Ministry of JUSTICE

National Offender Management Service

PHYSICAL CONTROL IN CARE TRAINING MANUAL

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Index

PHYSICAL CONTROL IN CARE SYLLABUS

SECTION 1: FOREWORD

SECTION 2: HOLDS - PHASE II

SECTION 3: HOLDS - PHASE III

INTRODUCTION

SECTION 4: SPONTANEOUS INCIDENTS

SECTION 5: HANDCUFFS

PHYSICAL CONTROL IN CARE

SECTION 1: FOREWORD

1.0 INTRODUCTION

The Secure Training Centre Rules require that the methods of physical restraint used in Secure Training Centres (STCs) are approved by the Secretary of State. The only method that has this approval is Physical Control in Care (PCC).

The PCC curriculum has been developed by NOMS Trainers from National Tactical Response Group (NTRG) formally C&R National Centres, to specifically ensure the safe custody of young people in care and those authorised to keep them in a secure environment.

The techniques are approved for use in all Secure Training Centres in England and Wales and for approved Escort Providers.

PCC is a system of holds designed to be used on young people. The holds do not rely on pain to regain control but PCC does include two distraction techniques that rely on the application of pain. These techniques are the rib distraction and thumb distraction.

These distraction techniques may only be used in violent situations where the safety of young people, staff or others is at risk.

This version of the PCC Manual has been developed as an interim curriculum pending the introduction of a new holistic behaviour management system known as Conflict Resolution Training (CRT). Due to the changing demographics of young people within STCs, PCC techniques may not be successful in managing conflict involving violence and risk to life or limb. This should be determined by staff carrying out a dynamic risk assessment at the scene. Establishments should have in place contingency plans to deal with any incident that falls under this remit.

It is vital to impress upon staff that physical contact to resolve situations is always a last resort. Staff will continue dialogue in order to try and calm the young person and de-escalate the situation.

In exceptional circumstances there will be occasions where, once it has been established that it is necessary to use force, it will not actually be possible for a member of staff to use PCC techniques. This may happen when PCC has been found to be or is likely to be insufficient, or where despite the use of PCC there remains a risk of serious harm.

We do not consider that there is any such thing as an absolutely safe physical restraint. Consequently staff must only use restraint as a last resort, and need to be aware of all the risks associated with using force on young people, including factors inherent in both the young person and the holds themselves that may present risks (see medical advice section).

1.1 TRAINING

All staff requiring PCC training will initially attend a five-day initial course. On successful completion the member of staff will be authorised to use PCC in the approved manner.

The initial course will comprise the following:

- An introduction to PCC and the Use Of Force Policy (including the relevant Rules and Regulations).
- Dealing with conflict
- The effects of stress
- Use Of Force Report Writing
- Medical advice
- The role of the PCC supervisor
- The FULL PCC syllabus

The full PCC course is compulsory for all staff as part of their initial training. The PCC course is a competency based course and all staff will have to achieve the required standard prior to receiving accreditation. PCC is only one part of the initial training syllabus for a custody officer.

All staff must receive a minimum of one-day day refresher training in any twelve-month period for them to continue to be authorised to use PCC techniques.

Any staff not requiring the full PCC training will receive training in personal protection / breakaways at the earliest opportunity. They will receive the entire initial course without the PCC holds.

Training may only be delivered by accredited instructors

1.2 INSTRUCTOR TRAINING

Selected staff will initially attend a local pre-selection. This will determine their suitability and potential to successfully complete the instructor's course.

Factors to consider are

- Technical ability
- Teaching experience / potential
- Experience in the childcare environment
- Knowledge of the Rules and Regulations
- Long term ambitions
- Appearance, demeanour, attitude

The Initial Instructors Course will be a ten-day pass or fail format, at either of the Prison Service Training Colleges:

NTRG Hatfield Woodhouse
Bawtry Road
Hatfield
Doncaster
(South Yorkshire)
DN7 6PQ

NTRG Kidlington
Evenlode Crescent
Kidlington
Oxfordshire
OX5 1RF

The course will cover the following:

- A full revision of the PCC syllabus
- Introduction to teaching skills
- Awareness of Health and Safety and Safe Systems Of Work
- Warm-ups, briefing and de-briefing

All candidates must demonstrate competence in technical ability, instructional ability, underpinning knowledge and attitude. On successful completion, candidates will be certified to instruct for twelve months. All instructors must attend an annual validation course of four days to re-qualify. Failure to attend will deem the instructor no longer eligible to instruct PCC. They may have up to six months to re-qualify and failure to do so will result in their having to complete the full PCC Instructors' Initial Course again.

1.3 PRINCIPLES OF PHYSICAL CONTROL IN CARE

The use of force to restrain a young person must always be viewed as the last option available to staff. All other methods of resolving the situation must be tried or deemed inappropriate in the prevailing circumstances.

Any person using force must be prepared to establish that the force used was reasonable in the circumstances. This means that they must be able to show why it was necessary to use force and the force used was proportionate to the threat presented.

RISK ASSESSMENT

In deciding to use physical force to restrain a young person, staff must quickly carry out a dynamic risk assessment using some or all of the following impact factors. This list is not exhaustive and each incident will present its own circumstances and potential risks.

- The risks of doing nothing
- The risks to themselves, the young person(s) and others
- The risks to the establishment
- The physical ability of the young person(s)
- The known history of the young person(s)
- The minimum intervention phase required to successfully resolve the situation
- The availability of other staff
- The presence of other young people
- The environment

Consideration of the above factors will enable staff to determine whether to physically intervene.

INTER-PERSONAL SKILLS

The use of physical force must never be used as a first option. The use of force must not be used to replace the ability and willingness of staff to use their inter-personal skills to successfully resolve difficult confrontational incidents.

A NON TAKE DOWN POLICY (Prone or Supine)

Within the PCC system there are no techniques which deliberately take a young person into the prone or supine position. There are techniques that require the young person to be placed onto their knees in order to maintain the safety of all involved in the incident. The PCC system aims to maintain the young person in a standing position. In the event of the restraint having to be conducted within a prone or supine position the hold(s) can be maintained and the young person brought to a standing position at the earliest opportunity, or released.

Within the system provision is made to physically hold the young person who is already in a prone or supine position, but once again the young person must be brought to their feet at the earliest opportunity, or released.

DE-ESCALATION

The de-escalation of physical holds placed on the young person by staff is of paramount importance. The PCC system is designed to encourage staff to systematically down-grade and ease hold(s). The ultimate aim is to release all physical holds on the young person as soon as practical and safe for all concerned.

HOLD RELEASE OPTION

Where continued application of physical holds by staff on a young person becomes unsafe for the young person or staff the hold(s) must be released. Safety of all involved with the restraint is the priority. All PCC holds and systems have the hold release option included.

ESCALATION

Where staff are having difficulties controlling the young person, they have the option to escalate the physical restraint used by moving to the next phase of holds within the system provided it is safe to do so.

With any escalation (including handcuffs), the force used must be necessary and proportionate to the threat presented.

TEAMWORK

The success of resolving difficult physical situations depends very much on a team approach to the resolution of these incidents. Staff should always bear in mind the effect that physical restraint may have on other young people not involved and the potential for them to influence the proceedings. Staff not involved in the actual physical restraint of a young person have an important role to play in supervising other young people, making the area safe for those staff carrying out the restraint, and helping to ensure that all proceedings are professionally carried out.

1.4 POLICY ON THE USE OF FORCE

Introduction

The use of force by one person on another without consent is unlawful unless it is carried out in accordance with the law governing the use of force applicable to the particular context in which that force is used. The rules governing the use of force in Secure Training Centres, Young Offender Institutions and Secure Children's Homes differ and the type of action that staff can take will depend upon the setting. Staff therefore need to understand the different legislative frameworks and general principles of the law on the use of force In their setting.

This volume will briefly set out the legislative framework which governs the use of force and will also set out the general principles which should be borne in mind when staff members are considering the use of conflict resolution.

Which rules govern the use of force?

