. With that in mind, it might be thought that a policymaker seeking to ban a particular intervention would have alternatives in mind but policymakers have consistently stated that alternative interventions are not matters for them. This leaves a wholly unacceptable vacuum which is regrettably all too often filled by the police who work to an entirely different set of standards to those that operate within healthcare settings. Not only are police officers not constrained by the prohibitions referred to above, but they are also trained in techniques and provided with equipment that healthcare staff would not wish to see used. These techniques and equipment include floor restraints, batons, irritant spray, and Taser. Calling the police who (if they turn up – see Chapter 1) might use the very techniques that healthcare staff are themselves prevented from using is utterly bizarre and can actually make the situation worse, particularly when one considers that the use of force by healthcare is likely to be predicated on safety whereas police officers might use force for other purposes as well, for example, where the person refuses to comply with instructions or shows unwillingness to engage in the investigative process. Police should not be seen as agents of coercion. As Brown (2016) explains "*[a]ll we will have done is ensure that when restrictive interventions are perceived to be necessary, we call upon other*

people to act who are not subject to the same rules, restrictions and regulations and who are perfectly at liberty to do all of those things and more, according to their own training guidelines". The answer must be to provide those within the various settings with appropriate training to increase the organisation's capacity and capability to deal with potentially violent situations without recourse to external agencies.

Much of the debate about common standards concentrates on the type of individual interventions used by different organisations which are often influenced by trainer choice. The choice of intervention ought to be secondary to and informed by principles and guidelines. Before considering these principles, it is important to emphasise that in all cases there needs to be a shift in focus from the reactive and limited approaches seen in restraint to more holistic approaches emphasising human rights, the better meeting of specific needs, prevention, non-escalation, de-escalation, reflective practice and, where appropriate, recovery. This shift in focus is crucial if we are to prevent over-reliance or dependence on restraint, so as to give proper meaning to last-resort principles, thereby helping prevent the organisation becoming *"dysfunctional and ultimately toxic"* to those who work in it and those it seeks to support (Paterson, 2011).

So, what would a common set of guidelines look like? The essential ingredients should include the following principles:

- A human rights based approach which emphasises the need to minimise the use of all restrictive interventions and ensures those that are absolutely necessary are rights-respecting. Although the Human Rights Act 1998 applies only to public authorities, many of its principles ought to be adopted in other settings. This approach requires a shift in focus from the reactive and limited approaches seen in restraint to more holistic approaches discussed above.
- With regard to children, reference should be made to the United Nations Convention on the Rights of the Child (UNCRC, 2022) which ensures that all children have the right to be heard and protected from harm. Reference should be made to Article 3 (the best interests of the child shall be a primary consideration); Article 16 (no arbitrary or unlawful interference with the child's privacy, etc.); Article 19 (protection from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation).

- With people with disabilities, reference should be made to the United Nation Convention on the Rights of Persons with Disabilities (UNCRPD, *year*) and, in particular, to Article 10 (right to life), Article 12 (equal recognition before the law), Article 14 (liberty and security of person), Article 15 (freedom from torture or cruel, inhuman or degrading treatment or punishment) and Article 16 (freedom from exploitation, violence and abuse).
- Compliance with the legislative framework governing restrictive interventions. This requires a thorough understanding of both primary and secondary legislation pertaining to the country and specific setting. This thesis will only consider the legislation pertaining to England and Wales although a significant part also applies throughout the UK and the legislation in other countries is often drafted in similar terms. The principal pieces of legislation for all settings include the Human Rights Acts 1998, Health & Safety at Work etc. Act, 1974 (together with The Management of Health and Safety at Work Regulations, 1999), Equality Act 2010, Criminal Law Act 1967 (section 3(1)), Criminal Justice and Immigration Act 2008 (especially sections 76 and 119-122). In the healthcare settings, the principal legislation includes the Mental Health Units (Use of Force) Act 2018, Mental Health Act 1983 (as amended, most recently by the Mental Health Act 2007), Mental Capacity Act 2005 and Mental Capacity (Amendment) Act 2019 (including the Liberty Protection Safeguards (LPS), which replaces the Deprivation of Liberty Safeguards (DoLS)), Care Act 2014. The relevant sections from the legislative framework should be incorporated into training.
- A statement about compliance with relevant guidelines, setting out which guidelines are relevant. Where guidelines cannot be complied with, the reasons must be properly documented.
- A statement setting out the organisation's position in respect of the tension between the rights of the patient and those of staff insofar as the use of restrictive interventions are concerned.
- Where it applies, conformity to the Restraint Reduction Network Training Standards. *"These standards will be mandatory for all training with a restrictive intervention component that is delivered to NHS commissioned services for people with mental health conditions, learning disabilities, autistic people and people living with dementia in England. Implementation will be via commissioning requirements and inspection frameworks from April 2020"* (Restraint Reduction Network, 2019).

We will now consider 2 of the most important sets of guidelines and standards. Although both refer specifically to healthcare settings, many of the principles can be adapted to other settings.

9.4 NICE Guideline NG10 'Violence and aggression: short-term management in mental health, health and community settings'

Published on 25 May 2015, NICE NG10 aims *"to safeguard both staff and people who use services by helping to prevent violent situations and providing guidance to manage them safely when they occur"*). It replaces the previous NICE guideline published in 2005 (CG25) and expanded its remit from the management of violence in people over 16 and in only two settings (psychiatric settings and emergency departments) to other settings, including the community. Thus, NG10 covers the short-term management of violence and aggression in adults (aged 18 and over), young people (aged 13 to 17) and children (aged 12 and under), and considered management in mental health, general hospital and other health and community settings. Two settings were omitted from NG10, these being violence from people with intellectual disability which NICE felt to be sufficiently different to require a separate guideline (NICE NG11) and violence from older people, the latter omission having been criticised as *"curious"* on the ground that NG10 does not offer any specific advice on managing aggression in older people leaving healthcare trusts to adapt local policies to the older adult population (Waite, *et. al.,* 2023). This criticism is well-founded, hence the inclusion of these populations in NG10 (Tyrer, *et. al.,* 2023).

Thirteen principles can be found in NG10 (NICE, 2015) aimed at assisting those who care for patients in any setting to reassure them that they are following best-known practice. These principles are:

- Prepare guidance and standards on topics that reflect national priorities for health and care.
- Describe our approach in process and methods manuals and review them regularly.
- Use independent advisory committees to develop recommendations.
- Take into account the advice and experience of people using services and their carers or advocates, health and social care professionals, commissioners, providers and the public.
- Offer people interested in the topic the opportunity to comment on and influence our recommendations.
- Use evidence that is relevant, reliable and robust.
- Base our recommendations on an assessment of population benefits and value for money.
- Support innovation in the provision and organisation of health and social care services.

- Aim to reduce health inequalities.
- Consider whether it is appropriate to make different recommendations for different groups of people.
- Propose new research questions and data collection to resolve uncertainties in the evidence.
- Publish and disseminate our recommendations and provide support to encourage their adoption.
- Assess the need to update our recommendations in line with new evidence.

9.4.1 The need to reduce the use of restrictive interventions

Restrictive interventions are defined in NG10 (NICE, 2015) as those that *"may infringe a person's human rights and freedom of movement, including observation, seclusion, manual restraint, mechanical restraint and rapid tranquillisation"* (p. 17). NG10 emphasised the importance of reducing physical interventions rather than merely managing violence once it occurred, an aim that has also been emphasised by the Restraint Reduction Network (discussed in the next section). NG10 also reinforced the importance of avoiding restrictive interventions wherever possible when dealing with imminent violence and recommends that all trusts have in place programmes to reduce restricted interventions, and for these to be both implemented and regularly reported.

NG10 emphasised the need for each trust to have a restrictive intervention reduction training programme aimed at concentrating more of efforts on preventing rather than managing violence. This is particularly important both in training and practice since too many training providers to trusts *"are preoccupied with restraint procedures once violence had been manifest* [and] *trusts seemed more interested in commissioning these programmes rather than trying to change policies and training so that restrictive interventions could be avoided"* (Tyrer, *et. al.,* 2023).

The programme for reducing restrictive practices is simple at one level but complicated in practice. Tyrer, *et. al.*, (2023) suggest that a good programme should include seven elements:

1. Avoiding restrictive interventions.
2. Working in partnership with service users.
3. Adopt approaches to care that respect service users' independence, choice and human rights.

4. Increase social inclusion by decreasing exclusionary practices and involve and empower service users and their carers.
5. Include leisure activities that are personally meaningful and physical exercise for service users.
6. Actions to be taken after episodes of violence.
7. Use crisis and risk-management plans and strategies to reduce the need for restrictive interventions.

Analysis of these elements is important.

9.4.1.1 Avoiding Restrictive Interventions

This is, of course, the ultimate aim when caring for people displaying challenging behaviour although sometimes restrictive interventions will be necessary to maintain the safety of the service user, staff and others. The effective reduction in the use of restrictive interventions requires effective leadership. Good therapeutic units have effective leaders who are reliable, consistent and respected by colleagues. Conversely, a poor leader with a controlling mien and little empathy or interest will convey that same message to others in their team. Even good policies can be undermined if the key decision-maker does not have the right philosophy of care and readily jumps to meeting displayed aggression with an equally aggressive response.

NICE has also recognised the need to address environmental factors that are likely to increase or decrease the need for restrictive interventions (NICE NG10, 2015; recommendation 1.2.7). Environmental factors are increasingly seen as important elements of violence reduction, especially, with patients who are kept in restrictive environments for other reasons, such as psychiatric intensive care units (PICU). Environmental factors encompass all aspects of the environment; its physical properties and its social and personal qualities, including interactions with staff. Tyrer, *et. al.*, (2023) provide a helpful illustration of the importance of the physical environment. A former PICU in the main psychiatric hospital in Sheffield was small and cramped. If a patient started lashing out or was otherwise extremely disruptive, it was impossible for others to escape the turmoil. If the behaviour was completely out of control the only place to house the patient was a small seclusion room. Pausing for a moment, it is important to emphasise that, like restraint, seclusion is not a desirable option and should be considered an intervention of last resort. It was often difficult for patients to escape the confines of the main part of the PICU. The only way to get outside was to climb some stairs and travel along a walkway within a cage to a small outdoor area. Change was needed and the importance

of the environment was taken into account when planning the new PICU in the hospital. This was made considerably larger to enable others to have space by moving to a quiet place away from the disturbed person. The new PICU also had a 'green room'. They found green to be the most calming background colour. The outside area was safe and purpose built, having a leisurely appearance with secure seating and an abundance of plant life. The consequence of this planned environmental change was that physical restraint (and rapid tranquillisation) were halved when the new unit opened. Staff also preferred this new environment, and this was seen to improve therapeutic interaction. In a study of different PICUs carried out by Bressington *et. al.,* (2011), it was found that service users' satisfaction with forensic services was strongly associated with their experiences of the therapeutic relationship with their key-workers and the social climate of the ward. The findings emphasise the importance of forming and maintaining effective therapeutic relations and reinforce the need to maintain a therapeutic environment free of aggressive tension and threats of violence.

9.4.1.2 Working in partnership with service users

The benefit of working with service users when developing guidelines and policies is the important experiences they bring relating to their personal experiences. Thus, NG10 recommends that trusts work in partnership with service users and their carers, adopt approaches to care that respect service users' independence, choice and human rights, increase social inclusion by decreasing exclusionary practices, such as the use of seclusion and the Mental Health Act 1983, involve and empower service users and their carers, include leisure activities that are personally meaningful and physical exercise for service users, use clear and simple care pathways, use de-escalation to calm things down, and use crisis and risk-management plans and strategies to reduce the need for restrictive interventions (NICE NG10, 2015; p. 21).

It is also important to appreciate that violence is often the offspring of coercion. Most people who are violent are subject to external control by others, most of which they can do nothing to reverse. Staff need to be aware of this imbalance in power when in coercion territory. Sadly, despite better understanding of mental illness at all levels of society, compulsory psychiatric admissions are increasing at the rate of 5% every year (Keown, *et. al.,* 2011). This is why the social climate in psychiatric settings is so important. It is always difficult to develop a collaborative relationship with someone who knows that 'the system' has the upper hand.

Nidotherapy is a systematic and collaborative way of working in partnership with service users to change physical, social and personal environments. When referring to the prevention of violence in therapeutic settings, Jordan, *et. al.,* (2023) observes that the majority of modern forensic hospitals operate a system of stratified therapeutic security, where patients are placed on the internal care pathway based on assessment of need for therapeutic security and individual risks. Nidotherapy was first piloted in a study of patients with multiple pathologies, mainly schizophrenia, substance misuse and severe personality disorder (more often in combination than separate), and was shown to reduce hospital bed use in a randomised trial (Ranger, *et. al.,* 2009). Tyrer, *et. al.,* (2018) described the ten principles of nidotherapy:

1. *All people have the capacity to improve their lives when placed in the right environment.*
2. *Everyone should have the chance to test themselves in environments of their own choosing.*
3. *When people become distressed without apparent reason the cause can often be found in the immediate environment.*
4. *A person's environment includes not only place but also other people and self.*
5. *Seeing the world through another's eyes gives a better perspective than your eyes alone.*
6. *What someone else thinks is the best environment for a person is not necessarily so.*
7. *All people, no matter how handicapped, have strengths that can be fostered.*
8. *A person's environment should never be regarded as impossible to change.*
9. *Every environmental change involves some risk, but this is not a reason to avoid it.*
10. *Mutual collaboration is required to change environments for the better."*

Those working in environments where violence is commonplace might view Tyrer's ten principles as unrealistic. But, as observed by the contributors to *'Transforming Environments and Rehabilitation: A Guide for Practitioners in Forensic Settings and Criminal Justice'*, positive environmental change can be achieved in almost every setting (Akerman, *et. al.*, 2018). Unsurprisingly, therefore, these positive changes have also been seen in prisons. Whilst there is growing acceptance in the NHS that involving service users in the delivery and planning of interventions is an effective model for change, His Majesty's Prison Service is only recently beginning to recognise and value the importance for its population, with, for example, the setting up a prison councils and greater prisoner involvement in their environment and regime (O'Rourke, *et. al.*, 2018; p.275). Benefield, *et. al.,* (2018) discusses the recently-introduced *'Psychologically Informed Planned Environments'* (PIPE) which involves:

1. *Maintaining the intention to support personal and relational experience.*
2. *Staff to always make meaning from everyday interaction.*
3. *Supporting communication and exchange and dialogue.*
4. *The recognition and acknowledgement of the importance of relationships.*
5. *Supporting thoughtfulness and thinking.*
6. *Encouraging choice appropriate to the person's capacity.*
7. *Recognising the importance of interdependence.*

9.4.1.3 Adopt Approaches to Care that Respect Service Users' Independence, Choice and Human Rights

Some may perceive the words in this section title as empty when dealing with people in potentially violent situations. But they are not because holding on to even a few trappings of independence is very important to those who have been stripped of everything else (Tyrer, *et. al.,* 2023). It is, therefore, necessary to point out what rights and options are available to people who are prone to violence, preferably at times apart from those when violence is presumed to be imminent.

'Choice' is another 'politically correct' word that is used so frequently that it has become almost meaningless, and in the case of detained patients it seems to be in very short supply. But it is not absent, and emphasising to people that they do have choices in many areas is a good way of defusing violence and aggression. Two examples of choice are provided in NG10 (NICE, 2015): advance decisions and advance statements. An advance decision is *"a written statement made by a person aged 18 or over that is legally binding and conveys a person's decision to refuse specific treatments and interventions in the future"*; an advance statement is *"a written statement that conveys a person's preferences, wishes, beliefs and values about their future treatment and care. An advance statement is not legally binding"* (NICE NG10, 2015; p. 16). These may be easily ignored, especially in acute episodes of violent confrontation when the person is seen for the first time, but for longer-term patients they should be considered, and organising them in advance may be a curious way of thwarting violence.

9.4.1.4 Increase Social Inclusion by Decreasing Exclusionary Practices and Involve and Empower Service Users and their Carers

The NICE (2015) NG10 guideline group was particularly critical of the ready use of seclusion in many psychiatric units. There is a place for seclusion, but it should be used late in the

management of violence, not as a reflex reaction to any disturbed episode (Khwaja, *et. al.,* 2023). If appropriate treatment is given early, the period in seclusion is greatly reduced (Tyrer, *et. al.,* 2012), thereby emphasising that seclusion should not be an excuse for leaving the person concerned unattended. Locking a secure room should only be necessary for very short periods, and should never be considered when secluding children (NICE NG10, 2015; recommendation 8.7.2.23).

9.4.1.5 Include Leisure Activities that are Personally Meaningful and Physical Exercise for Service Users

Leisure activities are an essential part of the social environment. If one is forced to spend all of one's time surrounded by people (often perceived to be enemies as they themselves are angry), in confined areas, there is great propensity to violence. Appropriate leisure activities are a way of escaping from potentially toxic environments.

9.4.1.6 Actions to be Taken after Episodes of Violence

Violence in any setting is often the precursor for more violence, and so it is wise to evaluate each episode and determine policies for the future (Baskind, 2014). This is supported by NICE NG10 (2015) which recommended a set of post-incident actions. Post-incident reviews are commonplace in forensic settings but less common elsewhere (Tyrer, *et. al.,* 2023). They are, of course, important in all settings. Service users are usually involved in such reviews but not in leading them. But the principle behind them is important because it makes the review an independent one, not a rubber-stamped exercise that is unlikely to identify systemic failings.

NG10 (NICE, 2015) recommends that such reviews should take place within 72 hours of an incident. This is sometimes difficult to arrange and emphasises the need for a standard procedure to be put in place. If the review is delayed it is likely that important memories will be distorted, particularly if they reflect badly on those involved. It is also valuable to have detailed notes completed immediately after the incident, in which the time lines are a very important component. The review should always be conducted in a neutral format that helps staff to learn and improve rather than get tied up in the useless assignation of blame.

NG10 (2015) provides that a good post-incident review will cover six areas:

1. the physical and emotional impact of the incident on everybody who was present,

2. clear identification of the precursors of the incident and what might have been done in terms of pharmacological and psychological intervention that could have defused the violence,
3. determine whether interventions were given at the right time and what warnings might have been detected earlier,
4. identify any existing barriers, protocols or constraints that might have contributed to the incident and whether these should be changed to reduce the likelihood of repeat episodes,
5. offer a wider look at the service's philosophy, education and training to see these if these were still appropriate,
6. make recommendations to avoid a similar incident happening in future, if possible.

9.4.1.7 Use Crisis and Risk-Management Plans and Strategies to Reduce the Need for Restrictive Interventions

Over the past few years, there has been a considerable number of research studies demonstrating that risk assessment instruments are very poor at identifying risk of violence. Put more bluntly, most of the measures that assess risk are no better than the single piece of knowledge 'this individual has been violent before'. Coid, *et. al.,* 2013) compared people at greater risk of violence (all offenders) using three commonly used instruments (HCR-20, VRAG, OGRS-II) in individuals with different diagnoses. Moderate-to-good predictive accuracy for future violence was achieved for released prisoners with no mental disorder, and low-to-moderate accuracy for clinical syndromes and personality disorder, but accuracy was no better than chance for individuals with psychopathy. They concluded that comprehensive diagnostic assessment should precede any assessment of risk and that risk assessment instruments cannot be relied upon when managing public risk from individuals with psychopathy.

A growing number of organisations, especially high and medium secure units as well as many acute and low secure psychiatric hospitals and units now use short term risk assessments such as the dynamic appraisal of situational aggression (DASA) and Brøset violence checklist (BVC). These are commonly linked to action triggers and have been shown to be effective both in reducing episodes of violence and in the use of restraint (Chu*, et. al.,* 2013; Maguire, *et. al.,* 2019; Lockertsen, *et. al.,* 2021). The research by Lockertsen *et. al.,* (2021) re-evaluated the BVC, a tool used for short-term risk assessments of imminent violence in acute psychiatric

inpatient settings. The study involved 528 patients admitted to an acute psychiatric ward over a 12-month period. Using logistic regression and generalised linear mixed model analyses, the researchers evaluated the BVC's effectiveness in predicting violence, differentiating between threats of violence and actual physical violence, and considering gender differences. The findings confirmed that the BVC is suitable for both male and female patients throughout the period of their hospitalisation.

9.4.1.8 Manual Restraint

One of the most important, and controversial, components of NG10 (NICE, 2015) concerns the recommendation set out in paragraph 2.1 on the use of manual restraint where the service user is taken to the floor:

> *2.1 This guideline recommends that taking service users to the floor during manual restraint should be avoided, but that if it is necessary, the supine (face up) position should be used in preference to the prone (face down) position. The Winterbourne View Hospital Department of Health Review reported that restraint was being used to abuse service users. Mind's Mental health crisis care: physical restraint in crisis found that restrictive interventions were being used for too long, often not as a last resort, and sometimes purposely to inflict pain, humiliate or punish. MIND also reported that in 2011/12 the prone position was being used, in some trusts as many as 2 to 3 times a day. This position can, and has, caused death after as little as 10 minutes, by causing a cardiac event. Consistent implementation of these recommendations will save lives, improve safety and minimise distress for all involved.*

It is important to point out that a service user might end up on the floor without being "taken" there, yet NG10 fails to recognise this. A significant number of violent incidents end up on the floor due to one or a combination of the following factors: (a) the service user drops to the floor, (b) staff take them to the floor, (c) or one or more people involved in the intervention lose their balance and fall to the floor typically taking everyone with them. It is only (b) that can realistically be prevented although there may be a good reason why staff take a person to the floor, which is usually because it is the safest place to manage the incident.