- Secure Training Centres

The Secure Training Centre Rules 1998[1], Rules 37 and 38:

> *"Rule 37: Use of Force*
>
> *(1) An officer in dealing with a trainee shall not use force unnecessarily and, when the application of force to a trainee is necessary, no more force than is necessary shall be used.*
>
> *(2) No officer shall act deliberately in a manner calculated to provoke a trainee."*
>
> *Rule 38: Physical restraint*
>
> *(1) No trainee shall be physically restrained save where necessary for the purpose of preventing him from-*
>
> *(a) escaping from custody;*
>
> *(b) injuring himself or others;*
>
> *(c) damaging property; or*
>
> *(d) inciting another trainee to do anything specified in paragraph (b) or (c) above,*
>
> *and then only where no alternative method of preventing the event specified in any of paragraphs (a) to (d) above is available.*
>
> *(2) No trainee shall be physically restrained under this rule except in accordance with methods approved by the Secretary of State and by an officer who has undergone a course of training which is so approved.*
>
> *(3) Particulars of every occasion on which a trainee is physically restrained under this rule shall be recorded within 12 hours of its occurrence and notified to the monitor".*
>
> [The STC Rules, made under the Criminal Justice and Public Order Act 1994 prescribe the strict circumstances in which force can be used in STCs. There is no basis in law for force to be used in STCs for the purposes of good order and discipline.]

[1] The STC Rules are made under section 47 of the Prison Act 1952 and section 7 of the Criminal Justice and Public Order Act 1994

- Secure Children's Homes

The Children's Homes Regulations 2001[2], Regulation 17:

"Regulation 17 – Behaviour Management, discipline and restraint

(1) No measure of control, restraint or discipline which is excessive, unreasonable or contrary to paragraph (5) shall be used at any time on children accommodated in a children's home."

Regulation 17(5) lists what may not be used as disciplinary measures on children (subject to 17(6)), and that lists includes corporal punishment. Regulation 17(6) allows any action to be taken which is immediately necessary to prevent injury to any person or serious damage to property.

The Youth Justice Board's Code of Practice supplements the sector specific rules applicable to YOIs, STCs and SCHs. *"Managing the Behaviour of Children and Young People in the Secure Estate*", published in December 2006, is consistent with and encourages recognition of the rights of children and young people in domestic and international law.

In addition to sector specific guidance outlined above, the legality of the use of force in STCs and in other parts of the estate will be considered in light of:

- The European Convention on Human Rights

The ECHR is partly incorporated into UK law by the Human Rights Act 1998 section 6 of which makes it unlawful for any public authority (such as a prison or YOI) to act in a manner incompatible with Convention rights. The Convention rights which may be engaged by any use of force are the right to life (Article 2), the right to protection from torture or inhuman or degrading treatment or punishment (Article 3) and the right to respect for private and family life (Article 8). Where

[2] The SCH Regulations are made under the Care Standards Act 2000. Other forms of regulation and guidance relevant to the use of force in SCHs include: the National Minimum Standards for Children's Homes 2001 (Standard 22) made under the Care Standards Act 2000; The Control of Children in the Public Care: Interpretation of the Children Act 1989 (Department of Health, 1997).

excessive or disproportionate force is used, or where the application of force is maintained for longer than necessary (even if its use is to achieve a lawful aim) this may constitute a breach of Convention rights.

- General principles of common law

  Common law is developed through the courts by way of judicial rulings as opposed to law expressed in statutes and subordinate legislation. As far as the use of force is concerned, there is an established common law principle that a person has the right to act in defence of themselves or others. The use of force in such circumstances will be justified provided that the individual considered the use of that force to be reasonable in the circumstances at that time.

Other relevant legislative frameworks:

- The Criminal Law Act 1967

  Section 3(1) of the Criminal Law Act 1967 governs the use of force permissible when an arrest is being made:

  "(1) 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."

- Health and Safety at Work Act 1974

  The use of force may also involve consideration of health and safety legislation. The use of force may be in response to work place violence categorised as any incident where a person is abused, threatened or assaulted in circumstances relating to their work. Members of staff employed across the secure estate are entitled to the protection afforded by the Health and Safety at Work Act 1974 and related legislation and their employer is obliged to comply with certain statutory duties:

  In relation to employers, section 2 states: *"It shall be the duty of every employer to ensure so far as reasonably practicable the health, safety and welfare at work of all his employees".*

In relation to employees, section 7 states: *"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".*

General principles to consider

The legislative frameworks and rules outlined above incorporate a number of similar general principles which will assist in determining whether the use of force is justified and in accordance with law. These principles should always be considered by staff prior to any use of force:

- Is the use of force **reasonable** in the circumstances?

The interpretation of reasonableness is a key issue concerning the use of force. The issue of reasonableness is a matter of fact to be decided in each individual case. Each set of circumstances will be unique and must be assessed on their own merits. Factors to be taken into account when deciding whether the use of force, or the use of a particular form of restraint, is 'reasonable' will be things such as size, age and sex of both the young person and the member of staff concerned in the case and whether any weapons are present. Another factor to take into account is whether another person would consider it reasonable to use force in that situation.

- Is the use of force **necessary** in the circumstances?

Force should only be used where it is absolutely necessary to do so. Restrictive physical interventions must only be used as a last resort, where there is no alternative available or other options have been exhausted. The use of force to restrain a young person must always be viewed as the last option. The application of physical techniques are to be used only when other methods not involving use of force have been tried and failed, or are judged unlikely to succeed, and action needs to be taken to prevent injury to young people, to staff, to other people or serious damage to property.

It is important to take into account the type of harm that a member of staff is trying to prevent - this will help determine whether force is

necessary in particularly circumstances they are faced with. Types of harm may include risk to life, limb or serious damage to property or other risk of harm. When the use of force is necessary, it must be used in ways that maintain the safety and dignity of all concerned.

- Is the use of force **proportionate** in the circumstances?

The use of force in any given circumstance must be a proportionate response to the incident. In other words staff should demonstrate a reasonable relationship of proportionality between the means employed and the aim pursued. Action taken is unlikely to be regarded as proportionate where less injurious or invasive, but equally effective, alternatives are available. Any incident of the use of force should be at the minimum level required and carried out for the shortest possible period of time.

1.5 CONFLICT RESOLUTION

STRESS

When faced with violent or confrontational situations, staff will be faced with feelings that are unusual to them. It is vital that staff accept and recognise these feelings in order to deal with not only the situation but also themselves

How will your staff be feeling prior to being deployed?

- Anxious
- Excited
- Apprehensive
- Worried
- Frightened
- Nervous

All adjectives to describe feelings, they describe the effects of the body's natural response.
The fight or flight response is the body's natural mechanism for dealing with confrontation and it strongly favours flight as its primary option. Unfortunately many situations dictate that flight is not the option, therefore a third option may take precedence – freeze.

If staff freeze in these situations then they are at high risk of becoming a victim. Therefore it is important that training prepares staff to deal with confrontation and that they are aware of what course of action is required:

- Escape
- Verbal reasoning
- Use of force

When we perceive a threat:

- Heart rate increases
- Breathing rate accelerates
- Blood vessels dilate
- Blood diverts from the digestive system
- Glucose and fat are released
- Brain releases stimulants
- Endorphins are released

Physiological effects of confrontation:

When we perceive a threat the body releases adrenal chemicals. The positive effects are:

- Heightened awareness
- Additional strength
- Increased pain threshold

The negative effects of adrenal response:

- Loss of fine motor skills (clumsiness)
- Tunnel vision
- Time distortion
- Auditory exclusion

Loss of fine motor skills

- Due to the acceleration of nerve impulses controlling muscle contraction, hand / eye co-ordination becomes impossible
- This clumsiness prevents a person performing any complex motor skills

Tunnel vision

- Under stress an individual will lose part of their peripheral vision as they focus on the direct threat

Time distortion (tachypsychia)

- Visual slow down
- The speed of events seem to be distorted, what happens in seconds seems to last for minutes
- Temporary memory loss
- Unable to recall key events

Conflict of perceptions

- The person involved cannot remember large parts of an incident but they can remember small details
- Witnesses can remember what happened generally but cannot remember minute details.

Auditory exclusion

- This occurs when the blood vessels in the ears are dilated by the adrenal hormones making it difficult to hear
- High-pitched sounds are predominant; other sounds fade into the background.

The Adrenal Map

When staff anticipate confrontation they may experience a slow release of adrenaline. Although the release is not as intense as a fast release of adrenaline it can tire and affect the member of staff. It is possible that working in a hostile environment may have this long-term effect on staff that can go unnoticed.

Fast release (adrenal dump) occurs when staff are not anticipating a confrontation and it happens without warning.

To combat the effects staff should attempt to remain in a constant state of readiness and be prepared to deal with all forms of conflict. This can lead to a combination of both releases and staff will need to

develop methods for releasing the stress they are faced with (i.e. gym, sport, relaxation techniques etc.)
Adrenal reactions:

- Shakes
- Dry mouth
- Voice quiver
- Tunnel vision
- Sweaty palms
- Nausea
- Bowel loosening
- Auditory exclusion
- Tachypsychia

Conflict Resolution

When faced with a conflict situation we should have one of three objectives, these are:

- Avoid danger
- Defuse the situation
- Control the situation

Avoid Danger

Awareness of a threat is an essential aspect of evading a problem as it “buys time”. The earlier a member of staff perceives a possible threat the more time they have for assessment and action. Awareness of surroundings will also help the member of staff to form a decision on how to deal with a situation a knowledge of exits, alarm bells, presence of other colleagues or young people will all impact on the decision making process.

Due to the physiological changes that take place when faced with a potentially dangerous situation one of three reactions normally occurs;

FIGHT

FLIGHT

OR FREEZE

Defuse the situation

It has always been recognised that the best defensive weapons that staff have are their verbal and nonverbal communication skills. Staff who successfully adopt effective communication strategies and interpersonal skills will find that they are usually able to defuse a potential conflict.

However even after attempts at effectively communicating and defusing a conflict, it is recognised that at times staff may have no other option than to use force'

Control the Situation

Adopting an approach that is positive, assertive and confident will help to reduce the likelihood of an incident escalating uncontrollably.

Controlling a conflict that has escalated beyond verbal reasoning may sometimes require the use of force.

However, all staff must make their own decision about how to respond to any particular situation.

If the use of force does become necessary, PCC techniques are always the preferred option.

Where PCC techniques are not practical or have become ineffective staff may have to resort to other means of protection, dependent upon the risk of harm presented to them.

De-escalation and Interpersonal / Communication Skills

Managing Aggression

The effective management of aggressive young people is one of the most demanding aspects of working in an establishment. It is an area where good interaction and communication skills are required.

The majority of situations, where there is a potential for violence, can be handled through communication.

Our objective when dealing with an aggressive young person is to prevent the aggression escalating into actual physical violence.

Signs of aggression:

- Standing tall
- Red faced
- Raised voice
- Rapid breathing
- Direct prolonged eye contact
- Exaggerated gestures

Why does aggression occur?

- Frustration
- Perceived unfairness
- Feelings of humiliation
- Immaturity
- Excitement
- Learned behaviour (it gets results)
- Means to an end
- Decoy

Assessing the risk of violence and aggression:

Consider the following questions, the more often the answer is “yes”, the greater the risk of violence or aggression:

- Is the young person facing a high level of stress? (e.g. a recent bereavement, a pending court date)
- Does the young person seem to be drunk or on drugs?
- Does the young person have a history of violence?
- Does the young person have a history of psychiatric illness?
- Has the young person verbally abused staff in the past?
- Has the young person threatened staff with violence in the past?

Recognising potential aggression at an early stage:

The following signs may indicate aggression:

- Any major change in behaviour that varies from what is normal for the young person.
- Pale or flushed face.
- Rising voice.
- Focusing / narrowing of gaze.
- Tensing of muscles
- Increased agitation and disturbance in behaviour (e.g. pacing)

Communication

Communication is a two way process that relates to verbal interaction (listening, speaking and hearing), non-verbal interaction (interpretation and observational skills – looking and seeing).

Many communication problems could be avoided by:

- Using more appropriate language
- Taking more time to communicate the message
- Checking for understanding
- Encouraging feedback
- Choosing a more appropriate time /place

There are many factors to consider when we communicate with others, we should be aware that all “messages” will contain facts, feelings, values and opinions.

Facts – are real and objective. We believe them because they can be verified.

Feelings – are our emotional responses to situations

Values – are the norms, which exist in society at large. They can be deep-seated beliefs about what is right or wrong.

Opinions – are our ideas about particular issues, events or situations. They are subjective and normally limited to the immediate environment.

Communication problems often occur in our environment when we, or others, get confused; perhaps interpreting an opinion as fact. So we must be aware that a message consists not only of content (facts) but also of values, opinions, assumptions and feelings.

Some of the common inhibitions to effective communication are:

- Noise
- Language
- Perception and prejudice
- Intrusion of personal space

We cannot necessarily avoid or overcome all these barriers but we need to find ways of minimising them.

Noise:
Noise is a major distraction when trying to communicate. It's hard to hold a discussion against a noisy background.

Language:
Staff need to express themselves in as direct and explicit manner as possible and avoid emotive language (for example – avoid power words).

Perception and prejudice:
Everybody has a unique background and history with influences and experiences that form our way of looking at the world. It is important to recognise our prejudices for what they are and to work round the prejudices of others. We have to maintain a professional attitude by not allowing our own perceptions to get in the way of our duties and responsibilities towards others, particularly in promoting equal opportunities, or to let our prejudices influence the way we communicate.

INTRUSION OF PERSONAL SPACE

Personal space is the space we require, or are comfortable with, between ourselves and other people.

- The Intimate Zone - This may refer to very close contact, from a point of touching to a point of around 18 inches.

  The space may be reserved for intimate contact or fighting.

- The Personal Zone - The area from 18 inches up to a distance of around 13 feet. This may be the zone in which most verbal and non-verbal interaction takes place.

- The Public Zone - Is the distance beyond 13 feet to any distance where you can still be seen.

When we invade someone's personal space we can easily cause them to become defensive and hostile resulting in poor communication.

Non-verbal Communication

In any interaction with other people it is impossible not to communicate in one way or another. Most people give off signals through "body language". Only a third of the meanings in communications are supplied by the spoken word. Some of the key areas to observe are:

- Facial expression
- Eye contact
- Posture
- Gesture
- Proximity
- Paralinguistics

Many of the points above encourage you to make judgements about personality and emotions on a subconscious level, leading to positive or adverse behaviour.

Defusion Strategies

Before anything else happens we need to defuse the situation. A young person who is displaying challenging behaviour will be under the influence of the adrenal cocktail. Our strategy should be to do nothing to escalate their level of aggression or anxiety whilst being prepared to defend ourselves if necessary.

Our actions should include:

- Appear confident, give the impression you are capable of dealing with the situation

- Displaying calmness, be aware of your body language
- Create some space, allow them to feel safe
- Speak slowly gently and clearly
- Lower your voice, they are more likely to lower theirs
- Don't stare, keep averting your gaze
- Ask questions to try to understand the trigger for their behaviour
- Don't argue
- Listen and show you are listening
- Don't try to solve the problem prior to calming the young person

Adopting a non threatening body posture:

- Use a calm, open posture (sitting or standing)
- Reduce direct eye contact (as it may be taken as a confrontation)
- Allow the young person adequate personal space
- Keep both hands visible
- Avoid sudden movements that may startle or be perceived as an attack
- Avoid audiences – as an audience may escalate the situation

Never Threaten: Once you have made a threat or given an ultimatum you have ceased all negotiations and have put yourself in a potential lose situation.

De-escalation techniques

Explain your purpose or intention:

- Give clear, brief, assertive instructions, negotiate options and avoid threats
- Ensure the young person understands what you are saying
- Move towards a 'safer place', i.e. avoid being trapped in a corner

Encourage reasoning (for their behaviour):

- Encourage reasoning by the use of open questions and enquire about the reason for the aggression
- Questions about the 'facts' rather than the feelings can assist in de-escalating (e.g. what has caused you to feel angry)

- Show concern through non-verbal responses
- Listen carefully and show empathy, acknowledge any grievances, concerns or frustrations. Don't patronise their concerns.