Tyrer, *et. al.*, (2023) provide the following opinion on paragraph 2.1:

> *The major reason for avoiding manual restraint in the prone position is simple: there is real danger of death. This is because for the person who is held down and whose breathing cannot be seen, there is a real danger of asphyxiation. There are dozens of examples of patients in secure care and prisoners in correctional institutions dying under such circumstances. Although more staff may be necessary*

> *for the use of manual restraint in the supine position, only under exceptional circumstances and when no other staff are around should the prone position be used. Norman Lamb MP, was a health minister in the coalition government of 2010–2015 and argued a strong case for banning face-down restraint after it was found that this was being used hundreds of times a year in some mental health trusts. He raised the profile of this problem, and there was an immediate fall in the recorded incidents of this type of restraint, but they still accounted for nearly 70% of cases of restraint in 2015–16.*

The use of prone restraint, and its controversies, are discussed in detail in Chapter 8 and will not be repeated here. The Author is extremely concerned that Tyrer *et. al.,* appear to be misled by the anti-prone brigade that has caused so much confusion to so many services and appear to be unpersuaded by the recent statement issued by the Royal College of Emergency Medicine that restraint in the prone position contributed to deaths *"has not been supported by recent research"* (Royal College of Emergency Medicine, Best Practice Guideline, 2022). The comment that *"there is a real danger of death […] because for the person who is held down and whose breathing cannot be seen, there is a real danger of asphyxiation"* is based on the misunderstanding that with prone restraint the service user's face is pointing down (hence the alternative name of *'face-down restraint'*). A person's face is never pointing down during prone restraint but is turned to the side to enable staff to monitor their breathing and aid de-escalation.

9.5 Restraint Reduction Network Training Standards

The Restraint Reduction Network (RRN) Training Standards (2019) are divided into four sections. Section 1 entails the process that needs to be completed before a training curriculum is developed. Section 2 covers what needs to be included in the curriculum. Section 3 comprises of the post-delivery processes. Section 4 relates to trainer standards. The author will refer to the relevant RRN standards as they apply.

9.5.1 before a training curriculum is developed

Before developing a training curriculum it is necessary to carry out a suitable and sufficient assessment of the risks. The curriculum must be based on a training needs analysis (RRN 1.1). Training is typically provided either by in-house trainers or by an external training provider. In-house trainers should already have a detailed knowledge of the service or services for which the training is being provided, including the population being supported and the needs and characteristics of the staff providing such support. External training providers will need to

understand as much about the population and staff as their in-house counterparts before developing any package of training. This helps to ensure that all training is appropriate, proportional and fit for the specific needs of the population, specific individuals and staff taking account of any specific needs that were identified during the initial fact-finding process. This process should be reviewed on a regular basis and updated where changes are identified with either the population, specific individuals, or staff, or where specific risks have been identified.

Commissioning organisations should check with prospective training providers that they have appropriate professional indemnity and public liability insurance cover (RRN 4.5) and that this insurance is maintained throughout the period of the contract.

9.5.2 what needs to be included in the curriculum

Physical intervention techniques should be considered part of the overall process in the prevention and management of violence and aggression rather than being taught in isolation. This helps ensure that these techniques are not seen as the only, or even the main, response to PMVA. In practice, physical intervention techniques ought to be a small part of the overall approach to PMVA, albeit an important one.

In terms of the training provided to staff, the emphasis should be on primary prevention skills, consisting largely of skills aimed at predicting and prevention violence and aggression and proactive de-escalation strategies. Where such primary prevention skills are unsuccessful, secondary intervention skills may be deployed. These consist mainly of supportive holds aimed at preventing any escalation in the incident. To achieve this, the secondary intervention skills should include active de-escalation responses. Only where the incident cannot safely be managed at the primary or secondary level should reactive responses be considered. These consist of physical intervention techniques aimed at bringing the incident under control as safely as possible.

All physical intervention techniques need to be risk assessed by a competent person before being considered for inclusion in any training package (RRN 1.3). This risk assessment should consider the risks associated with each technique in respect of its biomechanical properties, its physical and psychological risks, and its suitability for the population and any specific individuals that the service supports as well as the staff who might need to utilise the skills. A legal review of the proposed training package should also be carried out to ensure compliance with all relevant legislation and necessary guidance. Trainers should be provided with copies

of all relevant risk assessments prior to the training taking place. Because physical intervention is a manual handling activity, this review should ensure compliance with the relevant manual handing regulations.

A process for the periodic review of each physical intervention technique should be included, the timing of which to be determined during the initial review. Such periodic review ought to be undertaken at least every two years (RRN 1.3.3) or immediately in the case of any variation to a specific technique is to be considered or where a technique or incident reasonably calls into question the safety or efficacy of a technique.

The choice of techniques to be included in the curriculum will, to a large extent, be dependent on a number of variables including the population and any specific individuals that the service supports as well as the staff who might need to utilise the skills. This will require regular monitoring to ensure that the techniques selected remain appropriate. Pain-compliance techniques, i.e. techniques that deliberately uses a painful stimulus to control or direct a person's actions and typically used to break the cycle of harmful, violent, or resistant behaviour and achieve compliance, remain the subject of huge controversy and debate. The RRN training standards (2019) *"do not support the use of pain to gain compliance. Training providers must not include the teaching of any restrictive intervention that uses pain to force an individual to comply"* (RRN 1.3.7) and appendix 21A of the standards goes on to confirm that *"the cross sector RRN steering group does not endorse the use of pain based techniques"*. Appendix 21B, however, acknowledges the argument that pain-compliance techniques may be needed *"for escape or rescue purposes"* and that *"where there is an immediate risk to life, the NICE Guidelines (NG10) refer to the use of techniques which may cause pain-based stimulus to mitigate the risk to life"*. Although the expression *"immediate risk to life"* is open to quite wide interpretation, the proper use of pain-compliance techniques should only be considered as an exceptional intervention. In *'Review of International Evidence and Practice on Non-Pain Inducing Techniques and Systems of Restraint'*, Dale and Duxbury (2016) concluded (in a different setting) that *"it was ... not possible, based on the evidence available, to identify a safe, more effective system of restraint readily available to specifically manage volatile and serious situations within the youth secure estate in England and Wales"*. The principal purpose of this review was to identify, review and assess alternatives to pain-compliance techniques across the youth secure estate which are used effectively to bring volatile and serious situations under control.

Whichever techniques are chosen for inclusion it is important that the training is provided within the context of an explicit commitment to the reduction of all restrictive practices (RRN 1.4) and that the views of appropriate people who have experienced restrictive practices should help inform the content of training (RRN 1.5). The content of the training should be person-centred and rights-based (RRN 2.1), both in respect of the people being trained and in respect of those upon whom the techniques may be used.

Once the initial training has been delivered, staff should undergo refresher training at least annually (RRN 1.6) with the full programme attended every fourth year (RRN 1.6.1). This means that the full training programme, as agreed with the commissioning organisation, will be delivered in full in year one, with refresher training in years two and three and the full programme repeated in year four. This is a curious requirement and is not how training is, or should be, delivered. Accordingly, it is hoped that this requirement is removed from the RRN standards. In any event, the frequency of refresher training may need to be increased if indicated by staff or organisation circumstances.

The RRN standards do not lay down a syllabus or specify which techniques should be included. Instead, the standards describe the principles which need to be followed when compiling the training syllabus. Questions as to which physical techniques or systems ought to be taught are complex and often used by training providers seeking to demonstrate the superiority of their own methods. It is hoped that future editions of the standards will look more closely at the specific techniques as it is often the use of inappropriate techniques, or appropriate techniques applied inappropriately, that cause the most harm.

Before considering which physical techniques to include it is important to consider how they will fit in with an organisation's overall violence and restraint reduction plans. A good example of this can be seen from figure 4 (see Chapter 5) which illustrates the *'hierarchy of responses'* approach, illustrating how the risks associated with a strategy increase as staff move up the hierarchy from primary through secondary and then to tertiary/escape and rescue interventions. Staff should aim to keep strategies insofar as possible in the primary proactive prevention section moving where necessary to secondary interventions. Primary responses are non-physical and include, as part of a proactive de-escalation process, a range of prediction and prevention strategies aimed at managing the incident without recourse to any hands-on intervention. Secondary interventions include supportive holds as part of the active de-escalation process. By contrast, a tertiary/escape and rescue response should be considered as

a medical/psychiatric or environmental/situational emergency and is therefore an exceptional intervention. Its use must be necessary, reasonable and proportionate to the risks presented by the patient or incident and only be used by staff who have been adequately trained in their use. A tertiary/escape and rescue response is the most-restrictive of holds and is designed to manage significant increases in risk in a patient's violence and aggression to themselves or others. These may include, where appropriate, placing the subject on the ground, in the most appropriate and safe position, and/or using one of the approved emergency distraction techniques. Such techniques may be justified when the patient cannot safely or reasonably be managed with less restrictive techniques or to prevent the dangers associated with prolonged restraint in any position; and then only for the shortest possible time and with appropriate monitoring to help ensure the patient's safety.

A figure 4 diagram has also been created to provide staff and patients with a visual tool to work collaboratively and design person-centred individualised support plans to manage differing levels of risk (RRN 2.6.1). Plans can be agreed at each stage of the triangle to provide advanced directions and expressed wishes to better predict and prevent behavioural disturbances that can often lead to acts of serious self-harm and interpersonal violence.

A small black triangle at the tip of the diagram has been provided by the RRN to cover a range of *'emergency response'* interventions, such as wrist flexion and so-called '*distraction'* techniques. These techniques are intended to cause pain and should be considered as truly exceptional interventions. They are referred to in the RRN standards under Appendix 21B *"the use of pain for escape or rescue purposes"*. The green double-headed arrow on the right of the triangle emphasises the importance of de-escalation throughout the entire process.

The duty of candour is of particular importance to healthcare professionals and it is unsurprising that RRN 2.2 requires training content to cover this in all settings. The duty of candour is also a CQC requirement, Regulation 20 explaining that its aim is *"to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment […]. Providers must promote a culture that encourages candour, openness and honesty at all levels. This should be an integral part of a culture of safety that supports organisational and personal learning. There should also be a commitment to being open and transparent at board level, or its equivalent such as a governing body"*. This duty also includes a duty of 'openness', enabling concerns and complaints to be raised freely without fear and questions asked to be answered and specific

reference to the commissioning organisation's whistle-blowing policy and procedures. This is to be welcomed not least because of the problem of the under-reporting of uses of restrictive interventions at both individual and organisational levels.

For any training in physical intervention skills to be worthwhile and beneficial to staff it should, subject to the confines of safety, replicate the aggression that staff are likely to encounter operationally. This requires a degree of resistance from those playing the part of the aggressive patient. RRN 2.8.11 states that where simulated resistance is used during training (which it must), the person playing the role of the aggressive patient must be taken by the trainer. This is impracticable for a number of reasons. First, it is beneficial for staff to have the technique applied on them so they can appreciate the same from the patient's perspective. Second, staff need to practise the techniques on people of different sizes, weights, etc. Third, staff need to practise the techniques a number of times until they become familiar with them and are able to perform them under stress. Restricting this training so that staff could only practise the techniques on the trainers would tie up the trainers preventing them from teaching other skills. Fourth, with certain types of intervention, practising them only on the trainers would give rise to foreseeable risk of injury to the trainers by having the same technique repeated on them by every member of the class. The normal method of practising these techniques whereby the trainers demonstrate the skills and then supervise the trainees whilst they practise them works perfectly well and should not be abandoned.

Any use of mechanical restraint needs to be approved at board level (RRN 2.8.A.1) and only considered for use "in exceptional circumstances in specific settings and under specific circumstances" (RRN 2.8.A.2). Moreover, the use of mechanical restraint should represent the least restrictive option for the individual upon whom it is to be used and it needs to be shown why alternatives would not be appropriate (CQC 2016). In no circumstances should mechanical restraint be used for the convenience of staff.

The training should make it clear that there is no such thing as a safe physical intervention as all of them carry risks of physical, psychological or emotional harm (RRN 2.9.1). Accordingly, the training should include all known risk factors associated with each technique with instruction how to perform each manoeuvre as safely as possible, setting out the factors that might contribute to or elevate the risk. Furthermore, the training should include instruction in emergency procedures in the event of a medical emergency arising during the intervention (RRN 2.10). These emergency procedures should also extend to the period following the

intervention as this period is also known to carry risks to the patient. The main risks associated with physical intervention are positional asphyxia, acute behavioural disturbance (ABD)/excited delirium (ExD) and limb deformity/fractures. These risks should be clearly explained, setting out their warning signs (RRN 2.10.2) and the appropriate response of staff should they occur. Most importantly, staff must be told that these conditions are medical emergencies and the well-being of the patient must take priority over the continuance of the intervention. Careful monitoring of the patient's airway, breathing and circulation during the intervention is crucial as is the appropriate monitoring of any known existing medical condition or injury (RRN 2.10.2). The above list of conditions is not an exhaustive list and staff must ensure the overall well-being of the patient. Given the significant risk of harm that can occur during physical intervention, it is important that the training affords a sufficient amount of time to the safety of those being restrained.

Hollins (2010) describes a dynamic risk process, based on the common first-aid ABC model, but expanded to provide a five-step approach, ABCDE, to help identify the risks in practice. This expanded approach helps ensure the total physical well-being of the subject throughout the period of restraint and thereafter as deemed necessary in the circumstances.

Figure 12. Dynamic Risk Assessment using ABCDE (adapted from Hollins, 2010)

Dynamic risk assessment process (ABCDE)	
Airway?	*Can they get air in?* • Is there any pressure to their neck? • Is there anything blocking their airway? • Is their mouth or throat free from vomit? • Are there any signs of airway obstruction? i.e. gurgling/gasping sounds; verbal complaints or difficulty speaking
Breathing?	*Are they able to breathe?* • Is their chest free to move? • Is their abdomen free from pressure? • Are there signs they are having difficulty breathing? i.e. an increased effort to struggle; or heightened distress/anxiety
Circulation?	*Can their blood be circulated efficiently?* • Are their limbs free from pressure? • Are there any signs of tissue hypoxia? i.e. pale/grey/blue skin colouring to the lips, nail beds or earlobes? • Are there reported symptoms of compartment syndrome? i.e. pain, pins and needles, pulselessness and/or paralysis

Deformity?	*Is there a risk of injuring any joints, limbs, or other skeletal/muscular structures?* • Is the spine in correct alignment? • Are the joints of the upper and lower limbs free from end-of-range stress? • Are they complaining of discomfort or pain to any part of their body?
Existing medical condition or injury?	*Is there anything known about the person's medical history that influences risk?* • Any known respiratory disease? • Any known cardiac or vascular disease? • Any other relevant pathology or injury?

The training curriculum should also include reference to the necessity for post-incident reviews (NICE, 2015, NICE, 2017, RRN 2.13). Baker (2017) describes two discrete components of post-incident review: post incident support covering both the physical and emotional wellbeing of those involved in the intervention, and a review covering post-incident reflection and learning. Both of these components should be covered in the curriculum.

9.5.3 Post-delivery processes

All training providers and in-house training departments should routinely review their training to ensure quality, effectiveness, and continued fitness for purpose, covering both the theoretical and practical elements of the curriculum (RRN 3.1).

Training providers and in-house training departments should complete and maintain records for each course delivered (RRN 3.2.1). These records should include the date and duration of the course, the names and status of the trainers and names of the participants. The records should also include details of the techniques taught and, as against each participant's name, whether they have been assessed as competent or whether further training is needed together with the specific details of the further training needed. The date when refresher training is due should also be recorded against each participant's name. A record confirming each participant's fitness to participate in the training and details of any injuries sustained during the training should also be kept.

To ensure the training meets the requirements of the organisation and its staff, all participants should be encouraged to complete a post-delivery evaluation questionnaire (RRN 3.4.1) and the responses used to improve the quality of the training and its effectiveness.

9.5.4 Trainer standards

Physical intervention trainers have three important tasks and these should be explained in the organisation's policy documents. These tasks are the same whether the organisation uses in-house trainers or engages an external training provider to provide the training. First, to deliver high quality and safe training according to the agreed curriculum. Second, to ensure that staff understand the need to minimise the use of all restrictive interventions and third, to challenge any unhelpful attitudes of staff or organisation.

Trainers have an important role in influencing staff attitudes and employers need to ensure that this role is exercised properly and effectively. To help achieve this, those providing training should have in place good quality assurance systems which, amongst other things, should monitor the competence of trainers (RRN 4.1). All trainers must hold, or be working towards, relevant qualifications and be able to demonstrate competence to deliver the training (RRN 4.2). In addition, all trainers should hold current first aid certification including immediate life support (RRN 4.2.2). The RRN also require trainers to *"be able to evidence that they have the qualifications, experience and competence in supporting people in the sector in which they are delivering training"* (RRN 4.3). This requires trainers to have a professional qualification (with current up to date registration) or have completed a programme of relevant vocational training, having received a qualification within health, education or social care. Evidence of this professional competence may include relevant vocational qualifications, social work qualifications, teaching or education-based qualifications, nursing qualification with current registration, or other health professional qualifications (RRN 4.3.1). Furthermore, *"all trainers must have been continuously employed in a support or care role within social care, education or a health care environment for a period of not less than two years"* (RRN 4.3.2). Whilst experience of relevant healthcare settings is clearly beneficial, these requirements will mean that many training providers and trainers will become ineligible to provide training to these sectors, including some exceptional trainers with considerable knowledge and expertise. It will have to be seen what resource implications this might have. Not only should the curriculum be based on a training needs analysis (RRN 1.1) but the delivery of training must be informed by training needs analyses with which trainers need to be familiar (RRN 4.4).

Paterson *et. al.,* (2014) identified a number of factors that should be considered for a 'charter' for PMVA trainers. These factors were split into three sections: the role of the trainer as a professional; the content of the training; and the provision of the training. With regard to the

role of the trainer as a professional, trainers should not provide training outside their scope of competence; they should embrace continuing professional development; and should at all times act in a professional and ethical manner. The training should be safe, evidence-based and meet best practice standards. Training should be designed following a needs analysis, be fit for the specific purpose of the organisation rather than delivered on a one-size-fits-all basis, conform to relevant legal and ethical guidance, and emphasise the importance of prevention and minimisation of restrictive practices. The training should be delivered in a way that it is integrated into a broader organisational agenda and carried out in a way that respects the safety, dignity and diversity of those participating.

The aim of any good guidance seeking to influence practices in the prevention and management of violence and aggression should be to minimise the need for any kind of restrictive intervention but where necessary to apply techniques as safely as possible within the relevant legislative framework.

Certain staff working in healthcare settings need to receive training to increase the organisation's capacity and capability to deal with potentially violent situations without recourse to external agencies, such as police, who operate to an entirely different set of standards to those that operate within healthcare settings and who use techniques that healthcare staff would not wish to see used. The introduction of the RRN training standards are relatively new although it seems that anything approaching a set of common guidelines that all settings can embrace is a long way off.

This chapter examined the need for a common set of guidelines and considered whether this was likely to be achieved. The final chapter draws together the various themes examined throughout the thesis and provides a number of key recommendations aimed at minimising the use of all kinds of restrictive and coercive interventions and making safer their use when absolutely necessary.

CHAPTER TEN: CONCLUSION AND RECOMMENDATIONS

10.1 Conclusion

This thesis aims to identify the key areas of controversy in the management of VAAoCB and by examining the literature and utilising the Author's 40 years of experience in advising most of the sectors, seeks to identify the key areas of concern and controversy and propose evidence-based recommendations for good practice so as to enhance safety both for individuals and staff.

Insofar as VAAoCB are concerned, subject and staff safety depends to a large extent on the ability of organisations and staff to avoid a physical response. Only when a physical response is either not possible or safe, should staff consider the use of coercive interventions, including restraint. Rather than focus on specific kinds of intervention, the emphasis should remain on the least restrictive kind of intervention and safety.

Despite a plethora of policies and guidelines touching on issues relating to the management of VAAoCB, few could properly be described as *vade mecums*. The guidelines that sought to ban the use of prone restraint and pain-compliance techniques, together with their consultation procedures, were hijacked for purposes of political expediency and social acceptability, irrespective of safety. The wholesale disregarding of the available evidence, the side-lining of true experts, and the lack of an evidence base for many of the recommendations is wholly unacceptable. Patients and staff deserve better.

10.2 Recommendations

Throughout this thesis, the Author has examined a range of key problematic issues and, by reference to the best available cross-sector knowledge, and the author's experience, set out a number of recommendations, which are summarised here for convenience. These recommendations will help improve the safety for all parties and will minimise the financial and reputational risk of employers and organisations. In providing these recommendations, the author acknowledges that parts will necessarily be sector specific.

1. Where possible, avoid the use of force and the circumstances that might give rise to the need to use force. Any use of force must be necessary.
2. Where it has not been possible to avoid the use of force, then the least restrictive and lowest level of force necessary should be used.

3. Where appropriate, use communication tactics with the aim of calming the person, removing confrontation and the need to use force.
4. Where a person is suspected of exhibiting the signs of ABD, then unless the person is considered to be a danger to themselves or others, contain the situation rather than restrain the person.
5. Consider all available information known about the subject including, but not limited to, medication and drugs.
6. Provide appropriate training to all relevant staff about excited delirium and acute behavioural disturbance providing guidance on how to recognise initial systems and manage the same. Consideration should be given to showing CCTV footage of a real incident and how staff responded to it.
7. Acute behavioural disturbance (ABD) should be treated as a medical emergency and the person's health should take priority. Staff should take every reasonable step to ensure that clinical assessment and management can begin as soon as possible.
8. Support and training should be extended to police, ambulance service, emergency departments and emergency operations centre staff to support early recognition and to ensure that appropriate care and management is available to all patients presenting with suspected ABD.
9. To enhance our understanding of ExD/ABH, a national database of cases should be created to facilitate clinical audit, research and quality improvement.
10. All PMVA training should include training specifically covering the safety of the restrained subject. As a minimum this should include the ABCDE method described in Chapter 9. This will help ensure the total physical well-being of the subject throughout the period of restraint and thereafter as deemed necessary in the circumstances.
11. A supervisor and safety supervisor should be deployed to oversee planned interventions. The supervisor's principal role is to ensure that the intervention is safe and to promote the safety of those involved in it.
12. The current coronial Prevention of Future Deaths system should be improved by creating a tracker to convert the information contained in the PFD reports into searchable data thus enabling others to identify key learning opportunities and act on them.
13. The coronial PFD system should be extended to cover serious incidents that do not result in death as these are not generally investigated unless there is involvement of a regulator or litigation is commenced. The involvement of regulators in such cases is

rare and the purpose of litigation is to resolve disputes between the affected parties with an award of damages (compensation) being the usual remedy.

14. To enhance the value of recommendations 12 and 13, a database of actions/proposed actions should be created. This will greatly improve lessons learned and ensure that actions taken are properly evidenced.

Bibliography

Adams, L., (2018). 'Shameful use of restraints on disabled patients', *BBC File on Four*, 2 October. Available at: https://www.bbc.co.uk/news/uk-45652339 [Accessed 27 July 2024].

Aiken, F., Duxbury, J., Dale, C. and Harbison, I., (2011). *Review of the Medical Theories and Research Relating to Restraint Related Deaths*. University of Central Lancashire, Preston, UK and Caring Solutions (UK) Limited, Southport, UK.

Allen, D., (2000). *Training Carers in Physical Interventions: towards evidence based practice*. Kidderminster: British Institute of Learning Disabilities.

Allen, D., (2001). Risk and Prone Restraint: For Our Own Safety: examining the safety of high-risk interventions for children and young people. In: M. Nunno, D. Day and L. Bullard, eds. *Risk and Prone Restraint: Reviewing the Evidence*, chapter 5. pp. 87.

Allen, M., (2017). *Criminal Law*. 14th ed. Oxford: Oxford University Press.

Alshayeb, H., (2010). Lactic acidosis in restrained cocaine intoxicated patients. *Tennessee Medicine*, 103, pp. 37–39.

American College of Emergency Physicians, (2009). White Paper Report on Excited Delirium Syndrome.

Ariel, B., Lawes, D., Weinborn, C., Henry, R., Chen, K. and Brants Sabo, H., (2019). The "Less-Than-Lethal Weapons Effect"—Introducing TASERs to Routine Police Operations in England and Wales: A Randomized Controlled Trial. *Criminal Justice and Behaviour*, 46(2), pp. 280–300.

Aristotle, (1926) *Nichomachean Ethics*. Translated by W.D. Ross. Oxford: Clarendon. Available at: http://classics.mit.edu/Aristotle/nicomachaen.2.ii.html [Accessed: 28 January 2025].

Auld, Lord Justice, (1998). R v Broadmoor Special Hospital Authority (ex parte S H & D) [1998] WL 1044171.

Aw-Yong, M., Ormrod Lecture, (2019): Police restraint - causes of death. *Medicine, Science and the Law*, 60(3), pp. 227–233.

Azeem, M.W., Aujla, A., Rammerth, M., Binsfeld, G. and Jones, R.B., (2011). Effectiveness of Six Core Strategies based on trauma informed care in reducing seclusions and restraints at a child and adolescent psychiatric hospital. *Journal of Child and Adolescent Psychiatric Nursing*, 24, pp. 11–15. Available at: https://doi.org/10.1111/j.1744-6171.2010.00262 [Accessed 27 July 2024].

Baker, D., (2018). Making Sense of 'Excited Delirium' in Cases of Death after Police Contact. *Policing*, 12(4), pp. 361–371.

Baker, P., (2017). Attending to debriefing as post-incident support of care staff in intellectual disability challenging behaviour services: An exploratory study. *International Journal of Positive Behavioural Support*, 7(1), pp. 38–44.

Barnett v Chelsea & Kensington Hospital Management Committee, (1969). [1969] 1 QB 428.

Barnett, R., Bower, E., Chan, A. and Stirling, C., (2018). An Investigation into the Range of Movement and Forces Involved by the Application of Wrist Flexion Restraint Techniques - Pain Inducing or Not? *Journal of Emergency Medicine and Care*, 1(2), pp. 203.

Barnett, R., Hanson, P., Stirling, C. and Pandyan, A.D., (2013). The physiological impact of upper limb position in prone restraint. *Med Sci Law*, 53, pp. 161–165.

Barnett, R., Stirling, C. and Pandyan, D., (2012). A review of the scientific literature related to the adverse impact of physical restraint: gaining a clearer understanding of the physiological factors involved in cases of restraint-related death. *Med Sci Law*, 52, pp. 137–142.

Baskind, E., (2003). Restraint conference, Lilleshall National Sports Centre, 11–12 June.

Baskind, E., (2006). Evidence given to The Lord Carlile of Berriew QC Independent Inquiry into the Use of Physical Restraint etc. in Prisons, Secure Training Centres, and Local Authority Secure Children's Homes. House of Lords.

Baskind, E., (2011). Planned Restraint Flowchart. *Centre for Physical Interventions*, British Self Defence Governing Body.

Baskind, E., (2014). "The use and misuse of physical restraint – some very recent developments and concerns", *European Violence in Psychiatry Research Group* annual conference, 8 May 2014, Liverpool.

Baskind, E., (2016). Physical interventions: can they ever be therapeutic? 'Safeguarding Vulnerable Persons in Custody: Minimising the Risk of Death in Detention', *Public Policy Exchange*, 12 October 2016, London.

Baskind, E., (2019). 'Zero tolerance and gesture politics', *Healthcare Conferences UK*, London.

Baskind, E., (2020). United Kingdom Report on The Efficacy and Safety of BolaWrap®. Available at: https://wrap.com/media/united-kingdom-report-on-the-efficacy-and-safety-of-bolawrap/#:~:text=BolaWrap%C2%AE%20is%20a%20new,parties%20in%20the%20immediate%20environment [Accessed 27 July 2024].

Baskind, E., Panorama (2021) BBC London.

Bath, H., (1994). Physical restraint of children: is it therapeutic?. *American Journal of Orthopsychiatry*, 64, pp. 40–49.

Batty, D., (2005). Call for restraint to tackle violent mental health patients. *The Guardian*, 2 February.

Bell, G., (1979). Training police in the management of domestic violence. *Canadian Police College Journal*, 3(4), pp. 305–315.

Bennett Inquiry, (2003). *Independent Inquiry into the death of David Bennett*. December.

Bensaid v UK, (2001) 33 EHRR 205. *European Court of Human Rights*, Strasbourg.

Beschizza, A., Dougall, D. and Khwaja, M., (2023). *Legislation Relevant to the Management of Violence by Persons With Mental Disorders*. Cambridge: Cambridge University Press.

Blomhoff, S., Seim, S. and Friis, S., (1990). Can prediction of violence among psychiatric inpatients be improved? *Hospital and Community Psychiatry*, 41, pp. 771–775.

Boser, U., (2022). The Learning Agency Lab. Available at: https://www.the-learning-agency-lab.com/the-learning-curve/learning-by-doing [Accessed 27 July 2024].

Bowers, L., (2014). Safewards: A new model of conflict and containment on psychiatric wards. *Journal of Psychiatric and Mental Health Nursing*, 21, pp. 499–508.

Bowlby, J., (1973). *Attachment and loss: volume 2. Separation, anxiety, and anger*. New York: Basic Book.

Brady, M.S., (2013). Emotional insight: The epistemic role of emotional experience. Oxford: Oxford University Press.

Brisco v Secretary of State for Scotland, (1997) [1997] SC 14. Inner House, Court of Session, Scotland.

British Self Defence Governing Body, (2018). Available at: www.bsdgb.co.uk [Accessed 27 July 2024].

Brooks, L., (2023). Police Scotland chief constable says force is institutionally racist, 25 May. Available at: https://www.theguardian.com/uk-news/2023/may/25/police-scotland-chief-constable-says-force-is-institutionally-racist [Accessed 27 July 2024].

Brown v Corus (UK) Ltd, (2004). [2004] EWCA Civ 374. UK Court of Appeal, Civil Division.

Brown, B., (1992). Assaults on police officers: An examination of the circumstances in which incidents occur. *Police Research Series*, Paper 10, Home Office Police Research Group, London.

Brown, M., (2016). The Mental Health Cop. Available at: https://mentalhealthcop.wordpress.com [Accessed 27 July 2024].

Bubbins v UK, (2005) 41 EHRR 458. *European Court of Human Rights*, Strasbourg.

Buck, C.J., (2009). *The international classification of diseases, 9th revision*. In: Mental disorders. Philadelphia: Elsevier Health Sciences, pp. 290–319.

Buttle, J., (2007). 'A Constructive Critique of the Officer Safety Programme Used in England and Wales'. *Policing and Society: An International Journal of Research and Policy*, 17(2), pp. 164–181.

Bwllfa and Merthyr Dare Steam Collieries (1891) Ltd v Pontypridd Waterworks Co, (1903). [1903] AC 426. House of Lords, London.

C v D, (2019). Case heard in the High Court, London, 18–21 March 2019. Parties' names anonymised.

CALM, (2019). Response from CALM Training to the Children and Young People's Commissioner Scotland report: *No Safe Place: Restraint and Seclusion in Scotland's Schools*.

Campbell, D., (2018). Figures reveal alarming rise in injuries at mental health units. *The Guardian*, 2018. Available at: https://bit.ly/2kYBkc8 [Accessed 27 July 2024].

Care Quality Commission, (2016). *Brief guide: restraint (physical and mechanical)*.

Care Quality Commission, (2017). *Mental Health Act: A focus on restrictive intervention reduction programmes in inpatient mental health services*.

Care Quality Commission, (2017–2018). *The state of health care and adult social care in England*.

Care Quality Commission, (2018). *The state of care in mental health services 2014 to 2017*. Findings from CQC's programme of comprehensive inspections of specialist mental health services.

Care Quality Commission, (2020a). CQC's response to Freedom of Information Request dated 1 May 2020. CQC reference: CQC IAT 1920 1361.

Care Quality Commission, (2020b). 'Out of Sight – Who Cares'.

Care Quality Commission, (2020c). 'Out of Sight – Who Cares', page 20.

Care Quality Commission, (2022). 'Out of Sight – Who cares: Progress Report'.

Care Services Improvement Partnership/National Institute for Mental Health in England, *Draft National Minimum Standards for the Safe and Therapeutic Management of Aggression and Violence in Mental Health Inpatient Settings*.

Carron, A.B., (1965). Complex Motor Skill Performance Under Conditions of Externally Induced Stress. M.A. thesis, University of Alberta.

Casseem, M., (1984). Violence on the wards. *Nursing Mirror*, 158(21), pp. 14–16.

Castro, B., (2024). Coroner reports not being used in a way that can help protect lives. *Law Society Gazette*, 22 February.

Chan, T.C., Vilke, G.M., Neuman, T., Clausen, J.L., (1997). Restraint position and positional asphyxia. *Annals of Emergency Medicine*, 30, pp. 578–586.

Chan, T.C., Neuman, T., Clausen, J., Eisele, J. and Vilke, G.M., (2004). Weight force during prone restraint and respiratory function. *American Journal of Forensic Medicine & Pathology*, 25, pp. 185–189.

Charlton v The Forrest Printing Ink Co Ltd, (1980). [1980] IRLR 331.

Chief Constable of West Yorkshire Police v Hunter, (2009). [2009] EWCA Civ 15. Court of Appeal, Civil Division, London.

Challenging Behaviour Foundation, (2020). *Reducing Restrictive Intervention of Children and Young People*. Kent.

Chan, T.C., Vilke, G.M., Neuman, T. and Clausen, J.L., (1997). Restraint position and positional asphyxia. *Annals of Emergency Medicine*, 30(5), pp. 578–586.

Children and Young People's Commissioner Scotland, (2018). *No Safe Place: Restraint and Seclusion in Scotland's Schools*. Edinburgh.

Chou, K., Lu, R. and Chang, M., (2001). Assaultive behaviour by psychiatric in-patients and its related factors. *Journal of Nursing Research*, 9(5), pp. 139–151.

Chouhan, K., (2003). 'Race issues in probation'. In: D. Ward, J. Scott and M. Lacey, eds. *Probation: Working for Justice*. Oxford and New York: Oxford University Press.

Christopher, S. and Noaks, L., (1990). Assaults upon the police: The assailant's perspective. *Police Research Awards Scheme*, Home Office, London.

Chu, C.M., Daffern, M. and Ogloff, J.R.P., (2013). Predicting aggression in acute inpatient psychiatric setting using BVC, DASA, and HCR-20 Clinical scale. *The Journal of Forensic Psychiatry & Psychology*, 24(2), pp. 269–285.

Cline, F.W., (1979). *What shall we do with this kid? Understanding and treating the disturbed child*. Evergreen Consultants.

Cobb, A., (2018). MIND. In: D. Campbell, 'Figures reveal alarming rise in injuries at mental health units'. *The Guardian*, 10 June. Available at: https://bit.ly/2kYBkc8 [Accessed 27 July 2024].

College of Paramedics, (2018). Position Statement on Acute Behavioural Disturbance.

College of Policing, (2017). *Memorandum of Understanding: The Police Use of Restraint in Mental Health & Learning Disability Settings*.

College of Policing, (2018). *Authorised Professional Practice, Detention and Custody, Control, Restraint and Searches*. Available at: https://www.app.college.police.uk/app-content/detention-and-custody-2/control-restraint-and-searches/ [Accessed 27 July 2024].

Connor, M., (2003). Excited delirium, restraint asphyxia, positional asphyxia and in-custody death syndromes. Available at: <www.educationoptions.org/programs/articles/SuddenDeath.htm> [Accessed 27 July 2024].

Cooper, A. and Medonca, J., (1991). A prospective study of patient assaults on nurses in a provisional psychiatric hospital in Canada. *Acta Psychiatrica Scandinavica*, 84, pp. 163–166.

Costello, D., (2003). Excited delirium as a cause of death. *Los Angeles Times*, 21 April, pp. 1A, 4A.

CRAG, (1996). *Clinical Research and Audit Guidelines (CRAG) Working Group on Mental Illness: The prevention and management of aggression - a good practice statement*. Scottish Office, National Health Service in Scotland. ISBN 0748031448, 9780748031443.

Cunningham, J., McDonnell, A., Easton, S., (2003). Social validation data on three methods of physical restraint: views of consumers, staff and students. *Research in Developmental Disabilities*, 24, pp. 307–316.

Dale, C. and Duxbury, J., (2016). *Review of International Evidence and Practice on Non-Pain Inducing Techniques and Systems of Restraint*. Youth Justice Board for England and Wales, London.

Davis, M. and Stark, A., (2001). Conflicts in rulemaking: hard cases and bad law. In: *Conflict of interest in the professions*. Oxford University Press, Oxford, UK.

Davison, S.E., (2005). The management of violence in general psychiatry. *Advances in Psychiatric Treatment*, 11, pp. 362–370.

Day, D.M., (2008). Literature on the Therapeutic Effectiveness of Physical Restraints with Children and Youth. Cornell University, Ithaca, New York.

De Brún, C., (2013). *The Information Standard Guide: Finding the Evidence*. Available at: https://www.england.nhs.uk/wp-content/uploads/2017/02/tis-guide-finding-the-evidence-07nov.pdf; https://www.nhs.uk/our-policies/the-information-standard/ [Accessed 27 July 2024].

De Souza, V., (2017). 'Co-production through building and celebrating communities'. *Health & Social Care Alliance Scotland*. Available at: https://www.alliance-scotland.org.uk/blog/opinion/co-production-through-building-and-celebrating-communities [Accessed 27 July 2024].

Department of Health, (2014). *Positive & Proactive Care: reducing the need for restrictive interventions*.

Department of Health, Northern Ireland, (2019). *Mental Capacity Act (Northern Ireland) 2016: Deprivation of Liberty Safeguards, Code of Practice*. Available at: <www.health-ni.gov.uk/publications/mcani-2016-deprivation-libertysafeguards-code-practice-november-2019>.

Department of Health and Social Care, (2017). *Statutory guidance. Code of Practice: Mental Health Act 1983*. Available at: <www.gov.uk/government/publications/code-of-practice-mental-health-act-1983>.

Descartes, R., (1991). *The Philosophical Writings of Descartes*, vol. 3. Edited and translated by J. Cottingham, R. Stoothoff, D. Murdoch, and A. Kenny. Cambridge: Cambridge University Press.

Di Maio, T.G. and Di Maio, V.J.M., (2006). *Excited delirium syndrome: Cause of death and prevention*. Boca Raton, FL: CRC, Taylor & Francis.

Dietz, C., (2021). Emotions, evidence, and safety. *Synthese*, 199, pp. 2027–2050. Available at: https://doi.org/10.1007/s11229-020-02871-1 [Accessed 27 July 2024].

Disability Rights Wisconsin, (2008). A Tragic Result of A Failure to Act: The Death of Angellika Arndt.

Donoghue v Stevenson, (1932). [1932] AC 562. House of Lords, Lord Atkin.

Dyson, S. and Boswell, G., (2006). Sickle Cell Anaemia and Deaths in Custody in the UK and the USA. *The Howard Journal*, 45(1), pp. 14–28.

Edwards (on behalf of the estate of the late Thomas Arthur Watkins) v Hugh James Ford Simey (A Firm), (2019). [2019] UKSC 54. UK Supreme Court, London.

Elgin, C. Z., (2008). Emotion and understanding. In: G. Brun, U. Dogluoglu & D. Kuenzle, eds. *Epistemology and Emotions*.

Equality and Human Rights Commission (2019) *Human Rights Framework for Restraint*. Available at: https://www.equalityhumanrights.com/sites/default/files/human-rights-framework-restraint.pdf [Accessed 28 January 2025].

European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, (2017). Council of Europe, Strasbourg. CPT/Inf (2017) 6.

Faculty of Forensic and Legal Medicine, (2010). *Acute behavioural disturbance: guidelines on management in police custody*.

Finfgeld-Connett, D., (2009). Model of therapeutic and non-therapeutic responses to patient aggression. *Issues in Mental Health Nursing*, 30(9), pp. 530–537.

Finogenov & Others v Russia, (2012). [2012] 2 EHRLR 233-237. European Court of Human Rights, Strasbourg.

Flannery, R., Jr., Hanson, M.A. and Rego, J., (2003). Precipitants of psychiatric patient assault on staff: Preliminary empirical inquiry of the Assaulted Staff Action Program. *International Journal of Emergency Mental Health*, 5, pp. 141–146.

Fleming v Stirling Council, Outer House, Court of Session, Scotland, (2000). [2000] ScotCS 87 (29 March 2000).

Fluttert, F.A.J., van Meijel, B., Nijman, H., Bjørkly, S., and Grypdonsk, M., (2010). Preventing aggressive incidents and seclusions in forensic care by means of the ‘‘Early Recognition Method’’. *Journal of Clinical Nursing*, 19, pp. 1529–1537.

Galián-Muñoz, I., Ruiz-Hernández, J.A., Llor-Esteban, B., and López-García, C., (2014). User violence and nursing staff burnout: The modulating role of job satisfaction. *Journal of Interpersonal Violence*, 31(2), pp. 302–315.

Gates, D., Fitzwater, E. and Succop, P., (2003). Relationships of stressors, strain, and anger to caregiver assaults. *Issues in Mental Health Nursing*, 24(8), pp. 775–793.

Georgieva, I., Mulder, C. and Whittington, R., (2012). Evaluation of behavioural changes and subjective distress after exposure to coercive inpatient interventions. *BMC Psychiatry*, 12, 54.

Ghaith v Indesit Co UK Ltd, (2012). [2012] EWCA Civ 642. UK Court of Appeal, Civil Division.

Gilburt, H., (2021). A tale of two Acts: The Mental Health Act, the Mental Capacity Act, and their interface. *The Kings Fund*. Available at: www.kingsfund.org.uk/blog/2021/02/tale-twoacts-mental-health-act-and-mental-capacity-act [Accessed 27 July 2024].

Gillings, M., Grundlingh, J. and Aw-Yong, M., (2016). *Guidelines for the Management of Excited Delirium/ Acute Behavioural Disturbance*. UK: Royal College of Emergency Medicine.

Godwin, S., (2012). Bad Science Makes Bad Law: How the Deference Afforded to Psychiatry Undermines Civil Liberties. *Seattle Journal for Social Justice*, 10, pp. 647.

Goldie, P., (2004). Emotion, feeling, and knowledge of the world. In: C.S. Robert, ed. *Thinking about feeling: Contemporary philosophers on emotions*. Oxford: Oxford University Press.

Goodall, C.M., (1967). Sixth National Burn Seminar. Sympatho-adrenal medullary response to thermal injury. *The Journal of Trauma*, 7(1), pp. 144–147.

Gournay, K., (2003). Professor Kevin Gournay’s evidence to the Bennett Inquiry.

Grant v Chief Constable of Grampian Police, (2001). [2001] ScotCS 101. Outer House, Court of Session, Scotland.

Greenberg, N., Docherty, M., Gnanapragasam, S., and Wessely, S., (2020). Managing mental health challenges faced by healthcare workers during COVID-19 pandemic. *BMJ*, 368, m1211.

Grimley, M. and Morris, S., (2001). The training of NHS staff in non-mental health settings in the recognition, prevention and management of violence and aggression, and conflict management. *School of Education, University of Birmingham*, UK.

Gulart, A., and Silva, I., (2020). Early prone position for COVID-19 patients with severe hypoxia: reduces the mortality but increases the intubation risk? *Intensive Care Medicine*, 46(11), pp. 2124–2125.

GR v Greater Glasgow and Clyde Health Board, Johnson and Johnson Medical Ltd, (2018). [2018] CSOH 109. Outer House, Court of Session, Scotland.

Haberfeld, M., (2002). *Critical Issues in Police Training*. Prentice Hall, USA.

Haimowitz, S., Urff, J., Huckshorn, K.A., (2006). Restraint and seclusion: A risk management guide. *National Association of State Mental Health Program Directors*, Alexandria, VA. Available at: http://www.nasmhpd.org/sites/default/files/R-S%20RISK%20MGMT%2010-10-06%282%29.pdf [Accessed 27 July 2024].

Hale, Baroness, (2012). In: *Rabone v Pennine Care NHS Foundation Trust*, 2 AC 72, [93]-[94].

Hall, C., Butler, C., and Kader, A., (2009). Police use of force, injuries and death: prospective evaluation of outcomes for all police use of force/restraint including conducted energy weapons in a large Canadian city. *Acad Emerg Med*, 16, pp. 198–199.