Impact Factors

At times the judgement of staff can be affected by the situation they are in. When deciding if a member of staff acted lawfully these factors have to be considered:

- Relative sex, age, size, strength, skill level
- Special knowledge
- Numbers involved
- Drugs, alcohol
- Perceived danger / disadvantage

1.6 REPORTING AND RECORDING THE USE OF FORCE

Use of Force/Incident Report Writing

A report is always completed by the member of staff involved in the use of force explaining the circumstances in which force was used and presenting their reasons for deciding to use force.

- Whenever a member of staff has found it necessary to use force on a young person they must record the circumstances that led up to the use of force that was used and why.
- "Use of Force" includes any and all types of force that may be used against a young person – this includes the use of planned and unplanned PCC and any other techniques that might have been necessary.
- The purpose of the member of staff writing the report is to explain their actions and to demonstrate that the use of force was:

  - Reasonable in the circumstances
  - Necessary
  - No more force than necessary
  - Proportionate

Outcome

Copies of the Use Of Force/Incident Report Form may be produced for internal or external investigations. It is important that when a written statement is given it creates as full a picture as possible in order to justify the actions that have been taken.

The Supervisor

The Supervisor is responsible for ensuring that Use Of Force/Incident Report Forms are completed by all staff involved in the incident and any other staff that were witness to the incident.

When an incident is spontaneous it is not always possible for the Supervisor to be present at the beginning of an incident. However, the Supervisor is still responsible for the completion their own Use of Force/Incident Report Form and the collation of those of the staff.

All staff involved in the Use of Force

It is important that all staff who were involved in the use of force complete a Use of Force/Incident Report Form. The purpose of completing this form is for each member of staff to justify and explain their actions and the circumstances in which they took them. They must present as clear a picture as possible and should reference:

- Where the member of staff was when they became aware of the incident
- Details of any briefing given to them by the supervisor
- Details of attempts at de-escalation
- What circumstances they are aware of that led up to the use of force.
- Instructions given to the young person prior to force being used – this must include whether the young person was made aware of the consequences of their actions
- Their perception of the behaviour of the young person and what he/she was saying and doing
- The names of others present (both staff and young people)
- What their role was
- A detailed description of how they applied force
- How they felt about the incident
- Their perception of the resistance offered by the young person
- Quote any instructions given to the young person and the response received
- De-escalation efforts made (try to quote the words used)
- Whether ratchet handcuffs were applied and who authorised their use
- Where the young person was relocated to and how the relocation took place e.g. in holds, walking, in ratchet handcuffs
- Any injuries observed to staff and / or young person (See YJB Code of Practice 10.13)

Duty Manager

The Duty Manager must ensure that:

1. The Use of Force/Incident Report Form is completed in full
2. An Exception Report is completed where necessary (STC's only)
3. Every member of staff who was involved in any use of force has completed an Officer's Statement
4. An Injury Report (body map) has been completed on any young person involved in the incident
5. The Duty Director/Director has been informed
6. All Use of Force incidents are recorded within twelve hours of occurrence
7. The incident must be properly recorded and all paperwork stored appropriately
8. All reports are completed individually in a secure area with restricted access. All reports should be made available when requested for the purpose of investigations or for collative statistics on the use of force.

Staff should complete a Use of Force Report at the earliest opportunity, however, should any information come to light at a later stage, additions can be made to the initial statement

1.7 MEDICAL ADVICE

NTRG would like to thank Mr John Parkes of Coventry University for his professional assistance with the compilation of this section of the manual.

Introduction

It is not possible to create a totally safe restraint system. Whilst the techniques documented in this manual are intended to minimise harm, any use of force will involve an element of risk, both to the person being restrained and to staff.

All techniques contained within this manual underwent a formal medical review in 2007. In addition the advice contained here must be followed during any use of force and all staff involved have a

responsibility to monitor the young person and initiate a response to any change in their condition.

It is extremely important that staff involved in the use of force on a young person are aware of the signs and symptoms that may indicate that the young person is in distress. It may be the case that an incident should be treated as a medical emergency rather than a use of force incident. A member of health care staff must, whenever reasonably practicable, attend every incident where force is used or has the potential to be used.

It must be stressed that the onset of a serious medical condition following the application of physical or mechanical restraints is extremely rare – however it has been known for those in custody to die as a result of physical restraint if the correct procedures are not followed or if a previously undetected health condition is worsened by the restraint.

If it is considered that a young person's abnormal behaviour may be due to physical illness, mental illness or drug abuse, where practical, advice should be sought urgently from health care staff before any use of force techniques are employed.

Aim

The aim of this section of the manual is to provide learners with knowledge in recognising the health conditions which could result in harm to young people during physical restraint.

Mechanics of breathing[3]

In order to breathe effectively, the following are required:

- Clear airway
  - Mouth
  - Nose
  - Back of mouth/throat
  - Trachea ('wind pipe')
  - Lungs (large and small airways within the lungs)

[3] McArdle, W.D., Katch, V.L., Katch, V.I. (2005) Essentials of Exercise Physiology.' Baltimore: Lipincott, Williams & Wilkins

- Free movement of the ribs
- Free movement of the diaphragm

Compromise of any one, or more, of these will restrict or prevent breathing.

At rest, only minimal movement is required, and this is largely achieved by the diaphragm and the inter-costal muscles between the ribs. Following exertion, or when an individual is upset or anxious, the demands of the body increase greatly. Due to increased carbon dioxide in the blood, the rate and depth of breathing increases. This will require the movement of both the rib cage and the diaphragm to allow increased lung inflation. Failure to supply the body with the additional demand for breathing (particularly during or following the stress of a physical struggle) is potentially dangerous and may lead to death within a few minutes.

Restraint Asphyxia

Any restraint technique that compromises the airway or expansion of the lungs may seriously impair a young person's ability to breath, and can lead to asphyxiation. This includes covering the mouth and/or nose, pressure to the neck region, restriction of the chest wall and restriction of the diaphragm, which may be caused by the abdomen becoming compressed in seated, kneeling or prone (face down) restraint positions[4].

There is a common misconception that if an individual can talk, they are able to breath. This is not the case. Only a small amount of air is required to generate speech in the voice box, a much larger volume is required to maintain adequate oxygen levels around the body, particularly over the course of several minutes of struggle during a resisted restraint. A person dying from restraint asphyxia may well be able to speak before collapse.

A degree of asphyxia can result from any restraint position in which there is restriction of the airway, chest or diaphragm, particularly in those where the head is forced downward towards the knees.

[4] 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) 24-30

Restraints where the subject is seated require particular caution, since the angle between the chest and the lower limbs is already decreased. Compression of the torso against or towards the thighs restricts the diaphragm and further compromises lung inflation. This also applies to prone restraints, where the body weight of the individual, and restraining staff, can act to restrict the chest wall and the abdomen.[5]

Subjects who are obese are particularly vulnerable when placed in either the prone position or are seated with their stomach pushed forward toward their legs. These positions restrict the diaphragm and can lead to difficulties in breathing.

The use of restraint holds around the neck may be very effective and therefore tempting to staff in serious situations. However, they have a long history of causing sudden death during restraint.[6] Therefore **restraint holds around the neck must not be used.**

Risk factors for restraint asphyxia

Any factors that increase the body's oxygen requirements or decrease the ability to breathe will increase the risk of restraint asphyxia. A list of identified risk factors[7] is given below:

- **Prolonged restraint, where the person violently resists for an extended period of time.** (This has been identified as the single greatest risk factor)
- Obesity
- Restriction of or pressure to the neck, chest and abdomen
- Restraint of an individual of small stature
- Any underlying respiratory disease (e.g. asthma)
- Alcohol, or drug intoxication (alcohol and several other drugs can affect the brain's control of breathing). Alcohol is associated with death at high levels, through alcoholic poisoning.

[5] Parkes, J. & Carson, R. (2008) 'Sudden Death During Restraint: Do Some Positions Affect Lung Function.' Medicine, Science and the Law 48(2) 137-41
[6] Reay, D.T., Eisele, J.W. (1982) 'Death from Law Enforcement Neck Holds.' The American Journal of Forensic Medicine and Pathology. 3(3) 253-8.
[7] Stratton, S.J., Rogers, C., Brickett, K., Gruzinski, G. (2001) 'Factors associated with sudden death of individuals requiring restraint for excited delirium.' American Journal Of Emergency Medicine 19(3): 187-91

Unconsciousness may be followed by aspiration of vomit/compromise of airway.

- Pre-existing heart conditions. It is possible for heart conditions to go undetected until it is too late - examples are apparently healthy young people suddenly collapsing during sports or physical exercise
- Psychotic states (see Psychosis section later in this manual)
- Presence of an excited delirium state (see Excited Delirium section later in this manual)
- The individual becoming more aggressive due to a personal fear or misguided opinion of staff intention – for example a belief that staff intend to kill them.
- A combination of chest-wall or abdominal restriction in a seated, kneeling or leaning forwards position (this is particularly dangerous). Young people must be kept as erect as possible when they are being restrained in a seated position.
- Any covering of the airway (nose/mouth) by clothing, towels, or anything else which may restrict breathing; if the young person is in the supine (face up) position and spits at staff there may be a temptation to cover the face with towels, clothes etc. This must be avoided as it reduces their ability to breath. A safer alternative is to protect the staff with full-face visors and protective clothing.

Important warning signs

There are a number of important asphyxia warning signs:

- An individual struggling to breathe/laboured breathing
- Complaining of being unable to breathe. Young people may complain of being unable to breathe to get staff to release the restraint. Staff should never presume this to be the young person's intention and should immediately release / modify the restraint to reduce a body / wall restriction. Verbal complaints of being unable to breathe may be accompanied by increased struggling as the young person experiences fear/panic.
- Evidence or report of individual feeling sick / vomiting
- Swelling, redness or blood spots to face or neck

- Marked expansion of veins in the neck
- The young person becoming passive very quickly and offering no resistance
- Loss, or reduced levels of, consciousness
- Cyanosis (blue) around lips and finger/toe tips; this may be more difficult to observe in young people from African/Caribbean background, therefore greater care should be taken to observe
- Respiratory or cardiac arrest

Actions

The actions to be taken are as follows:

- **Immediately release or modify the restraint as far as practicable to achieve an immediate reduction in any restriction of breathing. Remove anything which may be blocking the airway.**
- Immediately summon medical attention and provide appropriate first aid in line with the policy of the establishment
- If subject is not breathing, administer rescue breaths
- If subject has no pulse, initiate CPR (cardio-pulmonary resuscitation), defibrillator if trained staff are in attendance
- Complete report
- Attend post incident de-briefing

Psychosis

Psychosis[8] is a general term used to describe mental conditions in which there is loss of contact with reality, abnormal experiences such as hallucinations and loss of insight.
Most people suffering from mental illness/psychosis are not violent, however fear, confusion and abnormal beliefs experienced by some people suffering from psychosis may cause them to respond in a violent manner.

[8] Puri, B.K., Laking, P.J., Treasaden, I.H. (2002) 'Textbook Of Psychiatry.' Edinburgh: Churchill-Livingstone.

There are many causes and types of psychosis, but common examples are:

Schizophrenia - a person may experience abnormal ideas, such as believing people will kill them. They may experience auditory hallucinations (voices which they can genuinely hear). These voices may make frightening comments or instruct them to behave in a certain way. The person's ability to concentrate and understand what is happening may be reduced.

Mania - the person will be over-active and excited. They may be unable to rest or sleep. They may be 'grandiose' believing themselves to be more important than they are, and therefore not obliged to listen to the instructions of others. The person may be irritable.

Drug Induced Psychosis - prolonged and/or excessive use of some drugs (for example amphetamines) may result in a psychosis which shows features of both of the above conditions.

Managing young people displaying psychosis

Young people experiencing psychosis must be regarded as seriously ill and in urgent need of medical attention.

Advice for dealing with young people displaying psychosis:

- Stay calm as this may have a calming effect
- Listen to what the person has to say – no matter how unusual
- Do talk to the person
- If safe to do so, remain at a distance and do nothing which may appear threatening
- Don't stare or make sudden movements which may be seen as threatening
- Ensure the presence of a member of healthcare staff
- Restraint may be necessary to ensure the safety of the young person or others

You should be aware that the person may be responding to their illness, for example hallucinatory voices, and may be unable to

comply with your instructions. Failure to respond to instructions should not be mistaken for deliberate non-compliance. It is valuable to listen to the person and attempt to understand why they are behaving as they are.

Even though what the person says may appear strange, it is often possible to understand, predict what they will do next and interact with them.

Using restraint on young people experiencing psychosis

There may be an increased level of risk in using any restraint techniques to control a psychotic young person without the benefit of medical support. As a result of fear or confusion the young person's responses may be abnormal, resulting in them struggling violently against persistent attempts to bring them under control through restraint. Prolonged restraint, which is violently resisted by a confused and frightened individual, may result in harm or death due to exhaustion.

Mental health services frequently use manual restraint with psychotic patients. Restraint may be necessary to prevent harm to themselves or others. Medical support is essential. In addition to providing physical health care, a doctor may consider disturbed behaviour caused by illness to be suitable for treatment by sedation, reducing the need for restraint. The length of time the person is restrained is a key issue: medical literature suggests **prolonged** restraint is the biggest risk factor and this is supported by the National Health Service and National Institute for Health and Clinical Excellence ('NICE') guidance.[9]

Excited Delirium

Description

Excited delirium[10] is both a mental state and a physiological arousal. It is closely associated with three underlying medical conditions:

[9] National Institute for Health and Clinical Excellence (2005) *Violence: The Short-Term management of Disturbed/Violent Behaviour in Psychiatric In-patient and Emergency Departments Guideline.* London: NICE

[10] Di Maio TG, and Di Maio VJM (2006) Excited Delirium Syndrome: Cause of Death and Prevention Taylor and Francis, New York.

- Prolonged use of illicit drugs (particularly cocaine, 'crack', methamphetamine and amphetamine)
- It has been associated with an abnormality which interferes with regulation of chemicals (dopamine) in the brain.[11]
- Psychiatric illness (Bi-polar Disorder and Schizophrenia)

The young person's underlying medical condition may be exacerbated by the psychological stress of being confronted or restrained.

Recognising a victim of Excited Delirium

Differentiating someone in excited delirium from someone who is simply violent is often difficult. People suffering from excited delirium may display the following symptoms:

- **Elevated body temperature**[8] (shedding clothes - sign of over-heating)
- Agitation or hyperactivity
- Hostility and violence
- Exhibit bizarre behaviour (paranoia or panic)
- Exhibit bizarre speech (incoherent shouting or grunting)
- Disorientation and impaired thinking
- Responding to hallucinations
- Unexpected strength and endurance, apparently without fatigue
- Insensitivity to pain
- Foaming at the mouth (drooling)
- Sudden passivity after frenzied activity

The shedding of clothes and raised body temperature are key symptoms to look out for.

Managing a victim of Excited Delirium

[11] Mash, D.C., Duque, L., Pablo, J., Qin, Y., Adi, N., Hearn, W.L., Hyma, B.A., Karch, S.B,, Druid, H., Wetli, C.V. (2009) 'Brain biomarkers for identifying excited delirium as a cause of sudden death.' Forensic Science International 190(1-3):e13-9. Epub 2009 Jun 21

Containment - where possible, to prevent the psychological reaction to perceived aggression exacerbating the condition, the young person should be given comparative freedom of movement in a cordoned area until appropriate medical assistance is available. However the need to protect the young person, staff and other young people from harm, and the security of the establishment, may make this strategy impractical.

Intervention - if containment is not an option then staff must gain control of the young person as quickly as possible.

The longer the restraint goes on the greater the risk of death becomes. It must be noted that pain compliance techniques may be ineffective in gaining control.

Restraint in a prone position (face down) should be avoided unless circumstances leave no other reasonable option.

Once control has been achieved, and **as soon as possible**, the young person should be placed in the supine position (face up).

Medical assistance must be sought immediately, particularly where the young person continues to behave in a disturbed manner and/or resist the restraint.