Hall, C., Kader, A., McHale, D., (2013). Frequency of signs of excited delirium syndrome in subjects undergoing police use of force: descriptive evaluation of a prospective, consecutive cohort. *Journal of Forensic and Legal Medicine*, 20, pp. 102–107.

Hall, C., Votova, K., Heyd, C., Walker, M., MacDonald, S., and Eramian, D., (2015). Restraint in police use of force events: examining sudden in custody death for prone and not-prone positions. *Journal of Forensic and Legal Medicine*, 31, pp. 29–35.

Hallett, H., (2011). *Coroners Inquests into the London Bombings of 7 July 2005*. Lady Justice Heather Hallett, Assistant Deputy Coroner for Inner West London, ruling 6 May 2011, page 15.

Hallett, N., and Dickens, G., (2017). De-escalation of aggressive behaviour in healthcare settings: Concept analysis. *International Journal of Nursing Studies*, July 2017. Available at: http://dx.doi.org/10.1016/j.ijnurstu.2017.07.003 [Accessed 27 July 2024].

Hampshire County Council, (2008). *Evidence given by Hampshire County Council Children's Services Department to the Independent Review of Restraint in Juvenile Secure Settings*, Smallridge & Williamson.

Harris, G. and Rice, M.E., (1986). Staff injuries sustained during altercations with psychiatric patients. *Journal of Interpersonal Violence*, 1(2), pp. 193–211.

Harris, J., (1996). Physical restraint procedures for managing challenging behaviours presented by mentally retarded adults and children. *Research in Developmental Disabilities*, 17, pp. 99–134.

Hart, D. and Howell, S., (2004). *Report on the use of physical intervention across children's services*. National Children's Bureau.

Hassell, M., (2013). Senior Coroner for Inner North London, St Pancras Coroner's Court, London. *Inquest into the Death of Michael Sweeney*.

Helm, B.W., (2009). Emotions as evaluative feelings. *Emotion Review*, 1(3), pp. 248–255.

Health and Safety Executive, (2006). *Research Report 440: Violence and aggression management training for trainers and managers: A national evaluation of the training provision in healthcare settings*. Prepared by the University of Nottingham for the Health and Safety Executive 2006.

Health and Safety Executive, (2017). *Health & Safety Executive guidance for prosecutors*, 2017.

Herczegfalvy v Austria, (1992). [1992] 15 EHRR 437. European Court of Human Rights, Strasbourg.

Hick, J.L., Smith, S.W., and Lynch, M.T., (1999). Metabolic acidosis in restraint-associated cardiac arrest: A case series. *Acad Emerg Med*, 6, pp. 239–243.

Hill, R.G., (1967). Non-restraint and Robert Gardiner Hill, *Bulletin in the History of Medicine*, 41(2), March-April, pp. 140–141, Johns Hopkins University Press.

Hillbrand, M., Foster, H., and Spitz, R., (1996). Characteristics and cost of staff injuries in a forensic hospital. *Psychiatric Services*, 47(10), pp. 1123–1125.

Ho, J.D., Dawes, D.M., Nelson, R.S., Lundin, E.J., Ryan, F.J., Overton, K.G., (2010). Acidosis and catecholamine evaluation following simulated law enforcement "use of force" encounters. *Academy of Emergency Medicine*, 17(7), e60–e68.

Ho, J.D., Dawes, D.M., Moore, J.C., Caroon, L.V., and Miner, J.R., (2011). Effect of position and weight force on inferior vena cava diameter – implications for arrest-related death. *Forensic Sci Int*, 212, pp. 256–259.

Holden, J., Johnson, T., and Nunno, M., (2011). Using a Prone/Supine Perception Survey and Literature Review to Forward the Conversation Regarding All Restraints. Available at: https://rccp.cornell.edu/_assets/ProneVsSupine_survey.pdf [Accessed 27 July 2024].

Hollins, L., (2010). Managing the risks of physical intervention: developing a more inclusive approach. *Journal of Psychiatric and Mental Health Nursing*, 17, pp. 369–376.

Home Office, (2019). *Police Use of Force Statistics, England and Wales, April 2018 to March 2019*.

HOMES, (2014). *Home Office Manual for Escorting Safely*. National Offender Management Service (now known as Her Majesty's Prison and Probation Service), Ministry of Justice, London.

Hooker, R., (1888). *The Works of Richard Hooker*, vol. 1. Oxford: Clarendon Press.

House of Lords, (2006). *R (on the application of Munjaz) v Mersey Care NHS Trust*, 2 AC 148.

House of Lords, (2006:1). *R (on the application of Munjaz) v Mersey Care NHS Trust*, 2 AC 148, pp. 189–190, Lord Bingham of Cornhill.

Humphries, C., Kelly, A., Sadik, A., *et al.*, (2023). Consensus on acute behavioural disturbance in the UK: A multidisciplinary modified Delphi study to determine what it is and how it should be managed. *Emerg Med J*. doi:10.1136/emermed-2023-213335.

Hussey, (1924). 18 Cr App Rep 160. Court of Appeal, Criminal Division, London.

Infantino, J., Musingo, S., (1985). Assaults and injuries among staff with and without training in aggression control techniques. *Hospital and Community Psychiatry*, 36(12), pp. 1312–1314.

Ingram v Worcestershire County Council, (2000). *The Times*, 11 January 2000.

INQUEST, (2017). *The tragic death of Olaseni Lewis*. Available at: https://www.inquest.org.uk/olaseni-lewis-officers-cleared [Accessed 27 July 2024].

Ireland v UK, (1979-1980). [1979-1980] 2 EHRR 25. European Court of Human Rights, Strasbourg.

Johannessen, (2021). Modern understanding of psychosis: from brain disease to stress disorder. And some other important aspects of psychosis. *Psychological, Social and Integrative Approaches*, Volume 13, 2021 - Issue 4.

Johnson, M., Hauser, P., (2001). The practices of expert psychiatric nurses: accompanying the patient to a calmer personal space. *Issues in Mental Health Nursing*, 22(7), pp. 651–668.

Jones, S., and Gournay, K., (2006). A systematic review of the safety and effectiveness of restraint and seclusion as interventions for the short-term management of violence in adult psychiatric inpatient settings and emergency departments. *Worldviews on Evidence-Based Nursing*, 3(1), pp. 8–18.

Jordan, L., Crudden, G., Mohan, D., Kennedy, H., Davoren, D., (2023). Stratified therapeutic security and understanding backwards care pathway moves. A 5-year retrospective cohort analysis from the Dundrum Forensic Redevelopment Evaluation (D-FOREST) study in Dublin, Ireland. Cambridge University Press (online) Stratified therapeutic security and understanding backwards care pathway moves. A 5-year retrospective cohort analysis from the Dundrum Forensic Redevelopment Evaluation (D-FOREST) study in Dublin, Ireland | European Psychiatry | Cambridge Core [Accessed 27 July 2024].

Justice Committee, (Coles, 2024; Castro, 2024). *Law Society Gazette*, 22 February 2024.

Kaplan, S.G., Wheeler, E.G., (1983). Survival skills for working with potentially violent clients. *Social Casework*, 64(6), pp. 339–346.

Karch, S.B., (2016). The problem of police-related cardiac arrest. *J Forensic Leg Med*, 41, pp. 36–41.

Keenan v UK, (2001). [2001] 33 EHRR 38. European Court of Human Rights, Strasbourg.

Keys v Shoefayre Ltd, (1978). [1978] IRLR 476.

Khwaja, M., Beer, D., (2013). *Prevention and management of violence: guidance for mental healthcare professionals*. Royal College of Psychiatrists, London.

Khwaja, M., Baskind, E., (2023). *The Relationship Between Violence and Mental Health Inequality in the Black, Asian and Minority Ethnic Communities*. Cambridge University Press.

Khwaja, M., Tyrer, P., (2023). *The Prevention and Management of Violence*. Cambridge University Press.

Kim, S., Park, T., (2019). Acute and Chronic Effects of Cocaine on Cardiovascular Health. *Int J Mol Sci*, 20(3):584.

Knox, D., and Holloman, G., (2011). Use and Avoidance of Seclusion and Restraint: Consensus Statement of the American Association for Emergency Psychiatry Project BETA Seclusion and Restraint Workgroup. *Western Journal of Emergency Medicine*, Department of Emergency Medicine, UC Irvine.

Knutzen, M., *et al*., (2012). Mechanical and pharmacological restraints in acute psychiatric wards—Why and how are they used? *Psychiatry Research*. Available at: http://dx.doi.org/10.1016/j.psychres.2012.11.017 [Accessed 27 July 2024].

Kuivalainen, S., Vehvilainen-Julkunen, K., Louheranta, O., Putkonen, A., Repo-Tiihonen, E., and Tiihonen, J., (2017). De-escalation techniques used, and reasons for seclusion and restraint, in a forensic psychiatric hospital. *International Journal of Mental Health Nursing*, 26, pp. 513–524.

Kutcher, S., Bowes, M., Sanford, F., Teehan, M., Ayer, S., Ross, J., Smith, J., and Thompson, S., (2009). Report of the Panel of Mental Health and Medical Experts Review of Excited Delirium. Nova Scotia.

Laporte, R. (on the application of) v Chief Constable of Gloucestershire, (2006). [2006] UKHL 55, House of Lords, UK.

Leadbetter, D., (2004). Exploring safe practice in physical interventions. *Nursing and Residential Care*, 6, pp. 232–234.

Leather, P., Lawrence, C., Beale, D., Cox, T., and Dickson, R., (1998). Exposure to occupational violence and the buffering effects of intra-organizational support. *Work & Stress*, 12(2), pp. 161–178.

Lepping, P., Masood, B., Flammer, E., and Noorthoorn, E.O., (2016). Comparison of restraint data from four countries. *Social Psychiatry and Psychiatric Epidemiology*, 51, pp. 1301–1309.

Lewis v Wandsworth London Borough Council, (2020). [2020] EWHC 3205 (QB). High Court of Justice, London.

Liddle, (2018). *Fatal Accident Inquiry into the Death of Allan Marshall*. Sheriff Gordon Liddle, [2018] FAI 35. Available at: https://www.scotcourts.gov.uk/docs/default-source/cos-general-docs/pdf-docs-for-opinions/2019fai35.pdf [Accessed 27 July 2024].

Lindon, G., and Roe, S., (2017). *Deaths in police custody: A review of the international evidence*. Research Report 95, Home Office, London.

Linklater, M., (2023). Institutional racism isn't confined to Police Scotland, says chief constable. *The Times*, 4 June 2023. Available at: https://www.thetimes.co.uk/article/institutional-racism-isnt-confined-to-police-scotland-says-chief-constable-g56p9cd5t [Accessed 27 July 2024].

Lintern, S., (2020). Whorlton Hall: Care regulator 'was wrong' to bury whistleblower's report into failings at hospital where patients were abused. *The Independent*. Available at: https://www.independent.co.uk/news/health/whorlton-hall-cqc-whistleblower-learning-disability-abuse-a9297496.html [Accessed 27 July 2024].

Little, I.M.D. (2002) 'Utilitarianism: Theory and Applications', In: Little, I.M.D. (ed), *Ethics, Economics, and Politics: Principles of Public Policy*. Oxford: Oxford University Press, pp. 39-52. Available at: https://academic.oup.com/book/9497/chapter/156456815 [Accessed: 28 January 2025].

Lion, J.R., (1987). Training for the battle: thoughts on managing aggressive patients. *Hospital & Community Psychiatry*, 38, pp. 882–884.

Lipsedge, M., (2016). Excited delirium: A psychiatric review. *Medicine, Science and the Law*, 56(2), pp. 121–127.

Lockertsen, Ø., Varvin, S., Færden, A., Vatnar, S.K.B., (2021). Short-term risk assessments in an acute psychiatric inpatient setting: A re-examination of the Brøset Violence Checklist using repeated measurements - Differentiating violence characteristics and gender. *Arch Psychiatr Nurs*, 35(1), pp. 17–26.

Longman, (1857). *A Concise History of the Entire Abolition of Mechanical Restraint in the Treatment of the Insane and of the Introduction, Success, and Final Triumph of the Non-Restraint System*. Longman, Brown, Green and Longmans, Bavarian State Library, 1857.

Lynch, S., (2017). Senior Coroner at South London Coroner's Court, *'Report to Prevent Future Deaths, Inquest into the Death of Olaseni Lewis'*. Available at: www.judiciary.uk/wp-content/uploads/2017/07/Olaseni-Lewis-2017-0205.pdf [Accessed 27 July 2024].

Lyon, C., and Pimor, A., (2004). *Physical interventions and the law: legal issues arising from the use of physical interventions in supporting children, young people and adults with learning disabilities and severe challenging behaviour*, British Institute of Learning Disabilities, Kidderminster.

Maguire, T., Young, R., and Martin, T., (2012). Seclusion reduction in a forensic mental health setting. *Journal of Psychiatric and Mental Health Nursing*, 19, pp. 97–106.

Maguire, T., Daffern, M., Bowe, S.J., and McKenna, B., (2019). Evaluating the impact of an electronic application of the Dynamic Appraisal of Situational Aggression with an embedded Aggression Prevention Protocol on aggression and restrictive interventions on a forensic mental health unit. *International Journal of Mental Health Nursing*, 28(5), pp. 1186–1197.

Mathew v Netherlands, (2006) 43 EHRR 23. European Court of Human Rights, Strasbourg.

McCann & Others v UK, (1996) 21 EHRR 97. European Court of Human Rights, Strasbourg.

McDonell, A., Sturmey, P., and Dearden, B., (1993). The acceptability of physical restraint procedures for people with a learning disability. *Behavioural and Cognitive Therapy*, 21.

McDonnell, A., (2010). *Managing aggressive behaviour in care settings: understanding and applying low arousal approaches*. Wiley, London.

McGinnes v Endeva Service Ltd, (2006). SLT 638.

Mantovani, C., Migon, M.N., Alheira, F.V., and Del-Ben, C.M., (2010). Management of the violent or agitated patient. *Braz J Psychiatry*, 32 Suppl 2, S96–103.

Maslow, A.H., (1966). *The Psychology of Science: A Reconnaissance*. Harper and Row Publishers, Wisconsin. p. 15.

Mash, D., (2016). Excited Delirium and Sudden Death: A Syndromal Disorder at the Extreme End of the neuropsychiatric Continuum. *Frontiers in Physiology*, 7:435.

Masters, K., (2019). Edgar Dale's Pyramid of Learning in medical education: Further expansion of the myth. Available at: https://onlinelibrary.wiley.com/doi/epdf/10.1111/medu.13813 [Accessed 27 July 2024].

Masters & Wandless, (2005). Use of Pulse Oximetry During Restraint Episodes. *Psychiatric Services*, 56(10), p. 1313.

Matthews, M., (2008). Evidence given by George Matthews, Team Teach, to the Independent Review of Restraint in Juvenile Secure Settings, Smallridge & Williamson.

Matthews, P., (2014). *Jervis on the Office and Duties of Coroners: With Forms and Precedents*, 13th ed. London: Sweet & Maxwell.

Mehrabian, A., (1971). *Silent Messages* (1st ed.). Belmont, CA: Wadsworth. University of California, Los Angeles, USA. ISBN 0-534-00910-7.

Mehrabian, A., (2009). *Silent Messages – A Wealth of Information About Non-verbal Communication (Body Language)*. Personality & Emotion Tests & Software: Psychological Books & Articles of Popular Interest. Los Angeles, USA.

Meredith, C., Taslaq, S., Min Kon, O., and Henry, J., (2005). The cardiopulmonary effects of physical restraint in subjects with chronic obstructive pulmonary disease. *J Clin Forensic Med*, 12, pp. 133–136.

Metropolitan Police Service, (2004). *Restraint and Mental Health Report*.

Metropolitan Police, (2023). Met Police launch 'Right Care, Right Person' to get mental health patients the right support. Available at: https://news.met.police.uk/news/met-police-launch-right-care-right-person-to-get-mental-health-patients-the-right-support-474539 [Accessed 27 July 2024].

Michalewicz, B.A., Chan, T.C., Vilke, G.M., Levy, S.S., Neuman, T.S., and Kolkhorst, F.W., (2007). Ventilatory and metabolic demands during aggressive physical restraint in healthy adults. *J Forensic Sci*, 52, pp. 171–175.

Miller, C., (2004). Restraint asphyxia: silent killer. Available at: www.charlydmiller.com/RA/restrasphyx02.html [Accessed 27 July 2024].

Millfields Charter, (2005). *Millfields charter: against abusive practice*. Available at: http://millfieldscharter.org/charter.php [Accessed 27 July 2024].

Milliken, D., (1998). Death by restraint. *Can Med Assoc J*, 158, pp. 1611–1612.

Ministry of Justice, (2008). *The Government's Response to the Report by Peter Smallridge and Andrew Williamson of a Review of the Use of Restraint in Juvenile Secure Settings*.

Ministry of Justice, (2018). *Assaults and Self-harm to September 2018*. https://www.gov.uk/government/organisations/ministry-of-justice/%20assaults [Accessed 27 July 2024].

Mistlin, S., (2021). So the term BAME has had its day. But what should replace it? *The Guardian*, 8 April 2021. Available at: https://www.theguardian.com/commentisfree/2021/apr/08/bame-britain-ethnic-minorities-acronym [Accessed 27 July 2024].

Mohr, W.K., Petti, T.A., and Mohr, B.D., (2003). Adverse effects associated with physical restraint. *Canadian Journal of Psychiatry*, 48(5).

Morales, E., and Duphorne, P.L., (1995). Least restrictive measures: alternatives to four-point restraints and seclusion. *Journal of Psychosocial Nursing and Mental Health Services*, 33(10), pp. 13–16.

Morrison, L., Duryea, P.B., Moore, C., and Nathanson-Shinn, A., (2001). The Lethal Hazard of Prone Restraint: Positional Asphyxiation. Protection & Advocacy, Inc. Investigations Unit Oakland, California.

Moxey, M., and McKenzie, I., (1993). Assaults on police. *Policing*, 9, pp. 172–186.

Mulcahy, J., (2018). Daring to Ask: "What Happened to You?". Why Correctional Systems Must Become Trauma-Responsive. *Advancing Corrections*, 5, pp. 71–86.

Munjaz, (2003), R (on the application of Munjaz) v Mersey Care NHS Trust. 2003 (Court of Appeal); 2005 (House of Lords); 2008, 2012 (European Court of Human Rights). Quote taken from Lord Bingham in the House of Lords, para 21.

Munjaz, (2005). R (on the application of Munjaz) v Mersey Care NHS Trust. House of Lords. Quote taken from Lord Hope, para 69.

Murphy, G., (2019). Whorlton Hall: a predictable tragedy? *BMJ*, 366, l4705.

NFPS, (2020). National Federation for Personal Safety. Available at: https://nfps.info/rrn-standards-and-bild-act-certification-are-they-mandatory-or-not/ [Accessed 27 July 2024].

NHS, (2018). Reintroduction of Zero Tolerance. Available at: https://www.gov.uk/government/news/stronger-protection-from-violence-for-nhs-staff [Accessed 27 July 2024].

NHS, (2021). Moving away from Zero Tolerance. Available at: https://www.england.nhs.uk/supporting-our-nhs-people/health-and-wellbeing-programmes/violence-prevention-and-safety/ [Accessed 27 July 2024].

NHS, (2022). NHS Staff Survey. Available at: https://www.nhsstaffsurveys.com/results/national-results [Accessed 27 July 2024].

National Institute for Health and Care Excellence, (2015). *Violence and aggression: short-term management in mental health, health and community settings*. NICE, London.

National Institute for Clinical Excellence, (2005). *Violence: the short term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments national cost-impact report*. National Institute for Clinical Excellence, London.

National Institutes of Health, (2022). ICD-11 Examples of Codes that describe the same behaviour as ExD/ABD. Available at: https://www.nih.gov/, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6861931/.

National Statistics, (2002). Available at: https://www.gov.uk/government/statistics/police-workforce-england-and-wales-31-march-2021/annex-statistics-on-the-number-of-police-officers-assaulted-in-the-year-ending-march-2021-england-and-wales.

Nau, J., Halfens, R., Needham, I., Dassen, T., (2010). Student nurses' de-escalation of patient aggression: a pre-test/post-test intervention study. *International Journal of Nursing Studies*, 47(6), pp. 699–708.

Needham, I., Abderhalden, C., Meer, R., Dassen, T., Haug, H., Halfens, R., Fischer, J.E., (2004). The effectiveness of two interventions in the management of patient violence in acute mental inpatient settings: report on a pilot study. *Journal of Psychiatric and Mental Health Nursing*, 11(5), pp. 595–601.

Nelstrop, L., Chandler-Oatts, J., Bingley, W., Bleetman, T., Corr, F., Cronin-Davis, J., Fraher, D., Hardy, P., Jones, S., Gournay, K., Johnston, S., Pereira, S., Pratt, P., Tucker, R., Tsuchiya, A., (2006). A Systematic Review of the Safety and Effectiveness of Restraint and Seclusion as Interventions for the Short-Term Management of Violence in Adult Psychiatric Inpatient Settings and Emergency Departments. *Worldviews on Evidence-Based Nursing*, 3(1), pp. 8–18. Sigma Theta Tau International.

NICE, (2005). *NICE Clinical Guideline CG25. The short-term management of disturbed/violent behaviour in psychiatric inpatient settings and accident and emergency departments*. National Institute for Health and Care Excellence.

NICE, (2015). *NICE Guideline NG10: Violence and Aggression - Short-term management in mental health, health and community settings*. National Institute for Health and Care Excellence.

NICE, (2017). *Quality Standard QS154. Violent and aggressive behaviours in people with mental health problems*. National Institute for Health and Care Excellence.

North West Integrated Workforce Unit, (2014). Core skills conflict resolution. NHS Health Education North West. Available at: http://www.cmtpct.nhs.uk/north-west-coreskills/resources/Conflict_Resolution_Trainer_Notes_Feb2014.pdf [Accessed 27 July 2024].

Nottinghamshire Healthcare NHS Trust v RC, (2014) [2014]. EWCOP 1136.