Sickle Cell Anaemia

Description

Sickle cell anaemia[12] is an inherited form of anaemia — a condition in which there are not enough healthy red blood cells to carry oxygen throughout the body. Sickle cell disorder is more common in black Africans, throughout the Mediterranean and Middle East and in some parts of India (and the descendents of these groups).

Under normal circumstances red blood cells are flexible and round, in people with sickle cell anaemia, the red blood cells are shaped like sickles or crescent moons. The haemoglobin (oxygen carrying) component of these blood cells is less effective than in healthy people, therefore the ability of the blood to carry oxygen is reduced. People with sickle cell anaemia may also be at greater risk of stroke

[12] Dyson, S., Boswell, G. (2009) Sickle Cell and Deaths in Custody. London: Whiting & Birch

and other organ damage. Clearly, both of these effects **increase the risk of death during restraint**.

Some people will have 'sickle cell trait' in which they carry the gene for the disease without experiencing the severe effects noted above.

Recognising a victim of severe Sickle Cell Anaemia

Some, but not all, young people who experience sickle cell disorder are aware of their condition and you should take seriously any information they tell you regarding their condition. The following signs may indicate a serious worsening of sickle cell anaemia,[13] sometimes referred to as "sickle cell crisis":

- Feels unwell, lethargic
- Jaundice (may be most noticeable as whites of the eyes being yellow in colour)
- Swollen hands and feet
- Pain in the chest, abdomen and joints (pain may be very severe)

Response

A person experiencing severe sickle cell anaemia will require urgent medical attention. There have been incidents where untreated sufferers have died in custody.

Sickle cell anaemia should be regarded as a factor which will increase risk of death during restraint. The following actions will reduce the risks:

- Ensure medical attention is provided
- De-hydration may increase the risks of sickle cell disorder – ensure access to fluids and encourage to drink
- Avoid restraint where possible
- Keep the duration of any unavoidable restraint to a minimum
- Avoid restraint positions likely to restrict breathing

[13] Sickle Cell Society (2007) Sickle Cell: A Guide For Teachers and Others Caring For Children. http://www.sicklecellsociety.org

Epilepsy

Epilepsy[14] is a medical condition involving abnormal activity of the brain which results in a 'seizure.' In some instances seizures will involve loss of consciousness, falling to the floor, and tensing of the whole body followed by rhythmical twitching of the muscles ('tonic-clonic seizure'). Other young people may experience seizures in which they appear absent and unresponsive without full loss of consciousness ('absence'). There are also seizures involving only part of the brain ('partial seizures') which may cause unusual experiences (for example seeing or hearing things) and behaviour dependent on the part of the brain affected.

Epilepsy is a common disorder (1 in 130 people) and is NOT normally associated with violence. However the following points are relevant in the context of safe management young people:

- If a young person discloses epilepsy, medical care and access to prescribed medication are essential. Seizures (and other serious reactions) may occur if anti-epileptic medication is suddenly stopped.
- A person recovering from an epileptic seizure may be confused and this should not be mistaken for wilful failure to respond to instructions. A young person may be resistive to interventions during this period if they do not understand what is happening. It is usually helpful to wait until full responsiveness returns (if no immediate risk is apparent).
- A young person experiencing an 'absence' type seizure may superficially appear to be conscious and able to respond. However, this is not the case and it is important not to mistake the seizure for a wilful failure to respond to instructions.
- There are comparatively rare reports of people engaging in potentially harmful actions whilst experiencing an 'absence' or 'partial' type seizure. Where possible allow the young person space to act without coming to harm. Move anyone who may be at risk out of the area. However, careful restraint might be needed if the young person puts them self at risk.
- A variety of issues may trigger a seizure. The young person may be aware of the triggers which are relevant to themselves.

[14] National Society for Epilepsy (2008) About Epilepsy. http://www.epilepsysociety.org.uk

A small number young people will experience seizures in response to flashing lights ('photo-sensitive epilepsy') and should not be deliberately exposed to strobe type lighting.

GUIDELINES FOR INSTRUCTORS

1.8 THE PROPER CONTEXT FOR TEACHING AND USING PHYSICAL CONTROL IN CARE

It is essential that Instructors, and the staff they instruct, should always have at the forefront of their minds that the techniques being taught are only one part of a range of possible responses to threatened or actual violent behaviour.

Such techniques are to be used **only when other methods not involving use of force have been tried and failed, or are judged unlikely to succeed, and action needs to be taken to prevent injury to young people, to staff, to other people or serious damage to property.**

THESE TECHNIQUES MUST ALWAYS BE SEEN IN THE CONTEXT OF THE TOTAL RELATIONSHIP BETWEEN CARE STAFF AND YOUNG PEOPLE.

Any suggestion that the appropriate response to disruptive or threatening behaviour is necessarily the use of force – or that violence should necessarily be met by violence – are unlawful and **must be discouraged**.

Instructors must always be conscious of the fact that, by what they say and do, they influence the attitudes and actions of the staff they are training. Instructors must at all times be mature and balanced in the attitudes and actions which they present. The presentation of a 'macho' approach is likely to be carried across into the manner in which staff perform their duties – to the serious detriment of their performance, their inter-personal relationships with young people and ultimately to the reputation of their employer.

APPROACH, ATTITUDE

Instructors teach skills which are vitally important to staff and their establishments. Only the very best will be acceptable.

Instructors will be instructing men and women of varying ages, physical competence, operational experience and aptitude to learn. Some may be over-confident, others apprehensive. The Instructor's task is to assess, reassure, teach and produce at the end of the

course a group both confident and competent to cope with violent situations, on different scales, which may arise in the course of performing their normal duties.

Each PCC course depends on the instructor's sensitivity, powers of observation, skill and ability to draw together all who take part in a shared objective. The instructor should always remember that a good course is much more than the sum of its parts. The importance of teamwork should be constantly stressed.

Often in the early stages of training courses members may discount PCC techniques in favour of a more physical approach towards resolving physical handling situations. The task of the instructor is to enable these staff to use their physical competence in a disciplined and controlled way for the common good.

It is important for instructors to bear in mind that all members of a course are colleagues and not recruits to be 'knocked into shape'.

No distinction of rank or sex is made on a PCC course. It is, and must always be seen as, a shared and unifying enterprise.

PRESENTATION

Instructors need to be in the training area well before the arrival of course members.

Their turnout must be exemplary.

An Instructor constantly represents the standards, which he/she expects, and will almost certainly get from the course members.

Regardless of an Instructor's own disposition on the day, or of the occasions on which he/she has taught the same skills, an Instructor must always present enthusiasm to pass on these skills. This is not without difficulty. If an Instructor cannot manage it, then perhaps he/she is not suited to be an instructor.

PREPARATION

FAIL TO PREPARE – PREPARE TO FAIL

The instructor should have thought about the session in advance and mapped it out with due regard to what is known about the skill of the class members and the time available.

The session timetable is merely a guide, and the instructor should not feel they must stick rigidly to it. Each course is different and the instructor must use judgement and experience to decide how best to use the time available to the best advantage of the course members. It is none the less important that instructors cover the full lesson programme where possible and not get entrenched in delivering only certain aspects of the course.

LESSON PLAN

It is not possible to reproduce within this manual all the teaching points that instructors must necessarily relate to staff as only a brief description of the techniques and systems of PCC training is given. Instructors should expand on the outlined points by producing a comprehensive lesson plan for each session they are to take.

INSTRUCTORS SHOULD NOT MAKE ANY CHANGES TO THE PROGRESSION IN WHICH PCC TRAINING IS TAUGHT, NOR MAKE ANY ADJUSTMENTS TO THE TECHNIQUES OUTLINED IN THIS MANUAL.

INSTRUCTION

Effective training must be demanding, reproduce so far as is possible the operational situations within which the techniques will be used. Instructors must ensure that this is not achieved at the expense of course members' safety.

TEACHING TECHNIQUE

Instructors should ensure that they are accompanied by another instructor whenever they are instructing. Class numbers should be relative to the facilities available and the number of instructors that can be used.

Instructors should be enthusiastic but avoid excess dialogue.