Nunno, M., Holden, M., and Tollar, A., (2006). Learning from tragedy: A survey of child and adolescent restraint fatalities. *Child Abuse & Neglect: An International Journal*, 30(12), pp. 1333–1342.

O'Halloran, R.L., Lewman, L.V., (1993). Restraint asphyxiation in excited delirium. *Am J Forensic Med Pathol*, 14, pp. 289–295.

O'Halloran, R.L., Frank, J.G., (2000). Asphyxial death during prone restraint position revisited: a report of 21 cases. *American Journal of Forensic Medicine & Pathology*, 21(1), pp. 39–52.

O'Hara, M., (2005). Straightjacket may be brought back into the NHS. *The Guardian*, February 2, 2005.

Office of the Public Guardian, (2020). *Mental Capacity Act Code of Practice: Giving guidance for decisions made under the Mental Capacity Act 2005*. Available at: www.gov.uk/government/publications/mental-capacity-act-code-ofpractice#history [Accessed 27 July 2024].

Osman v UK, 2000. (2000) 29 EHRR 245. European Court of Human Rights, Strasbourg.

Otahbachi, M., Cevik, C., Bagdure, S., and Nugent, K., (2010). Excited Delirium, Restraints, and Unexpected Death: A Review of Pathogenesis. *American Journal of Forensic Medicine & Pathology*, 31(2), pp. 107–112.

Overlooked in the Undercounted, (2015). *The Role Of Mental Illness In Fatal Law Enforcement Encounters*. United States of America. Available at: https://www.treatmentadvocacycenter.org/overlooked-in-the-undercounted [Accessed 27 July 2024].

Oxendine, J., (1968). Emotional arousal and motor performance. *Psychology of Motor Learning*, Appleton-Century-Crofts, New York.

Paley, S., (2009). Time out and seclusion. *British Institute of Learning Disabilities*, Kidderminster.

Palmer, (1971). [1971] AC 814, Privy Council, Lord Morris.

Park, K.S., Corn, C.S., Henderson, S.O., (2011). Agitated delirium and sudden death: two case reports. *Prehosp Emerg Care*, 5, pp. 214–216.

Parkes, J., (2002). A review of the literature on positional asphyxia as a possible cause of sudden death during restraint. *British Journal of Forensic Practice*, 4(1), pp. 24–30.

Parkes, J., Carson, R., (2008). Sudden death during restraint: do some positions affect lung function? *Med Sci Law*, 48, pp. 137–141.

Parkes, J., Thake, D., Price, M., (2011). Effect of seated restraint and body size on lung function. *Med Sci Law*, 51, pp. 177–181.

Paquette, M., (2003). Excited delirium – does it exist? *Perspectives in Psychiatric Care*, 39(3), pp. 93–94.

Paterson, B., (2011). How corrupted cultures lead to abuse of restraint interventions. *Learning Disability Practice*, 14(7), pp. 24–28.

Paterson, B., (2020). Regulating the Regulation of the use of Restrictive Practices: Transparency and Innovation vs Repetition and Failure. CALM Training, 12/11/2020. Available at: https://calmtraining.co.uk/2020/11/12/regulating-the-regulation-of-the-use-of-restrictive-practices-transparency-and-innovation-vs-repetition-and-failure [Accessed 27 July 2024].

Paterson, B., Leadbetter, D., McComish, A., (1997). De-escalation in the management of aggression and violence. *Nursing Times*, 93(36), pp. 58–62.

Paterson, B., Bradley, P., Stark, C., Saddler, D., Leadbetter, D., & Allen, D., (2003). Deaths associated with restraint use in health and social care in the UK. The results of a preliminary survey. *Journal of Psychiatric and Mental Health Nursing*, 10(1), pp. 3–15.

Paterson, B., Leadbetter, D., Miller, G., (2004). Workplace violence in health and social care as an international problem: a public health perspective on the 'Total Organisational Response'. Available at: http://www.nm.stir.ac.uk/documents/ld-integrated-response.pdf [Accessed 27 July 2024].

Paterson, B., McKenna, K., Bowie, V., (2014). A charter for trainers in the prevention and management of workplace violence in mental health settings. *Journal of Mental Health Training, Education and Practice*, 9(2), pp. 101–108.

Payne, H., (2005). Use of Physical Restraint on Children and Young People – safety and effectiveness. Evidence to Howard League Carlile Group.

Perry, (2008). Evidence given by Dr David Perry to the Independent Review of Restraint in Juvenile Secure Settings, Smallridge & Williamson.

Pestka, E.L., Hatteberg, D., Larson, L.A., Zwygart, A.M., Cox, D.L., Borgen, E.E., (2012). Enhancing safety in behavioural emergency situations. *MEDSURG Nursing*, 21(6), pp. 335–341.

Petit, J.R., (2005). Management of the acutely violent patient. *Psychiatric Clinics of North America*, 28(3), pp. 701–711.

Petancevski, E., Inns, J., Fransen, J., Impellizzeri, F., (2022). The effect of augmented feedback on the performance and learning of gross motor and sport-specific skills: A systematic review. *Psychology of Sport and Exercise*, 63, pp. 102277. Available at: https://doi.org/10.1016/j.psychsport.2022.102277 [Accessed 27 July 2024].

Peters Jr., J.G., (2012). Excited Delirium: Fallacy or Reality? University of Phoenix, Las Vegas.

Philips, S., & Cochrane, R., (1991). Assaults Against the Police: A Study in Three Phases. *School of Psychology, University of Birmingham*. Research Based Management Information for West Midlands Police, Unpublished Report.

Pinel, P., (1745-1826). Noted in *One Hundred Years of American Psychiatry*, pp. 276–277.

Police Complaints Authority, (2002). *Policing Acute Behavioural Disturbance*.

Pountney v Griffiths, (1976). [1976] AC 314, 318G. UK House of Lords.

Powers, J.L., Mooney, A., Nunno, M., (1990). Institutional abuse: A review of the literature. *Journal of Child and Youth Care*, 4(6), pp. 81.

Price, O., Baker, J., (2012). Key components of de-escalation techniques: a thematic synthesis. *International Journal of Mental Health Nursing*.

Price, O., Baker, J., Bee, P., Lovell, K., (2015). Learning and performance outcomes of mental health staff training in de-escalation techniques for the management of violence and aggression. *British Journal of Psychiatry*, 206(6), pp. 447–455.

Price, O., Baker, J., Bee, P., & Lovell, K., (2018). The support-control continuum: An investigation of staff perspectives on factors influencing the success or failure of de-escalation techniques for the management of violence and aggression in mental health settings. *International Journal of Nursing Studies*, 77, pp. 197–206.

Procter, N., (2011). "It all happened quite quickly really": emergency de-escalation in mental health crisis and violence. *Australasian Emergency Nursing Journal*, 14(3), pp. 137–140.

Public Health England, (2015). *Prescribing of psychotropic drugs to people with learning disabilities and/or autism by general practitioners in England*.

R (Munjaz) v Ashworth Hospital Authority, (2003). [2003] EWCA Civ 1036, Court of Appeal, UK.

Re F (Mental patient sterilisation), (1990). [1990] 2 AC 1, House of Lords, UK.

Radmore, A., (2013). Response by London Ambulance Service to Michael James Sweeney – Prevention of Future Deaths report. London: Courts and Tribunals Judiciary.

Reay, D., Howard, J., Fligner, C., Ward, R., (1988). Effects of positional restraint on oxygen saturation and heart rate following exercise. *The American Journal of Forensic Medicine and Pathology*, 9(1), pp. 16.

Restraint Reduction Network, (2023). Available at: https://restraintreductionnetwork.org/rrn-responds-to-new-literature-review-on-staff-training-and-physical-

interventions/#:~:text=The%20RRN%20welcomes%20efforts%20to,outcomes%20for%20people%20accessing%20services [Accessed 27 July 2024].

Richmond, J.S., Berlin, J.S., Fishkind, A.B., Holloman, G.H., Zeller, S.L., Wilson, M.P., Rifai, M.A., Ng, A.T., (2012). Verbal de-escalation of the agitated patient: consensus statement of the American Association for Emergency Psychiatry project BETA de-escalation workgroup. *West J Emerg Med*, 13(1), pp. 17–25.

Richter, D., (2006). Nonphysical conflict management and de-escalation. In: Richter, D., Whittington, R. (Eds.), *Violence in mental health settings: Causes, consequences, management*. Springer, New York, pp. 127–144.

Rimmer, A., (2021). Excited delirium: what's the evidence for its use in medicine? *British Medical Journal*, BMJ 2021;373.

Royal College of Psychiatrists, (2007). p10. Available at: https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr144.pdf?sfvrsn=73e437e8_2 [Accessed 27 July 2024].

Royal College of Psychiatrists, (2021). Statement on Excited Delirium and Acute Behavioural Disturbance, 16 July 2021. Available at: https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2021/07/16/follow-up-on-our-statement-regarding-acute-behavioural-disturbance-(abd) [Accessed 27 July 2024].

Ruttenber, A.J., McAnally, H.B., & Wetli, C.V., (1999). Cocaine-associated rhabdomyolsis and excited delirium: Different stages of the same syndrome. *American Journal of Forensic Medical Pathology*, 2, pp. 120–127.

Saheed, M., (2013). Management of agitation and violence. In: Chanmugam, A., Triplett, P., Kelen, G. (Eds.), *Emergency psychiatry*. Cambridge University Press, New York, pp. 25–40.

Safety in Custody statistics, (2022). Available at: https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-december-2021/safety-in-custody-statistics-england-and-wales-deaths-in-prison-custody-to-march-2022-assaults-and-self-harm-to-december-2021 [Accessed 27 July 2024].

Schwarz, N., (1990). Feelings as information: Informational and motivational functions of affective states. In E.H. Sorrentino (Ed.), *Handbook of motivation and cognition: Foundations of social behaviour* (Vol. 2, pp. 527–561). New York: Guilford Press.

Sim, M.G., Wain, T., Khong, E., (2011). Aggressive behaviour: prevention and management in the general practice environment. *Australian Family Physician*, 40(11), pp. 866–872.

Simpkins, D., Peisah, C., Boyatzis, I., (2016). Behavioural emergency in the elderly: a descriptive study of patients referred to an Aggression Response Team in an acute hospital. *Clinical Interventions in Aging*, 11, pp. 1559–1565.

Smith, S.B., Tutor, R.S., Phillips, M.L., (2001). Resolving conflict realistically in today's health care environment. *Journal of Psychosocial Nursing and Mental Health Services*, 39(11), pp. 36–48.

Steinert, T., Lepping, P., (2009). Legal provisions and practice in the management of violent patients: a case vignette study in 16 European countries. *Eur Psychiatry*, 24(2), pp. 135–141.

Stevenson, S., (1991). Heading off violence with verbal de-escalation. *Journal of Psychosocial Nursing and Mental Health Services*, 29(9), pp. 6–13.

Stringer, S., (2016). Safety and verbal de-escalation. In: Stringer, S., Hurn, J., Burnside, A.M. (Eds.), *Psychiatry: Breaking the ICE*. Wiley Blackwell, Chichester, pp. 19–24.

Quanbeck, C., McDermott, B.E., Lam, J., Eisenstark, H., Sokolov, G., & Scoatt, C.L., (2007). Categorization of aggressive acts committed by chronically assaultive State hospital patients. *Psychiatric Services*, 58(4), pp. 521–528.

R (on the application of AB) v Secretary of State for Justice, (2021). [2021] UKSC 28.

R (on the application of Bennett) v HM Coroner for Inner South London, (2007). [2007] EWCA Civ 617.

R (on the application of Munjaz) v Mersey Care NHS Trust, (2006). *UK House of Lords*, [2006] 2 AC 148.

Race Disparity Unit, UK Government, (2022). Available at: https://equalities.blog.gov.uk/2022/04/07/why-we-no-longer-use-the-term-bame-in-government [Accessed 27 July 2024].

Rasmussen, K., Levander, S., (1996). Individual rather than situational characteristics predict violence in a maximum-security hospital. *Journal of Interpersonal Violence*, 11(3), pp. 376–390.

Reade, C., Nourse, R., (2012). Intervening to prevent violence in psychiatric units. *Nursing*, 42(7), pp. 14–17.

Repper, J., Breeze, J., (2007). User and carer involvement in the training and education of health professionals: A review of the literature. *International Journal of Nursing Studies*, 44, pp. 511–519.

Roche, M., Diers, D., Duffield, C., Catling-Paull, C., (2010). Violence toward nurses, the work environment, and patient outcomes. *Journal of Nursing Scholarship*, 42(1), pp. 13–22.

Russell, S., (2014). Engaging undergraduate mental health nursing students in recovery-oriented practice through service user involvement: A mixed methods study. Available at: http://doras.dcu.ie/20195/1/Submitted_PhD_thesis_September_2014.pdf [Accessed 27 July 2024].

Restraint Reduction Network, (2019). Available at: https://restraintreductionnetwork.org/know-the-standard [Accessed 27 July 2024].

Restraint Reduction Network, (2019). *Training Standards*, page 11.

Ribbich v Austria, 1995. (1995) 21 EHRR 573. *European Court of Human Rights*, Strasbourg.

Rice, M.E., Helzel, M.F., Varney, G.W., Quinsey, V.L., (1985). Crisis prevention and intervention training for psychiatric hospital staff. *American Journal of Community Psychology*, 13(3), pp. 289–304.

Rich, C.R., (1997). The use of physical restraint in residential treatment: An ego psychology perspective. *Residential Treatment for Children and Youth*, 14, pp. 1–12.

Rivas v France, (2003). [2004] ECHR 131. *European Court of Human Rights*, Strasbourg.

Robinson, B., Grant, P., (2017). 'Assaults on mental health staff up 25% in four years.' *5 Live Investigates*, 8 October 2017. Available at: https://www.bbc.co.uk/news/health-41514011 [Accessed 27 July 2024].

Roche, M., Diers, D., Duffield, C., Catling-Paull, C., (2010). Violence toward nurses, the work environment, and patient outcomes. *Journal of Nursing Scholarship*, 42(1), pp. 13–22.

Rogers, P., Ghroum, P., Benson, R., Forward, L., & Gournay, K., (2006). Is breakaway training effective? An audit of one medium secure unit. *Journal of Forensic Psychiatry and Psychology*, 17(4), pp. 593–602.

Rogers, P., Miller, G., Paterson, B., Bonnett, C., Turner, P., Brett, S., Flynn, K., & Noak, J., (2007). Is breakaway training effective? Examining the evidence and the reality. *The Journal of Mental Health Training, Education and Practice*, 2, pp. 5–12.

Royal College of Emergency Medicine, (2022). Best Practice Guideline, "Acute Behavioural Disturbance in Emergency Departments", February 2022.

Royal College of Nursing, (2013). Annual Congress, Liverpool.

Royal College of Nursing, (2018). Speech delivered to the Royal College of Nursing, "My mission to make sure NHS staff feel safe and secure at work".

Royal College of Psychiatrists, (2007). *Royal College of Psychiatrists, British Psychological Society, Royal College of Speech and Language Therapists 'Challenging behaviour – a unified approach'*.

Royal College of Psychiatrists, (2021). Available at: https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2021/06/09/joint-statement-intellectual-disabilities-is-everyones-business?searchTerms=winterbourne [Accessed 27 July 2024].

Royal Opera House Covent Garden Foundation v Goldscheider, (2019). [2019] EWCA Civ 711. *UK Court of Appeal, Civil Division*.

Ruttenber, A., Lawler-Heavner, J., Yin, M., Wetli, C.V., Hearn, W., Mash, D., (1997). Fatal excited delirium following cocaine use: epidemiologic findings provide new evidence for mechanisms of cocaine toxicity. *J Forensic Sci*, 42, pp. 25–31.

Ruttenber, A., McAnally, H., & Wetli, C., (1999). Cocaine-associated rhabdomyolsis and excited delirium: Different stages of the same syndrome. *American Journal of Forensic Medical Pathology*, 2, pp. 120–127.

Ryan, C.J., Bowers, L., (2005). Coercive manoeuvres in a psychiatric intensive care unit. *Journal of Psychiatric and Mental Health Nursing*, 12(6), pp. 695–702.

Sacks-Jones, K., (2017). The Last Resort, *Criminal Law and Justice Weekly*, 180, pp. 223–224.

Safety in Custody Statistics, (2018). *Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to December 2018*.

Security Industry Authority, (2020). *First Aid Training for private security personnel*. Home Office.

Sequeira, H., and Halstead, S., (2001). "Is It Meant To Hurt, Is It?" Management of violence in women with developmental disabilities. *Violence Against Women*, 7(4), pp. 462–476.

Sethi, F., Parkes, J., Baskind, E., Paterson, B., & O'Brien, A., (2018). Restraint in mental health settings: Is it time to declare a position? *The British Journal of Psychiatry*, 212(3), pp. 137–141. doi:10.1192/bjp.2017.31.

Shaw v Northumberland County Council, (2019). *Newcastle-upon-Tyne County Court*, His Honour Judge Freedman.

Sheldon, M., (2006). The use of pulse oximetry in response to violence. *Mental Health Practice*, 9, pp. 32–35.

Shepherd, R., (2003). Dr Richard Shepherd, Consultant Forensic Pathologist, evidence to the Bennett Inquiry.

Sjöström, N., Eder, D., Malm, U., Beskow, J., (2001). Violence and its prediction at a psychiatric hospital. *European Psychiatry*, 16(8), pp. 459–465.

Smallridge, P., & Williamson, A., (2008). *Independent Review of Restraint In Juvenile Secure Settings*. London: HMSO.

Somes, J., Donatelli, N.S., Kuhn, S., (2011). Controlling aggressive behaviour in the geriatric patient. *Journal of Emergency Nursing*, 37(3), pp. 275–277.

Soininen, P., Putkonen, H., Joffe, G., Korkeila, J., Puukka, P., Pitkänen, A., Välimäki, M., (2013). Does experienced seclusion or restraint affect psychiatric patients' subjective quality of life at discharge? *International Journal of Mental Health Systems*, 7, pp. 28.

Sourander, A., Ellilä, H., Välimäki, V., & Piha, J., (2002). Use of holding, restraints, seclusion and time-out in child and adolescent psychiatric in-patient treatment. *European Child & Adolescent Psychiatry*, 11, pp. 162–167.

Spector, P.E., Zhou, Z.E., Che, X., (2014). Nurse exposure to physical and nonphysical violence, bullying, and sexual harassment: A quantitative review. *International Journal of Nursing Studies*, 51(1), pp. 72–84.

Speers, J., & Lathlean, J., (2015). 'Service user involvement in giving mental health students feedback on placement: a participatory action research study. *Nurse Education Today*, doi: 10.1016/j.nedt.2015.07.004. Available at: http://oro.open.ac.uk/43877/ [Accessed 27 July 2024].

Steinert, T., & Lepping, P., (2009). Legal provisions and practice in the management of violent patients. A case vignette study in 16 European countries. *European Psychiatry*, 24, pp. 135–141.

Stewart, D., Bowers, L., Simpson, A., Ryan, C., & Tziggili, M., (2009). Mechanical restraint of adult psychiatric inpatients: A literature review. Report from the Conflict and Containment Reduction Research Programme. *City University, London*.

Stewart, D., Bowers, L., Ross, J., (2012). Managing risk and conflict behaviours in acute psychiatry: the dual role of constant special observation. *Journal of Advanced Nursing*, 68(6), pp. 1340–1348.

Stirling, C., & McHugh, A., (1998). Developing a non-aversive intervention strategy in the management of aggression and violence for people with learning disabilities using natural therapeutic holding. *Journal of Advanced Nursing*, 27, pp. 503–509.

Storck v Germany, (2005). (2005) 43 EHRR 96. *European Court of Human Rights*, Strasbourg.

Stratton, S., Rogers, C., Brickett, K., Gruzinski, G., (2001). Factors associated with sudden death of individuals requiring restraint for excited delirium. *Am J Emerg Med*, 19, pp. 187–191.

Stubbs, B., (2009). The manual handling of the aggressive patient: a review of the risk of injury to nurses. *Journal of Psychiatric and Mental Health Nursing*, 16, pp. 395–400.

Stubbs, B., Knight, C., & Yorston, G., (2008). Physical interventions for managing aggression in mental health: should physiotherapists be involved? *International Journal of Therapy and Rehabilitation*, 15, pp. 8–12.

Sullivan, C., & Yuan, C., (1995). Workplace assaults on minority health and mental health care workers in Los Angeles. *American Journal of Public Health*, 85(7), pp. 1011–1014.

Tamsen, F., & Thiblin, I., (2014). Deaths during apprehensions of agitated persons. A review of proposed pathophysiological theories. *Scandinavian Journal of Forensic Science*, 20(1), pp. 3–8.

Turnbull, J., Aitken, I., Black, L., Patterson, B., (1990). Turn it around: short-term management for aggression and anger. *Journal of Psychosocial Nursing and Mental Health Services*, 28(6), pp. 6–10, 13.

Tyrer, P., Kendall, T., (2023). *Anticipation and Reduction of Violence*. Cambridge University Press.

Van der Bijl, N., (2019). *National Association for Healthcare Security*, London, in Professional Security Magazine "Zero Marks for NHS on Reducing Violence".

Vilke, G., Mash, D., Pardo, M., Bozeman, W., Hall, C., Sloane, C., *et al*., (2019). Excitation study: Unexplained in-custody deaths: Evaluating biomarkers of stress and agitation. *Journal of Forensic and Legal Medicine*, 66, pp. 100–106.

Vilke, G.M., DeBard, M.L., Chan, T.C., *et al.*, (2012). Excited delirium syndrome (ExD): defining based on a review of the literature. *J Emerg Med*, 43, pp. 897–905.

Vilke, G.M., Payne-James, J., & Karch, S.B., (2012). Excited delirium syndrome: Redefining an old diagnosis. *Journal of Forensic and Legal Medicine*, 19(1), pp. 7–11.

Vilke, G.M., Sloane, C., Castillo, E.M., Kolkhorst, F.W., Neuman, T.S., Chan, T.C., (2011). Evaluation of the ventilatory effects of a restraint chair on human subjects. *J Emerg Med*, 40, pp. 714–718.

Waite, J., Brown, J., (2023). *Management of Violence in Older Adults*. Cambridge University Press.

Wand, T.C., Coulson, K., (2006). Zero tolerance: a policy in conflict with current opinion on aggression and violence management in health care. *Australasian Emergency Nursing Journal*, 9(4), pp. 163–170.

Ward-Stockham, K., Kapp, S., Jarden, R., Gerdtz, M., Daniel, C., (2022). Effect of Safewards on reducing conflict and containment and the experiences of staff and consumers: A mixed-methods systematic review. *International Journal of Mental Health Nursing*, 31, pp. 199–221.

Weissberg, K.D., (2018). Physical restraint defined. *Physical Therapy*, Houston, Texas, USA.

Welsh Assembly Government, (2004). *All Wales NHS Violence and Aggression Training Passport and Information Scheme*.

Welsh Assembly Government, (2005). *Framework for Restrictive Physical Intervention Policy and Practice*.

West Bromwich Building Society v Townsend, (1983). [1983] ICR 257.

West Sussex County Council v Fuller, (2015). [EWCA Civ 189]. *UK Court of Appeal, Civil Division*.

Whitfield, J., (2010). In *The Great British Bobby: A History of British Policing From the 18th Century to the Present*, Emsley, C. (Ed.), Quercus Books, London, pp. 289–290.

Whitmore, (2017). *Coaching for Performance, The Principles and Practice of Coaching and Leadership*, International Coach Federation, Nicholas Brealey Publishing, Boston, Massachusetts, USA.

Whittington, R., Wykes, T., (1996). An evaluation of staff training in psychological techniques for the management of patient aggression. *Journal of Clinical Nursing*, 5(4), pp. 257–261.

Whittington, R., Bowers, L., Nolan, P., Simpson, A., & Neil, L., (2009). Approval ratings of inpatient coercive interventions in a national sample of mental health service users and staff in England. *Psychiatric Services*, 60(6), pp. 792–798.

Williams (Gladstone), (1984). 78 Cr App Rep 276. *Court of Appeal, London*.

Winnicott, D. W., (1965). *The Maturational Process and the Facilitating Environment*. New York: International University Press.

Winship, G., (2006). Further thoughts on the process of restraint. *Journal of Psychiatric and Mental Health Nursing*, 13, pp. 55–60.

Winston, M., Fleisig, N., Winston, L., (2009). The Premature Call for a Ban on Prone Restraint: A Detailed Analysis of the Issues and Evidence. *The Professional Crisis Management Association*, USA.

Winterbourne View Serious Case Review, (2012). Winterbourne View Hospital, A Serious Case Review, 2012.

World Health Organisation, (2002). *World Report on Violence and Health*, Resolution WHA49.25 of the 49th World Health Assembly, 1996, Geneva.

Wright, S., Gray, R., Gournay, K., (2002). The recognition, prevention and therapeutic management of violence in acute in-patient psychiatry: a literature review and evidence-based recommendations for good practice. *United Kingdom Central Council for Nursing, Midwifery and Health Visiting*, London.

Y.F. v Turkey, (2003). (2003) 39 EHRR 715. *European Court of Human Rights*, Strasbourg.

Yamamoto, Y., Mutoh, Y., Kobayashi, H., & Miyashita, M., (1987). Effects of reduced frequency breathing on arterial hypoxemia during exercise. *European Journal of Applied Physiology and Occupational Physiology*, 56(5), pp. 522–527. doi: 10.1007/BF00635364.

Yamamoto, Y., Takei, Y., Mutoh, Y., & Miyashita, M., (1988). Delayed appearance of blood lactate with reduced frequency breathing during exercise. *European Journal of Applied Physiology and Occupational Physiology*, 57(4), pp. 462–466. doi: 10.1007/BF00417994.

Yerkes, R.M., Dodson, J.D., (1908). "The relation of strength of stimulus to rapidity of habit-formation". *Yerkes-Dodson Law*, Journal of Comparative Neurology and Psychology, 18, pp. 459–482. doi: 10.1002/cne.920180503.

Youth Rights UK, (2007). The death of Gareth Myatt, http://www.youth-rights-uk.org [Accessed 27 July 2024].

Ziaei, M., Massoudifar, A., Rajabpour-Sanati, A., Pourbagher-Shahri, A., Abdolrazaghnejad, A., (2019). Management of Violence and Aggression in Emergency Environments: a Narrative Review of 200 Related Articles. *Advanced Journal of Emergency Medicine*, 3(1):e7. doi: 10.22114/AJEM.v0i0.117.

Zaslow, R. W., & Breger, L., (1969). A theory and treatment of autism. In Breger, L. (Ed.), *Clinical-cognitive psychology: Models and integrations* (pp. 246–291). Englewood Cliffs, NJ: Prentice Hall.

Zaslow, R. W., & Menta, M., (1975). *The psychology of the Z process: Attachment and activation*. San Jose, CA: San Jose State University Press.

Appendix 1 – Legal considerations

Introduction

It would not be possible to formulate an ethical, therapeutic and safer approach to managing challenging and violent behaviours without exploring the legal considerations that apply. This chapter explores the various, and sometimes conflicting, legal issues that arise. It is essential, therefore, that staff and managers have a thorough grasp of the legal issues, not least because "*[s]ome services use overly restrictive practices because they lack understanding of the legislation*" (Care Quality Commission 2017-2018, page 16). This lack of understanding is not limited to healthcare settings and can be seen across all sectors.

There is no single source of law that sets out the various duties, liabilities, defences and other legal matters relating to PMVA. This is because, depending on the circumstances, numerous pieces of legislation, and case law, will be in play.

It is widely understood that the use of force against another person must be 'reasonable' for it to be lawful (Criminal Law Act 1967, section 3(1); Criminal Justice and Immigration Act 2008, section 76). But the law also talks about 'necessity' and contrasts the use of force with other kinds of intervention, such as solitary confinement (*Mathew v Netherlands* (2006). In *Mathew*, the applicant complained under Article 3 both that he had been kept in solitary confinement, and that violence in the form of physical restraint had been inflicted upon him by prison staff. In relation to the complaint concerning the use of physical force, the court applied a test of 'strict necessity' (paras 176-179) whereas the court applied no such test in relation to the complaint concerning solitary confinement, but instead followed the same approach as in later cases such as *Ramirez-Sanchez* and *Ahmad*. This position has been followed by the UK Supreme Court *(R (on the application of AB) v Secretary of State for Justice* (2021)).

The legislation, case law, codes of practice and various pieces of guidance are not always easy to reconcile which is made more difficult due to separate, and often conflicting, interests being considered. In the straightforward case of an elderly patient who needs their arms restraining (holding) due to their state of confusion the interests of the patient and the staff are perfectly aligned. This situation can be contrasted with a patient who has attacked medical staff in the emergency department as a result of having to wait his turn to be treated. In this case, although

the medical staff owe him a duty of care, they are also entitled to use reasonable force to protect themselves, others and property.

The principal pieces of legislation that affect or touch upon matters relating to PMVA are the Criminal Law Act 1967, section 3(1); Criminal Justice and Immigration Act 2008, sections 76 and 119-122; Mental Health Acts 1983 and 2007; Mental Capacity Act 2005; Health and Safety at Work etc. Act 1974; Manual Handling Operations Regulations 1992; Management of Health and Safety at Work Regulations 1999; and the Assaults on Emergency Workers (Offences) Act 2018. In addition, the Mental Health Units (Use of Force) Act 2018 is an important piece of legislation although its application is limited to mental health units as defined therein.

Before examining the various pieces of legislation it is necessary to consider the position of staff injured as a result of workplace violence. In what circumstances will their employer be held liable so that their injured employee can recover damages? The answer to this question is found largely in the Health and Safety at Work etc. Act 1974 and in common law, both of which are discussed in the next section. But, it should be noted at the outset, that where the employer has provided the employee with appropriate and adequate training, he will not be liable for injuries sustained by an employee assaulted by a service user to whom the employee was providing care (Baskind 2006). Neither will an employer be held liable in circumstances where the employee's injury came about as a result of an unforeseeable act or where further training would not have prevented the injury (*Shaw v Northumberland County Council* 2019). Reasonable foreseeability alone will not be sufficient to establish liability; the chances of an accident occurring, the potential seriousness of it, and the measures that could be taken to minimise risk or avoid the accident must also be considered (*Lewis v Wandsworth London Borough Council* 2020).

The question of what training should be provided is important as it informs the courts whether or not the training was adequate and whether or not there has been a breach of duty. Questions of prohibitions of certain kinds of intervention, and the legal implications, will be discussed later in this thesis but for present purposes it is important to note that to discharge the duty of care owed to patients, organisations must be able to identify and properly manage the risks flowing from any foreseeable circumstances. Consequently, it is important to provide staff with the necessary training to help them identify and manage these risks as they occur operationally whether or not certain kinds of intervention have been prohibited or discouraged by policy or guidance.

Health and Safety at Work etc. Act 1974

There is a host of legislation that emphasises the legal duty to protect staff from violence and aggression. Section 2(1) of the Health and Safety at Work etc. Act 1974, provides that employers have a legal duty "to ensure, so far as is reasonably practicable, the health, safety and welfare at work of all his employees". This duty includes the provision of systems of work that are, so far as is reasonably practicable, safe and without risks to health (section 2(2)(a)); the provision of such information, instruction, training and supervision as is necessary to ensure, so far as is reasonably practicable, the health and safety at work of his employees (section 2(2)(c)); and the provision and maintenance of a working environment for his employees that is, so far as is reasonably practicable, safe, without risks to health, and adequate as regards facilities and arrangements for their welfare at work (section 2(2)(e)).

The repeated use of the words "so far as is reasonably practicable" make clear that the duty is not absolute but involves "weighing a risk against the trouble, time and money needed to control it" (Health & Safety Executive). The concept of "reasonably practicable" lies at the heart of the British health and safety system and plays an important part of the general duties of the Health and Safety at Work etc. Act 1974 as well as the regulations applicable to health and safety.

The Court of Appeal has commented on the meaning of 'reasonable practicable: *"Reasonably practicable" is a narrower term than "physically possible" and seems to me to imply that a computation must be made by the owner, in which the quantum of risk is placed on one scale and the sacrifice involved in the measures necessary for averting the risk (whether in money, time or trouble) is placed in the other; and that if it be shown that there is a gross disproportion between them - the risk being insignificant in relation to the sacrifice - the defendants discharge the onus on them.* (Edwards v National Coal Board (1949).

Given that the legal test therefore concerns the weighing of the risk against the sacrifice needed to further reduce it, the employer's decision needs to be weighted in favour of health and safety because of the presumption that the duty-holder should implement the risk reduction measure. The duty-holder may be able to avoid making such a sacrifice by showing that it would be grossly disproportionate to any benefits of risk reduction that would be achieved. A more accurate way of summarising the risk-sacrifice debate is not one of balancing the costs and

benefits of measures but of implementing measures except where they can reasonably be ruled out because they involve grossly disproportionate sacrifices.

The application of the above to a case where it had to be decided whether or not it was reasonably practicable to erect anti-bandit screens in a building society can be seen from the judgment of Mr Justice McNeill in *West Bromwich Building Society v Townsend* (1983), Townsend, an Environmental Health Officer, had served on the Building Society an improvement notice which stated that the Building Society was in breach of section 2(1) of the Health and Safety at Work etc. Act 1974 in that "staff engaged in the handling of money and in general office duties in the premises are not properly protected so far as is reasonably practicable from the risk of attack or personal injury from persons frequenting the area of the premises normally opened to the general public". The improvement notice required the Building Society to fit anti-bandit screens. At first instance, the tribunal found that the risk to employees from robberies was more than minimal and that the measures required by the notice were both physically and financially within the Building Society's capability. The tribunal, therefore, upheld the improvement notice. The Building Society appealed the tribunal's decision to the High Court which allowed the appeal and held that it is not sufficient merely to establish that it was *physically* practicable to fit anti-bandit screens but it is also relevant to consider whether in all the circumstances it would have been *reasonable* for such measures to have been taken. This necessarily requires an examination of what the employer has done to safeguard workers. In this case, the Building Society had under continual consideration the question of how best to protect their staff against the risk from violent criminals and that after having considered the situation carefully and discussed it with their insurers as well as with their staff association they were not convinced of the value of fitting anti-bandit screens. Further, the evidence was such that staff were instructed not to offer any resistance if threatened with violence (West Bromwich Building Society v Townsend, 1983).

The question of risk is often a matter of balance. Section 3(1) of the Health and Safety at Work etc. Act 1974 should be read alongside section 2(1) as this section provides that employers must conduct their undertaking to ensure that persons who are *not in their employment* but who may be affected by their actions are not exposed to risks to their health or safety. Therefore, it is necessary to consider all the effects of implementing preventive measures. For example, anti-bandit screens in a building society may well protect staff but may also create a corresponding risk to customers who must also be considered under section 3(1).

An employer is required to take such steps that are reasonable in all the circumstances to eliminate the risk (*Keys v Shoefayre Ltd,* 1978). In this case, the applicant worked part-time in a shoe shop in Peckham. One afternoon in April 1977 the shop was robbed by a number of youths. Following the robbery, the applicant spoke to her district manager to ask what he could do to ensure staff safety. When the district manager said there was nothing he could do the applicant replied that she would look for another job. Less than a month later, the shop was again robbed. After this second robbery, the applicant did not return to work and claimed that, in view of her employer's failure to take steps to improve security and safety at the shoe shop, she had been constructively dismissed. The Industrial Tribunal held that the applicant was entitled to treat the respondent's failure to take steps to improve security at the shop as conduct entitling her to resign and claim that she had been constructively dismissed. The Tribunal noted that it is a fundamental term of an employee's contract of employment that the employer will take reasonable care to operate a safe system of work and ensure that the premises are reasonably safe. If, in an area where crime is rife and violent crime is known, an employer fails to take any precautions to protect staff, the employer is guilty of a breach of this term. The Tribunal said that it was no answer that other employers with similar shops in the area had also failed to take precautions to safeguard their staff.

Substantial compensation was paid in an out-of-court settlement to the employee in *Ingram v Worcestershire County Council* (2000). In this case, the employee was a council worker who supervised a travellers' campsite as a warden and was attacked by residents of the site after the council changed its policies on the treatment of the residents. Other council workers also undermined his decisions. He also had dogs set on him and was shot at and unable to work from 1997 onwards. He was inadequately protected by his employers.

In *Charlton v The Forrest Printing Ink Co Ltd* (1980) an employee received serious eye injuries when he was robbed and sprayed with ammonia whilst collecting money from the bank to pay the company's wages. The amount of money which was collected during these journeys was between £1,500 and £2,000. Following an earlier unsuccessful robbery the company's managing director reviewed the security position and decided that it would be safer for some of the wages to be collected from a bank which was more local to one of the company's offices. The managing director implemented a number of security measures such as the varying of the route taken, the use of different methods of transport, and the sending of different people to collect the money. However, after a short time, the claimant and one other employee were

usually the people who collected the wages from the bank using a set pattern. The Court of Appeal reversed the judgment of Forbes J who had held that the company was liable in damages to the claimant on the ground that they failed in their duty to take reasonable care for his safety in that they should have employed a firm of security specialists to collect the wages from the bank. The Court of Appeal held that the company had taken proper steps to instruct the claimant in the need to vary the method used for collecting the money from the bank and that it was not necessary to employ security specialists to collect such small sums of money as were involved in this case. The company was, therefore, not liable to the claimant.

In *McGinnes v Endeva Service Ltd* (2006) the pursuer[9] was a field service engineer employed by the defender[10]. He was carrying out a television repair when he was attacked by two men with knives and sustained serious injuries. He alleged that his employers were in breach of their common law duty of care to provide him with a safe system of work where, in a known dangerous area, the allocated repair should have been designated as a two-man job or at least a system should have been in place whereby the assistance of a second man could have been requested. He submitted that the double-manning system that his employers had previously operated demonstrated both acceptance of the relevant risk to employees' safety in particular areas and the protective measures that were reasonably required. He also argued that the employer's decision to discontinue that system, without carrying out a risk assessment or formally notifying employees of the change, meant that the onus was on them to show that any arrangements in place at the material time still fulfilled their common law duty to take reasonable care for his safety. His action failed. The court held that the onus was on the employer to prove that, at the material time, his employers were in breach of their common law duty of care to take reasonable care for his safety, and, but for that breach, that the assault would have been avoided. The court noted that while the history of events could legitimately be considered, negligence on the employer's part at the time of the incident could not be established by simply showing that an allegedly safe system was in place at some earlier stage. The court held that the evidence fell well short of what would be required to show, on the balance of probabilities, that the employers were in breach of their common law duty of reasonable care for his safety and it would not be fair, just or reasonable to impose a legal duty on them to do more in that connection. The pursuer had failed to prove that the foreseeable risk of a field service engineer being criminally assaulted at the particular destination was so great

[9] The Scottish equivalent of Claimant
[10] The Scottish equivalent of Defendant

as to justify the double-manning system for which he contended. The existence of an automatic double-manning system in and before 2001 and the apparent failure to carry out a risk assessment on reverting to a request-based system could have no more than an incidental bearing on whether the employer's arrangements in place at the material time were adequate to fulfil their duty of reasonable care and the fact that the pursuer did not request any assistance for an early morning job weighed heavily against his claim that double-manning in the area was obviously necessary. Further, the pursuer fell well short of satisfying the legal test for causation where, at best, the presence of a second man might have reduced the risk of criminal assault to some degree but any reduction would not have been sufficiently material to bring him close to proving that, but for the absence of a second man, he probably would not have been assaulted.

Although much of the focus is on sections 2 and 3 of the Health and Safety at Work etc. Act 1974, section 7 must not be overlooked. Section 7 lays down the general duties of employees at work and provides that "it shall be the duty of every employee while at work to take reasonable care for the health and safety of himself and of other persons who may be affected by his acts or omissions at work". Section 7 makes it clear that an individual can be held accountable for their own actions whilst at work. It also imposes a duty on the employee to co-operate with their employer (so far as is necessary) to enable the employer to comply with their own duties under sections 2 and 3. Where the employer has taken all reasonably practicable steps to ensure compliance then action against the employee should be considered under section 7 (Health and Safety Executive, 2017).

In practical terms, this means that employees are required to obey any policies or procedures that are put in place by their employer for the purpose of ensuring the health, safety and welfare of the workforce whilst at work. But what if these policies or procedures are themselves unsafe? For example, the author has dealt with a number of cases where staff have been instructed by their employers to deal incidents in a particular, but unacceptable, way. This has included a case where the employer has an absolute no-restraint policy and another case, where the employer prohibited its staff from using prone restraint and pain-compliance techniques. If harm results from the employee following such unsafe policies or procedures, he is liable to face prosecution under section 7. Guidance notes from the Health & Safety Executive indicate that consideration for potential prosecution under section 7 should take account of how other employees were conducting themselves. If a number of employees were acting in the same

unsafe manner then the HSE indicate that liability should rest with the employer, rather than against the individual employees under section 7, for allowing an unsafe culture to develop in the workplace. This conundrum can only be settled by the court. However, HSE inspectors are required to supply certain information on health, safety and welfare matters including enforcement action to employees or their representatives (Health & Safety at Work etc Act 1974, section 28(8)).

Section 69 of the Enterprise and Regulatory Reform Act 2013

Section 69 of the Enterprise and Regulatory Reform Act 2013 has significantly changed the landscape of health and safety personal injury law. It came into force on 1 October 2013 and impacts on causes of action after that date. It amends the law such that a breach of duty imposed by health and safety regulations will no longer be actionable in the civil courts unless the regulation says so. It does this by amending s.47 HSWA. Section 47 provided that:

"Breach of a duty imposed by health and safety regulations…shall so far as it causes damage, be actionable except in so far as the regulations provide otherwise".

An employee will now only succeed in a claim for breach of statutory duty if the regulation expressly says they can. This means the employee must prove that the employer was negligent rather than was merely in breach of the HSWA. Thus, strict liability has been removed. Section 69 provides:

"(2) Breach of a duty imposed by a statutory instrument containing (whether alone or with other provision) health and safety regulations shall not be actionable except to the extent that regulations under this section so provide. (2A) Breach of a duty imposed by an existing statutory provision shall not be actionable except to the extent that regulations under this section so provide (including by modifying any of the existing statutory provisions)."

The above legislative amendment is significant. Claimants will doubtless seek to rely on breaches of health and safety legislation as *evidence* of negligence but such breaches are not, without more, *proof* of negligence.

Management of Health and Safety at Work Regulations 1999

Regulation 3(1) of the Management of Health and Safety at Work Regulations 1999 requires every employer to make a suitable and sufficient assessment of the risks to the health and safety

of its employees to which they are exposed whilst they are at work and the risks to the health and safety of persons not in its employment arising out of or in connection with the conduct by him of his undertaking. The requirement for a risk assessment extends to those who are self-employed (regulation 3(2)). Every self-employed person is required to make a suitable and sufficient assessment of the risks to his own health and safety to which he is exposed whilst he is at work and the risks to the health and safety of persons not in his employment arising out of or in connection with the conduct by him of his undertaking.

The assessments required under section 3 need to be reviewed by the employer or self-employed person who made it if there is reason to suspect that it is no longer valid or there has been a significant change in the matters to which it relates and, where as a result of any such review changes to an assessment are required, the employer or self-employed person concerned shall make them (regulation 3(3)). The risk assessment must be recorded in writing in cases where the employer employs five or more employees. This written record must record the significant findings of the assessment and any group of its employees identified by it as being especially at risk (regulation 3(6).

In addition to the formal risk assessment process, staff should always dynamically risk assess a situation before acting. A dynamic risk assessment is 'the continuous assessment of risk in the rapidly changing circumstances of an operational incident, in order to implement the control measures necessary to ensure an acceptable level of safety' (HM Fire Service Inspectorate, 1998). Dynamic risk assessments are discussed in various parts of this thesis.