Five minutes of practice are worth an hour of talking. As a general rule instructors should:

- Demonstrate the full technique
- Break into parts (talk through)
- Demonstrate once more
- Use progressions to facilitate learning
- Allow the course to practise
- Circulate amongst the course

Instructors must always bear in mind that the purpose of training is to prepare staff to manage real-life situations, not to re-create them exactly.

It follows that it is the responsibility of the instructor and their training managers to ensure that the degree of realism simulated in training is no more than is necessary to achieve the training objective. Training simulations should reflect operational circumstances.

Instructors need to take every possible precaution to minimise injury and, in legal terms, to ensure that there can never be any question of negligence on the part of the instructor or their employer.

When use of physical handling skills are used in training scenarios an instructor must supervise the event and act as a safety officer. Should a safety problem arise the training should be stopped immediately.

COACHING

Instructors must also satisfy themselves on a number of important points, which are presented below in checklist form:
Instructors should: -

- Draw attention to the main faults
- Avoid identifying individuals (faults are shared)
- Follow this with more practice
- Discuss any operational difficulties
- Ensure that the demonstration can be seen by everyone
- Speak clearly and distinctly
- Encourage and allow questions
- Maintain careful observation
- Stop activity immediately if there is any likelihood of injury
- Be on the lookout for signs of boredom and fatigue
- Be prepared to modify the lesson to meet the needs of the class
- Return to basics if the need arises

EQUIPMENT

Ensure that all equipment used in training is in good order, regularly maintained, sufficient to meet the needs of the class and in the right position.
Ensure the class members wear correct equipment when they are required to do so.

SAFETY PRECAUTIONS

No training that is effective, challenging or involves physical contact can be entirely free of risk of injury**.**

DRESS

Instructors should ensure that course members are appropriately dressed for the activity. Potentially dangerous items such as belts, watches, and jewellery should not be worn during training sessions. Suitable footwear should also be worn.

VENUE

Instructors are responsible for ensuring that the venue for use has sufficient space for the activity, has an appropriate covering on the floor and any structural problems that might affect the running of the course are catered for.

ORGANISATION

Instructors should ensure that best use is made of the area available. Working the course in pairs, threes, fours or groups requires pre-planning and good organisation.

DISCIPLINE

In general PCC training imposes its own discipline. However instructors need to be observant and continually ask themselves:

“Are things in control?”

“Are members of the group likely to prejudice this control through lack of effort, apathy, irresponsible behaviour or sheer lack of interest?”

FEMALE YOUNG PEOPLE

Where necessary instructors should give advice to staff regarding specific issues that affect the physical restraint of young females.

In particular the possibility of pregnancy has a direct bearing on several techniques within the PCC syllabus. The techniques concerned will be covered as part of the physical techniques section of this manual.

DE-BRIEFING

Following the end of each session, each instructor should ask themselves;

- Did the session achieve its objective?
- Could the session be improved?
- Does there need to be a review of the progressions?
- Did I take account of the course members comments?
- Were there any salient operational points to take away from the session?

MONITORING OF INJURIES

At the end of every session involving physical handling, instructors must ask course members if anyone has been injured.

Injuries should be recorded in the Accident Report Book and a report obtained from the injured person plus any witness statements.

The frequency and type of injuries should be monitored. This information should be used to identify possible ways of reducing injuries and improving the delivery of training.

Each injury must be fully investigated and fully recorded.

GUIDANCE FOR PREPARING A PRESENTATION

Before Starting

- Make a note of your start and finish time
- Remove your watch and place it on the desk
- Make a note of the visual aids and handouts (if you want to use them) and make sure they are ready
- Do not prepare too much material
- Have some questions ready in case you have time to fill

OHPs / Power Point / Flip chart / Whiteboard

- Don't walk in front of the projector light; it can damage your eyes
- Ensure print is large enough to be seen by all candidates
- If you need to mask some of the print use 2 sizes of masks
- Use bullet points on the OHP/Power Point and read from your notes
- Use upper case and lower case text.

Starting your presentation

- Introduce yourself and your subject
- State the aims and objectives of the presentation
- State if you want questions during or after your presentation
- Don't rush your presentation

During the Presentation

- Maintain eye contact with candidates
- Use humour, but don't overdo it
- Illustrate any points made by examples
- Get feedback

End

- Ensure you have achieved your aims and objectives
- Ask for questions

SAFE SYSTEM OF WORK

Physical Control in Care Basic Training

General

1) Only approved techniques contained in the Physical Control in Care Manual will be taught, demonstrated and practised.
2) Only qualified Physical Control in Care Instructors will deliver this training.
3) No Physical Control in Care training will take place without the correct amount of Instructors present i.e.
    - 1 to 16 pupils require a minimum of 2 Instructors.
    - For each additional 8 or part of, an extra Instructor will be required

4) Before any training session takes place, the Instructor will check the following;

    - That the training area is safe i.e. there are no tears or rips on the crash mats and it is of adequate size for the numbers being trained
    - The equipment to be used is safe and adequate
    - The location of the First Aider, if there is not one present in the actual training room
    - The location of the First Aid Kit, First Aid Room and be aware of local Fire Rules and Muster Points.
    - All staff will be asked by the instructors if they have a medical condition, disease or injury that would prevent them from participating in this training, or that such training would cause

more distress. Those who have should be excluded until such time as they are fully fit to take part.

- All staff will remove jewellery, watches, rings, chains and belts etc
- All staff will be correctly attired i.e. training shoes, appropriate comfortable clothing

5) All students will take part in the 'warm up'. The 'warm ups', although not requiring a high level of fitness, will be sufficient so as to prepare all muscle groups for the activity they are about to practise.
6) All techniques will be taught and practised in progressive stages taking account of the capabilities of the class.
7) Instructors will ensure that pupils are not using excessive force when practicing Physical Control in Care techniques and that if they hear the word '**OXO'** everyone must stop and release any holds immediately.
8) Staff will be reminded of the law and the STC rules governing the use of force.
9) At the end of each session, all staff will be asked if they have any injuries. Any reported injury, however small, will be correctly recorded and documented. Students will be advised of reporting procedures for injuries that are a direct result of the training but not diagnosed at the time of training.

WARM UPS

Prior to any PCC session the Instructor must physically prepare the students for the session. This promotes good practice and ensures that the Instructor is adhering to the Safe Systems of Work of the PCC Manual.

The warm up should be effective and specific, taking no longer than necessary and taking into consideration the students age and physical condition.

OBJECTIVE

The objective is to ensure that Instructors plan and deliver a safe warm up.

TYPES OF WARM UPS

A **general** warm up involves rhythmic body movements unrelated to the proposed activity. A **specific** warm up relates to the area of the body to which attention is needed.

THE COMPONENTS OF A WARM UP

1. Pulse raising exercises
2. Body weight exercises
3. Mobility exercises
4. Stretching exercises

PULSE-RAISING EXERCISES

The purpose of the pulse-raiser is to warm the body and **gradually** elevate the heart rate. Graduation of the exercise intensity is important as it provides the heart with time to increase stroke volume and cardiac output. Just as important is the time needed to establish vasodilatation, (dilation of the blood vessels) within the muscles. The capillary beds within the muscles dilate; this enables

more blood, heat, nutrients and oxygen to be circulated through the muscles. Sudden exertion without a gradual build up can lead to an abnormal heart rate and inadequate blood flow to the heart. This could be potentially dangerous to an unfit person. To avoid suddenly stressing the cardiovascular system, the pulse-raiser should be of low to moderate intensity.

BODY WEIGHT EXERCISES

The purpose of body weight exercises is to enable the warm blood to flush into the muscle groups within the body. By utilising exercises such as press ups and free standing squats, Instructors can ensure that the majority of the primary and secondary muscle groups have been prepared for any further physical activity.

MOBILITY EXERCISES

Before an exercise session it's advisable to mobilise and prepare the specific joints to be used in that activity. These activities refer to slow and gentle rhythmic joint movements. For example, shrug your shoulders and gently roll them back and repeat in the opposite direction. This would be an example of a mobility exercise for the shoulder girdle.

From the point of preparing the body for an activity, it makes sense that all the major joints are mobilised.

For example, preparation for a PCC session may include the following mobility exercises.