For present purposes, the risks noted in the Regulations include the risk of harm from violence and aggression. In practical terms, employers also need to establish procedures to be followed in the event of serious or imminent danger, and provide information and training on health and safety risks and control measures. There have been several prosecutions of NHS organisations for failing to adequately follow these procedures. In one of the most significant, St George's Mental Health NHS trust in South London was fined £28,000 with £14,000 costs after a nurse was killed by a psychiatric patient. The junior member of staff was working alone at some distance from other staff members, without clear procedures and with inadequate measures to check on his safety. In other cases trusts have been fined for not adequately assessing risks and failing to implement procedures. Staff members who are the victims of an assault may also sue their employers for compensation. In one case, a healthcare assistant sued after she was attacked by a psychiatric patient while she delivered coffee to colleagues in a seclusion suite.

The court heard that the risk to her could have been lessened by not letting the man out of his room.

Furthermore, staff have no obligation to intervene if the situation is one of "serious, imminent and unavoidable danger" and the employer must in such a case enable staff to stop work and proceed to a place of safety (reg 8(2)(b) and(c)). Staff will be protected against any detrimental action taken by their employers in cases where the employee reasonably believed that he was in serious or imminent danger and, as a result, he left (or proposed to leave) or, while the danger persisted, he refused to return to his place of work or if he took, or proposed to take, appropriate steps to protect himself or other persons from the danger (sections 44(1)(d) and (e) of the Employment Rights Act 1996) and should the employer dismiss him as a result of the above, such dismissal will constitute unfair dismissal (section 100(1)(d) and (e) Employment Rights Act 1996).

The Regulations also require employers, in entrusting tasks to its employees, to take into account their capabilities as regards health and safety (regulation 13(1)). This requires employers to ensure that their employees are provided with adequate health and safety training, on their being recruited into the employer's undertaking and on their being exposed to certain new or increased workplace risks (regulation 13(2)).

This training must be repeated periodically where appropriate, be adapted to take account of any new or changed risks to the health and safety of the employees concerned and be provided during working hours (regulation 13(3)). This is known as "refresher training". There is no legal requirement to provide refresher training at any given interval although it is generally accepted that it should be provided annually (Baskind 2014). This is despite a study prepared by the University of Nottingham for the Health and Safety Executive (Health and Safety Executive 2006) observing that:

What is clear is that any benefit of training is largely lost within a matter of months.

The study measured the "perceived capability of the individual him/herself to deal with a physical attack (PCPA) originating in a variety of situations and contexts to do with clients, patients and other members of the public" and concluded that the PCPA fell significantly in the three months post training. The only way of reconciling the optimal three-monthly "need" for refresher training with the 12-monthly interval commonly seen in all settings throughout

the UK is that employers simply cannot afford the staff absences that would result from three-monthly training intervals (Baskind 2014).

In practice, where the employer fails to assess and act against a risk of injury a court is likely to cast the evidential burden on it to show that protective steps would not have been effective (see, for example, Brown v Corus (2004), Ghaith v Indesit (2012), West Sussex County Council v Fuller (2015) and Royal Opera House v Goldscheider (2019)). This will prove difficult for many employers.

Mental Health Units (Use of Force) Act 2018

Commonly referred to as 'Seni's Law', the Mental Health Units (Use of Force) Act started its life as a Private Members' Bill sponsored by Mr Steve Reed MP and was inspired by the death of Mr Olaseni (*'Seni'*) Lewis, who died on 4 September 2010, aged 23, after he was restrained by 11 police officers at a mental health ward in Bethlem Royal Hospital, Beckenham. At an inquest into Mr Lewis's death in 2017, the restraint which had been used was deemed to be *"excessive, unreasonable and disproportionate"* whilst the actions of healthcare staff and police were condemned.

Receiving Royal Assent on 1 November 2018, the Act extends to England and Wales only and its provisions came into force as follows: Section 11(3), which requires the Secretary of State to consult prior to publishing guidance under section 11(1) about functions under that Act came into force on 28 October 2019 (Mental Health Units (Use of Force) Act 2018 Commencement (No. 1) Regulations 2019). The remaining provisions of the Act came into force on 31 March 2022, except for sections 7 (statistics prepared by mental health units), 8 (annual report by the Secretary of State), 12 (police body cameras), 14 (transitional provision), and the following provisions which were already in force: section 11(3) (consultation on guidance) which came into force on 28 October 2019 and sections 16 (regulations) and 17 (commencement, extent and short title) which came into force on 1 November 2018 (Mental Health Units (Use of Force) Act 2018 (Commencement No. 2) Regulations 2021).

This new legislation will result in implementation costs for the Department of Health and Social Care and for mental health units. This will be paid out of money provided by Parliament and will include any expenditure incurred under or by virtue of the Act as well as any increase attributable to the Act in the sums payable under any other Act. For the Department this will include costs relating to publication of reports and for mental health units this will include costs

relating to the preparation of statistics and record-keeping. The estimated costs (discounted) range from £1.8 million in year 1 to £1.0 million in year 10, and amount to £12.1 million over a 10-year period (Explanatory notes to the Mental Health Units (Use of Force) Bill 2017-2019, paragraph 65).

A key purpose of the Act is to increase the oversight and management of the use of force in mental health units by imposing a number of requirements around the use of force in such units. The Act also requires police officers attending these units to wear and operate body-worn cameras if reasonably practicable although curiously there is no corresponding requirement for medical staff and others to do likewise. This is particularly disappointing since the majority of uses of force will be carried out otherwise than by police officers. The Act also places positive obligations on such units to provide policies, information and training in the appropriate use of force and to provide techniques for avoiding, and strategies for reducing, the use of force.

The Act introduces a number of key provisions. These include that mental health units will need to appoint a 'responsible person' for purposes relating to the Act (section 2(1)). This person needs to be employed by the relevant health organisation (section 2(2)(a)) and be of an appropriate level of seniority (section 2(2)(b)). The responsible person for each mental health unit must publish a policy regarding the use of force by staff who work in that unit (section 3(1)) and must also publish information for patients about their rights in relation to the use of force by staff (section 4(1)). The published policy must set out what steps will be taken to reduce the use of force in the mental health unit by staff who work in that unit (section 3(7)). The responsible person for each mental health unit must provide training for staff that relates to the use of force by staff who work in that unit (section 5(1). This training must include training on how to involve patients in the planning, development and delivery of care and treatment in the mental health unit (section 5(2)(a)), showing respect for patients' past and present wishes and feelings (section 5(2)(b)) including showing respect for diversity generally (section 5(2)(c)), avoiding unlawful discrimination, harassment and victimisation (section 5(2)(d)), the use of techniques for avoiding or reducing the use of force (section 5(2)(e)) and the risks associated with the use of force (section 5(2)(f)), the impact of trauma (whether historic or otherwise) on a patient's mental and physical health (section 5(2)(g)), the impact of any use of force on a patient's mental and physical health (section 5(2)(h)), the impact of any use of force on a patient's development (section 5(2)(i)), how to ensure the safety of patients and the public (section 5(2)(j)), and the principal legal or ethical issues associated with the use of force (section 5(2)(k)).

The responsible person for each mental health unit must keep a record of any use of force by staff who work in that unit (section 6(1)), although this will not be required if the use of force is negligible (section 6(2)). What amounts to negligible in this regard is to be determined in accordance with guidance published by the Secretary of State (section 6(3)). These records must be kept by the responsible person for 3 years from the date on which they were made (section 6(6)). The detail to be recorded on the records are comprehensive and must include the reason for the use of force (section 6(5)(a)); the place, date and duration of the use of force (section 6(5)(b)); the type or types of force used on the patient (section 6(5)(c)); whether the type or types of force used on the patient formed part of the patient's care plan (section 6(5)(d)); the name of the patient on whom force was used (section 6(5)(e)); a description of how force was used (section 6(5)(f)); the patient's consistent identifier (section 6(5)(g)): this being the consistent identifier specified under section 251A of the Health and Social Care Act 2012; the name and job title of any member of staff who used force on the patient (section 6(5)(h); the reason any person who was not a member of staff in the mental health unit was involved in the use of force on the patient (section 6(5)(i)); the patient's mental disorder, if known (section 6(5)(j)); the relevant characteristics of the patient, if known (section 6(5)(k)); whether the patient has a learning disability or autistic spectrum disorders (section 6(5)(l)); a description of the outcome of the use of force (section 6(5)(m)); whether the patient died or suffered any serious injury as a result of the use of force (section 6(5)(n)); any efforts made to avoid the need to use force on the patient (section 6(5)(o)); and whether a notification regarding the use of force was sent to the person or persons (if any) to be notified under the patient's care plan (section 6(5)(p)). The patient's 'relevant characteristics' relate to their age, whether they have a disability (and if so, the nature of that disability); their status regarding marriage or civil partnership; whether they are pregnant; their race, religion or belief; and their sex and sexual orientation (section 6(10)).

The Secretary of State must ensure that at the end of each year statistics are published regarding the use of force by staff who work in mental health units. These statistics must provide an analysis of the use of force in mental health units by reference to the relevant information recorded by responsible persons as noted above (section 7)). In addition, as soon as reasonably practicable after the end of each calendar year, the Secretary of State must also conduct a review of any reports made under paragraph 7 of Schedule 5 to the Coroners and Justice Act 2009 (relating to Coroners' Prevention of Future Death Reports) that were published during that year relating to the death of a patient as a result of the use of force in a mental health unit

by staff who work in that unit, and may conduct a review of any other findings made during that year relating to the death of a patient as a result of the use of force in a mental health unit by staff who work in that unit (section 8(1)).

Having conducted this review, the Secretary of State must publish a report that includes the Secretary of State's own conclusions arising from that review (section 8(2)) although the conduct of such a review and the publication of the report may be delegated (section 8(3)). Any review that the Secretary of State may conduct would include any finding or determination that is made by the Care Quality Commission as the result of any review or investigation conducted by the Commission or by a relevant health organisation as the result of any investigation into a serious incident (section 8(4)).

These requirements are comprehensive and unnecessarily onerous. It is extremely doubtful that such onerous requirements are necessary or indeed useful and risks losing the critical information in the plethora of data that will be collected. It is also likely that much of the information that the responsible person deems to be irrelevant will not be provided thereby reducing the accuracy and value of data that is submitted.

Given that one of the most important aspects of any guidance or legislation in this area is to minimise the use of force and make the use of any necessary force as safe as possible, it is difficult to see how this Act will achieve these aims. The preamble to the Act explains that it is an Act "to make provision about the oversight and management of the appropriate use of force in relation to people in mental health units; to make provision about the use of body cameras by police officers in the course of duties in relation to people in mental health units; and for connected purposes". The author was invited to meet Mr Steve Reed MP in his Parliamentary offices to discuss the Bill and to make any suggestions he thought necessary to improve it. One of the suggestions the author made was to set out what is meant by the "appropriate use of force". The author expressed the importance of doing this since it is often the inappropriate use of force that harms people and has been responsible for numerous restraint-related deaths. This was not included in the Act although his Parliamentary office has announced that these issues will be dealt with by guidance that will be published from time-to-time. Given the importance of the meaning of "appropriate use of force" leaving its meaning to subsequent guidance is not acceptable.

Criminal Law Act 1967

The main purpose of the Criminal Law Act 1967 was "to amend the law of England and Wales by abolishing the division of crimes into felonies and misdemeanours and to amend and simplify the law in respect of matters arising from or related to that division or the abolition of it; to do away (within or without England and Wales) with certain obsolete crimes together with the torts of maintenance and champerty; and for purposes connected therewith" (Preamble to the Act). For our purposes, however, we are concerned with section 3(1) which is the principal statutory provision that regulates the use of force. Section 3(1) provides that:

'[a] person may use such force as is reasonable in the circumstances in the prevention of crime, or in effecting or assisting in the lawful arrest of offenders or suspected offenders or of persons unlawfully at large.'

Mental Capacity Act 2005

The application of the Mental Capacity Act is different in each of the UK's four nations. In England and Wales, the Act provides a statutory framework for professionals and others who care for people with impaired capacity. Any action resulting from the use of the Act must be assessed as being in the person's best interests (Herczegfalvy v Austria 1993). Consideration must also be given as to whether the decision can be deferred until the person regains capacity (Beschizza, A., *et al*, 2023).

It is important to recognise when the Act may be indicated or when the Mental Health Act is more appropriate. A patient with a mental disorder who lacks capacity to consent to treatment in a psychiatric hospital is liable to be detained under the Mental Health Act rather than receive treatment under the Mental Capacity Act.

The Mental Capacity Act and an evaluation of 'best interests' are both relevant when considering the legality of administering rapid tranquillisation to a patient who is refusing treatment or lacks capacity to consent to treatment. Subject to the Mental Health Units (Use of Force) Act 2018, sections 5 and 6 of the Mental Capacity Act provide a defence against liability in relation to acts such as restraining mentally incapacitated adults using reasonable force or giving them medication without consent which is necessary in their best interests. Where treatment or restraint is necessary not because it is in the patient's best interests but for the protection of others, defence would come from the common law doctrine of necessity. Prior to

the Mental Capacity Act, the duty of "necessity" provided a general power to take such steps that were reasonably necessary and proportionate to protect others from the immediate risk of significant harm. It further provided doctors with both the authority and the duty to give medical treatment to adult patients lacking decision-making capacity (Re F, 1990). The common law doctrine of necessity, enabling treatment without capable consent and restraint, has now been codified by ss 5 and 6 of the Act thereby drastically limiting the scope of the common law in this regard.

The procedure for determining the best interests of a person with impaired capacity is laid down in section 4 of the Mental Capacity Act. This takes into account any valid advanced decisions and statements, the patient's past and present feelings, beliefs and values likely to influence their decision, and any other factors which they would be likely to consider if able to do so. If practicable and appropriate, the views of anyone named by the patient, such as a carer or person interested in their welfare, must also be consulted.

In relation to the management of violence, the Mental Capacity Act Code of Practice attempts to make clear the nature of restraint that is acceptable. Section 6 of the Act provides authority to restrain a person who lacks capacity. Restraint is defined as: (1) 'the use, or the threat of the use of force against a person who resists the action', and (2) 'restricts a person's liberty of movement, whether or not the person resists'. Two conditions are applied to the use of restraint: First, 'to reasonably believe that it is necessary to prevent harm to a person', and secondly, 'that it is a proportionate response to the likelihood of the person suffering harm and the seriousness of that harm'. In addition, the Code of Practice describes circumstances where the Mental Capacity Act may be relevant in the prevention of violence: 'a person may also be at risk of harm if they behave in a way that encourages others to assault or exploit them (for example, by behaving in a dangerously provocative way)' (Office of the Public Guardian, 2020).

Restraining a person who is likely to cause harm but is not at risk of suffering harm themselves appears not to be covered by the Mental Capacity Act. Any such action would have to be justified in terms of the professional's duty of care to the person at risk of suffering harm and may need to be managed under common law. If restraint is used frequently, this may amount to a deprivation of liberty. This is not covered by Section 6, and if a patient in a hospital or a resident in a care home is at risk of deprivation of liberty, authorisation should be sought. This is currently carried out by Deprivation of Liberty Safeguards (DoLS) from the appropriate

supervisory body, but this will be replaced by a new scheme, the Liberty Protection Safeguard Scheme (LPS), which was due to come into force in April 2022. However, on 16 December 2021, the Department of Health and Social Care announced that this implementation date could not be met, given the impact of the Covid pandemic. A new implementation date has not been set. The key changes that will be introduced by the LPS (if brought into force) are:

- Three assessments will form the basis of the authorisation of the LPS: mental capacity assessment, medical assessment, necessary and proportionate assessment.
- Greater involvement for families: there will be an explicit duty to consult those caring for the person.
- Best interest assessors (BIA) to be replaced with approved mental capacity professionals (AMCP). This will mean that LPS will become everybody's business and assessments will form part of routine care-planning considerations.
- LPS scheme extending to 16 and 17-year-olds.
- LPS scheme will extend to domestic settings, residential schools, day services and commuting from one place to another without the need for a court order.
- Clinical commissioning groups (CCGs)/integrated care systems (ICS), NHS trusts and local authorities as responsible bodies. The LPS creates a new role for CCGs/ICS and NHS trusts in authorising arrangements.

It should be noted that both DoLS (and the LPS in the future) cannot normally be used for a patient in hospital if the necessary care or treatment consists in whole or in part of the medical treatment for a mental disorder. The interface between the Mental Capacity Act and the Mental Health Act continues to cause confusion, with a lack of 'clarity and consistency' both in practice and in research (Gilburt, H. 2021).

Under the provisions of 'advance decisions to refuse treatment' (sections 24–26), it is possible to make an advance decision to refuse any specified medical treatment; this might include medication for the management of potential violence (Department of Health and Social Care, 2017). Medication given under Part IV of the Mental Health Act is not covered by these provisions.

In Scotland, the relevant provision is the Adults with Incapacity (Scotland) Act 2000. This is broadly similar to the Mental Capacity Act applicable in England and Wales. Guidance specific

to violence is found in Section 47. This provides that the use of force or detention is not authorised unless it is immediately necessary. The use of force or detention should only be maintained for as long as is necessary and should be consistent with a decision that may be made by a competent court. The Act should not be used to treat a patient for a mental disorder in hospital against their will.

In Northern Ireland, the Mental Capacity Act (Northern Ireland) 2016 was enacted by the Assembly in May 2016. The first Phase of the Act came into operation in two stages: research provisions commenced on 1 October 2019, and provisions in relation to deprivation of liberty, offences, and money and valuables in residential care and nursing homes commenced on 2 December 2019. The Act provides a statutory framework for people who lack capacity to make a decision for themselves and for those who have capacity now but wish to prepare for a time in the future when they lack capacity. Restraint and detention amounting to a deprivation of liberty are closely interlinked as they relate to compulsory limitations to a person's liberty. Restraint is not covered by the first phase commencement of the Act. However, restraint that is ongoing, planned or regular will most likely be regarded as deprivation of liberty (Department of Health, Northern Ireland, 2019).

Mental Health Act 1983 (as amended by the MHA 2007)

Where a person has been detained in hospital under the MHA, decisions regarding treatment may be taken without consent under part IV of the Act. This includes the use of reasonable, least restrictive force.

As with the Mental Capacity Act 2005, the application of the Mental Health Act is different in each of the UK's four nations. In England and Wales, the potential for a mental health service user to be responsible for acts of violence is frequently the reason for seeking detention under the Mental Health Act. It is recognised that where a patient has been detained under the MHA, there is an implied right for staff to exercise a degree of control over the activities of patient (Pountney v Griffiths; R v Bracknell Justices, ex parte Griffiths, 1976). In this case, the applicant was a male nurse at Broadmoor Special Hospital (as it was then known). He was on duty while patients were saying goodbye to visitors. He approached the detained patient telling him to "come on" and allegedly punched him on the shoulder. The patient brought criminal proceedings for assault without first obtaining the leave of the High Court as was then a requirement under section 141(2) of the Mental Health 1959 Act. The applicant was convicted and applied for certiorari to quash the conviction on the ground that since the leave of the High

Court had not been obtained the proceedings were a nullity. The House of Lords noted that the case questioned the rights of nurses in secure mental hospitals to oblige patients to return to their wards at the end of visiting time and accepted that the power to detain brought with it powers of control which would allow this practice. In an earlier hearing in the Divisional Court, Lord Widgery had explained that "where a male nurse is on duty and exercising his functions of controlling the patients in the hospital, acts done in pursuance of such control, or purportedly in pursuance of such control, are acts within the scope of section 141, and are thus protected by the section." On appeal to the House of Lords. Lord Edmund-Davies said "That, in my respectful judgment, was the correct view to take of the case, and it follows that, since the leave of the High Court was not obtained, the proceedings before the magistrates were a nullity and the Divisional Court had no alternative but to quash the conviction." Lord Simon of Glaisdale observed that section 141 placed a hindrance on the recourse of a class of citizens to the courts and drew a comparison with the requirement for a vexations litigant to obtain the permission of the court before commencing proceedings.

The MHA requires appropriate medical treatment to be available to a patient in order to meet the criteria for section 3 detention or a community treatment order (CTO) as defined by section 145 and Chapter 23 of the Code of Practice. CTOs will be discussed below. The Code of Practice states that medical treatment also includes interventions other than medication. This may consist of nursing treatment only, which could include restraint (Department of Health and Social Care, 2017).

Specific reference to violence is made in two places in the MHA in relation to emergency treatment. Section 62 authorises treatment which is immediately necessary and of minimum interference to prevent a 'patient from behaving violently or being a danger to himself or to others'. Further, in section 64C there is provision for treatment which would normally require either consent from the patient or authorisation from a second opinion appointed doctor (SOAD) in certain circumstances where the treatment 'is immediately necessary, represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself or to others and is not irreversible or hazardous'.

The Code of Practice contains extensive guidance on responses to violence, principally in Chapter 26: 'Safe and therapeutic responses to behavioural disturbance'. Recommendations include suitable assessment for potential risk of violence, identification of warning signs, de-escalation, control and restraint, and seclusion policies.

CTOs have been in place for some years in the USA, Canada, Australia and New Zealand. They were introduced in Scotland in October 2005, and in England and Wales in November 2008 (Beschizza, A., *et al*, 2023). Under a CTO, patients who have been detained in hospital for treatment under section 3 and unrestricted Part III (forensic) patients will, on discharge, become subject to a CTO, requiring them to comply with certain conditions. Patients have to be considered for a CTO if they are receiving more than seven days of home leave under section 17, and if a CTO is not implemented then the responsible clinician must document the reason for not doing so. Equally, responsible clinicians must not discharge patients onto a CTO prematurely before there is good evidence, including trials of section 17 leave, that demonstrates that the patient is sufficiently stable, and that the use of a CTO is appropriate and workable. A CTO can only be imposed on a patient directly following a period of compulsory detention in hospital. Patients with mental disorders who do not continue with their treatment (in particular, their medication) when they are discharged from hospital may, if their mental health deteriorates, become a danger either to themselves or to other people, and may eventually have to be compulsorily readmitted to hospital. The aim of a CTO is to maintain stability and reduce the risk of relapse through the use of conditions that ensure the patient receives the necessary treatment (Beschizza, A., *et al*, 2023). Supervised community treatment allows for recall to a designated hospital. This may allow risks associated with relapse, such as violence, to be more effectively managed and reduced through earlier readmission. Ideally, the conditions of the CTO will have prevented a relapse in the first case. Recall to an outpatient facility, as well as to a designated hospital, is legally permitted, but other than to consider renewal of a CTO under section 20 or to allow an assessment by a SOAD, recall to an outpatient facility is usually an impracticable approach as the patient may require inpatient care, and transporting the patient safely from an outpatient to an inpatient facility may prove problematic (Mental Health Act Code of Practice, Chapter 29).

Before the advent of the CTO, the MHA included various powers to manage patients by compulsion in the community and these included guardianship (sections 7 and 37), supervised aftercare (section 25) and leave of absence (section 17). Of these, guardianship remains relevant (although longer-term section 17 leave is still indicated in some cases, the majority of section 17 leave is now mostly short-term leave) and enables patients to receive care in the community where it cannot be provided by the use of compulsory powers. The powers of a guardian (who may be a local authority or a named private individual) may include requiring a person to live at a specified address, attend for treatment at a specified place and allow health

professionals access to their home. However, unless the patient consents, treatment cannot be imposed. However, the guardian does not have powers to use force, including restraint, to make a patient attend for treatment or to enter their home.

The benefits of CTOs have long been questioned and evidence for their effectiveness in various parts of the world is questionable (Moncrieff, J., *et al*, 1999). Three randomised controlled trials (Swartz, M., *et al*, 1999; Steadman, H., *et al*, 2001; and Burns, T., *et al*, 2013) have failed to show any benefits of CTOs in reducing the primary outcome measure of readmission to hospital, reduction in clinical symptoms or use of services. CTOs also fail to show improvement in secondary outcome measures such as quality of life, substance abuse, employment and satisfaction with services (Burns, T., *et al*, 2013). Meta-analyses have also failed to support benefits of CTOs in terms of readmission, social functioning or symptomatology (Kisely, S., *et al*, 2014; Barnett, P., *et al*, 2018). Burns *et al*'s follow-up of their OCTET study (Oxford Community Treatment Order Evaluation) found no evidence that CTOs improved readmission outcomes or reduced likelihood of disengagement from services in patients with psychosis over 36 months (Burns, T., *et al*, 2015). Although widely cited, the OCTET trial has been criticised by some, including Curtis, D., (2014) who states that 'OCTET does not demonstrate a lack of effectiveness for community treatment orders' arguing that 'the patients studied were not those who might have benefited from a CTO and that the psychiatrists involved were unlikely to have used the provisions of a CTO assertively'.

When considered in relation to reducing the risk of violence and homicide, CTOs appear to be effective when compared to no action, but 'probably not' when compared with good community mental health care. The difficulty in predicting a risk incident is acknowledged and there is no reliable way of calculating exactly how many homicides might be prevented by a CTO. It has also been suggested that thousands of people may have to be placed under compulsion in the community to prevent one homicide (Crawford, M., 2000; Szmukler, G., 2000. Furthermore, there has been no discernible reduction in the overall rates of homicides by people with a mental illness in Canada, Australia or New Zealand as a result of CTOs having been in place for some years. In England, independent inquiries into cases of homicide committed by those who have been in contact with the psychiatric services, mandatory since 1994, have commonly cited non-adherence to medication as one factor leading to the incident (University of Manchester, 2006).

In such cases it is possible that, had the individual been under a CTO, they may have adhered to their treatment regime, potentially averting a homicide, but in the absence of other evidence this remains speculative. Despite a lack of evidence of their effectiveness, CTOs continue to be used. They are perceived as useful in clinical practice and they remain a less restrictive alternative to compulsory admission to hospital. In justifying the use of CTOs, supporters also point towards the limitations of randomised (Mustafa, F., 2017; Segal, S., 2017) and non-randomised controlled studies (Mustafa, F., 2015) in evaluating CTOs and, in particular, the inability of randomised trials to recruit representative patients (Mustafa, F., 2018).

Continued 'targeted' use of CTOs is supported by the government's independent review of the Mental Health Act (H.M. Government, 2018), the summary report of which states: 'During the course of the Review we have become convinced that there are some service users for whom, despite our doubts, the CTO does play a constructive role. For these reasons we do not propose their abolition at this stage' (p. 28). The report acknowledges that CTOs are 'significantly overused' and that the authors would like to see a 'dramatic reduction' in their use, hence a recommendation that the criteria for CTOs should be tightened and that it should be made especially difficult to extend a CTO beyond two years without a compelling reason.

Whilst the debate continues and CTOs remain available, clinicians must ensure that they are only considered for use with patients for whom they were originally intended; namely, those with severe mental illnesses, an established history of non-adherence with medication and disengagement from services, and for whom the use of a CTO is proportionate to the risks associated with the patient's history and presentation. It is also important regularly to review whether a CTO is indicated, and CTOs should only be continued if use has demonstrated benefit (Beschizza, A., *et al*, 2023). Additionally, when considering conditions of a CTO, clinicians must also consider representations from victims who may be involved with or connected to the patient. The responsible clinician must inform the hospital managers if the patient comes within the scope of the Domestic Violence, Crime and Victims Act 2004.

Review of the Mental Health Act

In October 2017, the UK government announced an independent review of the Mental Health Act 1983. The review was tasked with making recommendations for improvements 'in relation to rising detention rates, racial disparities in detention, and concerns that the Act is out of step with a modern mental health system'. The review team were asked to look at both legislation and practice. On 1 May 2018, an interim report was published which summarised the work to

date and outlined emerging priority areas. The review's final report was published on 6 December 2018 and made a total of 154 recommendations. For our purposes, the review made three significant proposals. First, that the Act's powers should be used in the least restrictive way. Secondly, that there should be therapeutic benefit in discharging any of the Act's powers. This will help ensure that patients are supported to get better so they can be discharged from the functions of the Act. Thirdly, it recommended that prison should never be used as 'a place of safety' for individuals who meet the criteria for detention under the Act.

In Scotland, the Mental Health (Care and Treatment) (Scotland) Act 2003 applies and differs from the MHA in relation to capacity, compulsion for more than 28 days, and responsibilities of practitioners. Scottish legislation does not allow compulsion when a person retains capacity, whereas the MHA will allow compulsion when there is risk to the safety of others, as well as risks to self and health, even when capacity is retained.

In Northern Ireland, the Mental Health (Amendment) (Northern Ireland) Order 2004 is not substantially different to the MHA although it does not provide for the use of CTOs.

Manual Handling Operations Regulations 1992

The Manual Handling Operations Regulations set out a hierarchy of measures which should be followed to reduce the risks from manual handling activities. Restraint is a manual handing activity (Baskind 2014) and therefore the Manual Handling Operations Regulations 1992, as amended by the Health and Safety (Miscellaneous Amendments) Regulations 2002, applies. Employers are required to fulfil a number of criteria to reduce the risk of manual handling accidents at work. This includes a requirement that employers "shall so far as is reasonably practicable avoid the need for his employees to undertake any manual handling operations at work which involve a risk of their being injured" (reg. 4(1)(a)). Manual restraint of individuals can be avoided or minimised by using mechanised devices, such as handcuffs, body belts and leg straps. These devices, and the controversies that they bring, are discussed in Chapter 8.

Assaults on Emergency Workers (Offences) Act 2018

In response to concerns over rising levels of violence against healthcare and other emergency workers, the UK passed the Assault on Emergency Workers (Offences) Act 2018. This law makes it an aggravating factor to assault an emergency worker, including healthcare staff in accident and emergency departments or urgent treatment centres, and all nursing staff. In doing

so, any individual who assaults or attacks emergency workers face longer jail terms with maximum sentence increasing from 6 to 12 months. This is achieved by doubling the maximum sentence from 6 to 12 months in prison for the assault of an emergency worker.

Human Rights Act 1998 and the European Convention on Human Rights

The use of restraint by employees of the State raises a number of potential actionable human rights issues. For these purposes, examples of an employee of the State are police officers, prison officers, and hospital workers. The most serious issue relates to death caused by excessive or inappropriate use of force as this might constitute a breach of the State's most fundamental duty not to deprive a person of life. Any death resulting from restraint places a heavy burden on the responsible authorities to justify their actions as being Article 2 compliant.

Article 2 of the European Convention for the Protection of Human Rights and Fundamental Freedoms provides:

(1) Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.

(2) Deprivation of life shall not be regarded as inflicted in contravention of this article when it results from the use of force which is no more than absolutely necessary:

   (a) in defence of any person from unlawful violence;

   (b) in order to effect a lawful arrest or to prevent escape of a person lawfully detained;

   (c) in action lawfully taken for the purpose of quelling a riot or insurrection.

Hale (2012) explained that the first sentence of Article 2(1) imposes three distinct obligations upon the state. The first is a negative obligation not to take life except in the limited cases provided for in Article 2(2) (eg, in defence of any person from unlawful violence). The second is a positive obligation to conduct a proper investigation into any death for which the state might bear some degree of responsibility. The third is a positive obligation to protect life. As a general rule, that positive obligation is fulfilled by having in place laws and a legal system which deter threats to life from any quarter and punishes the perpetrators or compensates the victims if deterrence fails.

However, in certain circumstances, the state's positive obligation to protect life goes further than that. It entails an obligation to take positive steps to prevent a 'real and immediate risk' to the life of a person in a recognised category of particularly vulnerable people from materialising. The origins of the 'real and immediate' test lie in the decision of the European Court of Human Rights in *Osman v United Kingdom* (2000) 29 EHRR 245. The positive steps required by the state to fulfil this duty are those measures within the scope of its powers which, judged reasonably, might be expected to avoid that risk. This duty is often referred to in the cases as the Article 2 'operational duty', or as the *Osman* duty.

The State could be in contravention of Article 2 where a state official uses force in circumstances not covered by the exceptions noted in Article 2(2) and death results. In this context, a state official includes police and prison officers or hospital staff.

Article 2 may be violated where the individual's death is caused by the intentional or negligent acts of State employees as well as where the death results from systemic failings including those of management, training or instruction, especially where such failings result in an unnecessary or excessive use of force. An example of this was seen in *McCann & Others v UK* (1996) where the planning and control of a police operation to arrest individuals suspected of terrorism offences and which led to the deaths of the suspects, was held by the Court to be a breach of Article 2 even though no blame was attached to the individual army officers involved on the ground. The Court emphasised in McCann that liability under Article 2 may arise from the planning, control, provision of information and training in the use of force which may endanger life. Furthermore, the Court noted that the relevant domestic case-law "establishes that the reasonableness of the use of force has to be decided on the basis of the facts which the user of the force honestly believed to exist: this involves the subjective test as to what the user believed and an objective test as to whether he had reasonable grounds for that belief. Given that honest and reasonable belief, it must then be determined whether it was reasonable to use the force in question in the prevention of crime or to effect an arrest". The objective part of the above test requiring the accused's honestly-held belief to be reasonable differs from English case-law which sets this test as subjective: requiring only that the defendant's use of force was based on a genuine belief, irrespective of whether or not the belief was reasonably held (*Williams (Gladstone)* (1984). That there is no requirement for English law to fall in line with European jurisprudence on this point was confirmed by the European Court of Human Rights in *Bubbins v UK (2005)* Court supported the English subjective approach to this test and stated

that "the use of force by agents of the State in pursuit of one of the aims delineated in paragraph 2 of Article 2 … may be justified under this provision where it is based on an honest belief which is perceived, for good reasons, to be valid at the time but subsequently turns out to be mistaken". The Court noted that to hold otherwise "would be to impose an unrealistic burden on the State and its law-enforcement personnel in the execution of their duty, perhaps to the detriment of their lives and the lives of others". Although at first glance the Williams approach might appear curious in that a defendant could be acquitted provided his use of force was based on a genuinely held, but not necessarily, reasonable belief, it must be remembered that it is for a jury, objectively, to determine whether or not his belief was honestly held: the more unreasonable that belief, the less likely it will be that the jury will conclude that, on the basis of the facts as the defendant believed them to be, a reasonable person would regard the force used as reasonable.

As yet, the European Court of Human Rights has not had to deal with an English case concerning a person killing another based on an irrational mistake although it might be that in a future case the Court will need to revisit the different approaches between McCann and Williams. That said, in R (on the application of Bennett) v HM Coroner for Inner South London (2007), the English Court of Appeal (Criminal Division) upheld the judgment of the Administrative Court where Collins J stated that:

"… It is thus clear that the European Court of Human Rights has considered what English law requires for self defence, and has not suggested that there is any incompatibility with Article 2. In truth, if any [police] officer reasonably decides that he must use lethal force, it will inevitably be because it is absolutely necessary to do so. To kill when it is not absolutely necessary to do so is surely to act unreasonably. Thus, the reasonableness test does not in truth differ from the Article 2 test as applied in McCann ."

An application to the European Court of Human Rights was held to be "manifestly ill-founded" and declared inadmissible. The Court stated that *"there was no sufficiently great difference between the English definition of self-defence and the 'absolute necessity' test for which Article 2 provides"*. Allen (2017) praises the judgment of Collins J as having "squared the circle quite cleverly" pointing out that "the European Convention is a document for application in the real world [and] not the perfect world of hindsight".

That said, English law and Article 2 are not wholly aligned on the use of force with the latter being more restrictive in certain situations. For example, in English law, a defendant may be acquitted where he has killed another person in response to a criminal attack on property (Criminal Law Act 1967, section 3(1); Hussey (1924)) whereas such a defence would not be available under Article 2.

Other Convention rights provide a framework in which an individual's Article 2 rights must be protected in connection with the use of restraint. In particular, the use of restraint engages Article 3 (prohibition on torture, inhuman and degrading treatment) and Article 8 (the right to private life including respect for autonomy, physical and psychological integrity). Article 3 provides particularly strong protection for those detained and it was held in Ribbich v Austria (1995) that there was a presumption that any unnecessary use of restraint against a person detained reaches the otherwise high threshold that the court requires to constitute inhuman and degrading treatment. The requirement for restraint to be necessary was emphasised in *Keenan v UK* (2001) where the European Court of Human Rights explained that:

… in respect of a person deprived of his liberty, recourse to physical force which has not been made strictly necessary by his own conduct diminishes human dignity and is in principle an infringement of the right set forth in Article 3. (para 112).

The contrasting approaches adopted to the use of physical force and the use of solitary confinement is illustrated in *Mathew v Netherlands* (2006). The applicant complained under Article 3 both that he had been kept in solitary confinement, and that violence in the form of physical restraint had been inflicted upon him by prison staff. In relation to the complaint concerning the use of physical force, the court applied a test of strict necessity (paras 176-179). On the other hand, the court applied no such test in relation to the complaint concerning solitary confinement, but instead followed the same approach as in later cases such as *Ramirez-Sanchez* and *Ahmad*. This position has been followed by the UK Supreme Court *(R (on the application of AB) v Secretary of State for Justice* (2021)).

Additionally, whether or not the use of restraint constitutes a breach of Article 3 will depend upon a number of other factors, including the characteristics of the complainant; especially their age, gender, health and the physical and mental effects the restraint had on their health (Ireland v UK 1979-1980). This also means that staff need to take account of any particular vulnerabilities known or ought to have been known about the individual, for example, a history

of past abuse, will be relevant factors that a court will take into consideration when determining whether or not there has been a violation of the individual's Article 3 rights.

It was held in Herczegfalvy v Austria (1992) that "a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading" for the purposes of Article 3. What amounts to a therapeutic intervention is discussed in Chapter 2 but for present purposes it is noted that it will be for the applicant to disprove the State's assertion that the use of force against him was a medical necessity.

An example of a case decided under Article 5 (right to liberty and security) is *Rivas v France (2004)* where the European Court of Human Rights stated that such rights are necessarily subject to implied exceptions in cases where a person's injuries have been inflicted in self-defence. In such a case, a person will not infringe another's Article 5 Convention rights by restraining and detaining him to prevent a further unlawful attack.

The requirement for physical interventions to be the least restrictive and intrusive necessary in the particular circumstances of the case are discussed throughout this thesis. In order for the intervention to be deemed least restrictive/intrusive it must satisfy the requirements of necessity and proportionality. For present purposes, it is important to note that unless the intervention satisfies these requirements, there will be a potential breach of Article 8 which provides that everyone has the right to respect for his private and family life. A person's body is an intimate aspect of his or her private life (Y.F. v Turkey 2003) and a sound mental state is an important factor for the individual to enjoy the right to private life (Bensaid v UK 2001). The protection of private life under Article 8 therefore encompasses a person's physical and psychological integrity. Although the European Court of Human Rights determined that measures which affect an individual's physical integrity or mental health have to reach a certain degree of severity in order to qualify as an interference with the right to private life under Article 8 (Bensaid v UK 2001, para 46), the Court has also held that even minor interferences with a person's physical integrity may fall within the scope of Article 8 if they are done against the person's will (Storck v Germany 2005). By its very nature, restraint is done against the person's will.

To avoid a breach of a person's Article 8 rights, any action that interferes with his physical integrity must be in accordance with established law and guidelines, for a legitimate purpose, and necessary for and proportionate to that purpose. For a physical intervention to be

considered proportionate, it needs to be the least intrusive measure possible in the particular circumstances of the case.

Many cases involving the use of force involve an omission or failure to act rather than a positive act. Osman v UK (2000) confirms that a breach of a Convention right can be founded upon a failure to act. Osman was a case concerning a civil claim against the police for failing to protect individuals whose life or safety was at risk from the criminal acts of another. In the result, the European Court of Human Rights found a violation of Article 6(1) because the English courts have generally upheld the immunity of the police from tortious liability for operational decisions. In order to avoid such a result in future cases, English courts must examine every case on its own merits. Moreover, in *Finogenov & Others v Russia (2012)* the Court modified the Osman test, by stating that:

The authorities' positive obligations under Article 2 … are not unqualified: not every presumed threat to life obliges the authorities to take specific measures to avoid the risk. A duty to take specific measures arises only if the authorities knew or ought to have known at the time of the existence of a real and immediate risk to life and if the authorities retained a certain degree of control over the situation.

With regard to PMVA, it is not difficult to see how such a duty would arise. Take, for example, a case of a person ("P") detained under the Mental Health Act and who is exhibiting significant violence. He is placed on a ward where violence and aggression is endemic. There is a strict "no restraint" policy at the hospital and staff are told to call police in the event they are unable safely to deal with an incident with de-escalation strategies. The police are called but before they arrive, P kills another person. In such a case, the authorities clearly retained control over the situation and ought to have known that the no-restraint policy was unsafe and placed staff and others at risk. The right, and where appropriate the duty, to use reasonable force is embedded throughout UK and international law. In a 1976 judgment (Pountney v Griffiths 1976), the Lord Chief Justice of England and Wales, Lord Widgery, stated in the House of Lords that:

There can however in my judgment be no doubt that the conception of detention and treatment necessarily implies that the staff at [Broadmoor] hospital … can and on occasion must use reasonable force in order to ensure that control is exercised over the patients.

Racial bias is a problem that appears in various restraint-related cases. Article 14 requires that there must be no discrimination in the protection of a person's Convention rights. Where any of these Convention rights are engaged, any difference in treatment which cannot be

objectively and reasonably justified in the circumstances of the case, will constitute a breach Article 14.

Children Act 1989

The Children Act 1989 provides that teachers have a duty of care towards the children under their supervision, as well as promoting the safety and welfare of the children in their care. The level of this duty of care is measured as being that of a 'reasonable parent'.

Section 3(5) further defines the duty of care to the effect that a person with care of a child may do what is reasonable in all the circumstances for the purpose of safeguarding or promoting the welfare of the child.

Under the Act, schools, as well as local authorities, academies and colleges, have a statutory duty to carry out their functions with a view to safeguarding and promoting the welfare of children under the Education Act 2002 and accompanying regulations.

This includes taking steps to protect children who are at risk of significant harm, which is further defined in the Children Act as ill-treatment or the impairment of a child's physical or mental health or of their physical, intellectual, emotional, social or behavioural development.

'In loco parentis' means 'instead of parents' and has legal significance when it comes to looking after other people's children. The term 'in loco parentis' was used to describe the duty of care that a teacher has towards a pupil, to the effect that a teacher has a duty to take the same reasonable care of the pupil that a parent would take in those circumstances. The term originally embodied the nineteenth-century common law principle that a teacher's authority was delegated by a parent so far as it was necessary for the welfare of the child.

The Education & Inspections Act 2006

Teachers in both England and Wales have a statutory power to use reasonable force to restrain pupils in a number of circumstances as set out in section 93 of the Education and Inspections Act 2006.

Section 93 provides teachers with the power to use of reasonable force to prevent pupils from hurting themselves or others, from damaging property, or from 'prejudicing the maintenance of good order and discipline'.

Criminal Justice and Immigration Act 2008

Described as “one of the worst examples of gesture politics resulting in pointless legislation” (Allen, 2017), section 76 of the CJIA 2008 was intended to clarify the operation of the common law rules relating to reasonable force in self-defence and related matters, and, by subsequent amendment, the defence relating to the defence of property. In practice, it did little more than put into statutory form what case law had already established.

Sections 119-122 of the Act create a specific offence of causing nuisance or disturbance on NHS (or in Northern Ireland, HSS (Health and Social Services)) premises and set out the power to remove persons causing nuisance or disturbance together with guidance in respect of this power. These sections extend to England and Wales, and Northern Ireland.

Social Action, Responsibility and Heroism Act 2015

This Act applies when a court, in considering a claim that a person was negligent or in breach of statutory duty, is determining the steps that the person was required to take to meet a standard of care.

The court must have regard to whether the alleged negligence or breach of statutory duty occurred when the person was acting for the benefit of society or any of its members (section 2).

The court must also have regard to whether the person, in carrying out the activity in the course of which the alleged negligence or breach of statutory duty occurred, demonstrated a predominantly responsible approach towards protecting the safety or other interests of others (section 3).

Finally, the court must also have regard to whether the alleged negligence or breach of statutory duty occurred when the person was acting heroically by intervening in an emergency to assist an individual in danger (section 4).