JOINT	MOBILITY EXERCISE
Ankles	Ankle circles
Knees	Knee bends and rolls
Hips	Hip circles
Thoracic spine	Trunk Twists
Shoulder Girdle	Shoulder rolls and circles
Elbows	Elbow bends

STRETCHING EXERCISES

The purpose of a preparatory stretch is to ready the large muscle groups which are to be used throughout a PCC training session. The stretches should be held for up to ten seconds. Remember the objective of a preparatory stretch is to ready the muscles and not to develop flexibility.

Although there is no significant scientific evidence to state that you need to stretch in a warm up. It's both logical and appropriate to do so to fully prepare the body for the training session. A cold muscle has a reduced blood flow and as such is relatively inelastic which would increase the potential for muscle strain.

KEY POINTS

- Stretching should **not** be performed prior to the pulse-raiser.
- Duration of the warm up should be between 5 – 10 minutes.
- De-conditioned, sedentary and unfit staff will require a longer and more gradual approach and will fatigue quicker on a training session.

PCC
HOLDS

SECTION 2: PHASE II

2.0 THE ROLE OF THE PCC SUPERVISOR.

Staff may be deployed only with the necessary authority.

Wherever possible every incident should be overseen by a supervisory member of staff. It is recognised that in some circumstances the staffing levels, or a need to resolve the incident quickly, may preclude the appointment of a supervisor. In these circumstances the No. 1 of the team must undertake the responsibility of the supervisor.

A supervisor must be appointed for every planned removal prior to the deployment of staff to resolve the incident. In all PCC incidents the Supervising Officer will be accountable for the management of the incident until the incident is resolved. Experience and knowledge are key factors in determining who fulfils this role.

The supervisor must make every reasonable effort to resolve the incident with the young person without the need for restraint.

The team will be deployed by the supervisor after all reasonable efforts at resolving the incident have failed or are judged unlikely to succeed, and if it is necessary to prevent injury to staff, young people, or serious damage to property.

Preparation:

The supervisor is in overall charge and will take no active part in the resolution of the incident, but will remain accountable for the management of it.

After all attempts to terminate the incident by persuasion, the supervisor must:

1. Assemble the staff with sufficient replacements/support.
2. Ensure that those staff participating are PCC trained and are currently qualified and fit to carry out the tasks.
3. Make arrangements to assemble such support services as may be needed (time permitting) e.g healthcare and other specialist staff.

4. They then must brief the staff about:

- The young person, including any non confidential medical issues.
- The current situation.
- The routes and relocation area.
- Their individual roles.

5. Ensure that the staff are properly attired and that articles that might cause injury to themselves or others during the resolution of the incident are removed. These would include obtrusive rings, necklaces, and security keys.
6. Consult healthcare staff where time permits for available information on medication, pregnancy, etc.
7. Brief support group staff as to their function.
8. Where possible ensure the incident area is cleared of other young people and any staff who are not required.

The Removal.

The supervisor must:

1. Unlock any door(s) to facilitate the entry of the team(s).
2. Monitor the condition of the young person and staff involved in the incident.
3. Be prepared to replace staff who show signs of fatigue or who have been injured.
4. Be prepared to release a young person immediately if there is a risk of harm or injury to them or a member of staff

The Role of the Healthcare Staff.

A member of the healthcare staff must attend every incident where PCC is used or likely to used to restrain young people.

The member of healthcare must monitor the young person and members of the PCC team, and provide clinical advice to the supervisor and/or team in the event of a medical emergency. Any clinical advice offered must be adhered to by the supervisor and/or team, including any decision by healthcare to release holds due to the potential health implications of continued restraint.

Moving a Young Person

The supervisor must:

1. Inform the team and ancillary staff about where the young person will be relocated.
2. Decide on the route to the relocation area.
3. Delegate staff to ensure the route is clear of other young people and staff are not involved.
4. Ensure that all gates and doors are unlocked/locked to aid the smooth passage of the team(s) through the establishment.
5. Continuously monitor the condition of the young person and the staff involved in the incident.
6. Ensure that communications between the No. 1 of the team and the young person take place in an attempt to de-escalate the incident.
7. Work in conjunction with the No. 1 of the team, continuously assessing whether restraints are still necessary and ensuring that no restraint is used once it is no longer necessary.

Relocation of a Young Person

The supervisor must:

1. Remain throughout and oversee the relocation of the young person.
2. Work in conjunction with the No. 1 of the team, continuously assessing whether restraint is used once it is no longer necessary.
3. Ensure that only those required in the relocation process are in the immediate vicinity.
4. Ensure that any members of staff vacate the area and that the room is secured.
5. Ensure that after the room has been secured the young person has been observed.
6. Ensure that any member of staff injured during the incident is offered medical attention.
7. Ensure that the young person is seen by a Medical Officer/Nurse as soon as is possible. If a Medical Officer is unavailable, the young person should be seen initially by a professional health care worker and then by a Medical Officer as soon as is practicable

8. Debrief all staff involved and collate the use of force reports - the use of force reports should be completed by staff independently of any other staff involved in the incident. Offer care services to all staff involved. Complete an injury form for the young person, even if no injury is visible or reported.
9. Collate any CCTV evidence and witness statements.
10. Consider Polaroid photos for any reported injuries.
11. Debrief the young person at the most opportune moment.

Resolution and Movement

If following a serious incident where negotiation takes place and proves to be successful the supervisor will consider whether it is safe to lead the young person away without having to use any form of physical restraint or force. If this is the case the following methods should be used to ensure staff safety:

Three members of staff are positioned near to, but out of the young person line of vision.

The sincerity of the young person is tested by the negotiator asking them to place any visible weapons on the ground and asking whether any other weapons are concealed on their person.

The negotiator will then ask the young person to walk slowly towards the door with their hands in a position that the negotiator can see.

The door will then be opened by the supervisor and the young person asked to step out of the room.

Once outside the room the young person will be asked to take a step to the side facing the wall and place their hands on the wall in front of them.

At every stage co-operation and understanding by the young person must be established and tested before moving to the next stage.

One of the three members of staff waiting outside the room will conduct an appropriate search and the young person led away in the following manner:

Two members of staff will take up a position behind the young person with an appropriate reactionary gap.

The third member of staff will take up a position in front of the young person with a similar reactionary gap with supervisor placed to the rear of the young person but in view of the number 1. Their role will be to oversee the safe conclusion of the incident and to support the staff.

The member of staff at the front of the team should give clear instructions to the young person.

The members of staff should always be in a position to react if the young person becomes violent again.

The young person will then be led away to an agreed destination where procedures under the 'Role of the Supervisor' should be adhered to.

Local handling/Care plans

Each establishment will have local handling plans in place for dealing with specific young people in their care where there are known medical implications or more general impact factors that may have a bearing on how and when restraint should be applied.

2.1 PROTECTIVE STANCE.

To reduce the risk of injury, staff should adopt a side on stance to the young person when dealing with a potentially violent situation.

To minimise the risk of injury, staff will adopt a protective stance when dealing with potentially dangerous situations.

This stance will:

- Reduce the target area.
- Allow good balance.
- Provide ease of movement in all directions.

The member of staff will adopt a side position with either left leg or right leg leading. Although each individual will have preference, it is

important that they practice in both stances as many of the techniques taught dictate which stance is required.

The hands at this stage will be at about waist level in an open gesture, palms up.

If the situation escalates and force or defensive techniques are likely to be necessary the member of staff will bring their hands up between the waist and shoulders, with the elbows tucked into the sides. The hands remain open with palms towards the young person. This position offers maximum protection and allows a smooth transition to approved holds.

Teaching points:

- The member of staff to turn side on, hands at waist level with an open gesture.
- The member of staff moves using a step and glide foot movement.
- The member of staff practices with alternate legs leading.

STUDENTS WILL PRACTICE MOVING FORWARD AND BACK, USING A 'SLIDING ACTION', PAYING PARTICULAR ATTENTION TO AVOID CROSSING THE FEET.

2.2 DOUBLE EMBRACE

The double embrace holds are the most frequently applied Phase 2 holds. All other Phase 2 and Phase 1 holds when escalated, ultimately end in a double embrace.

The preferred option is for two staff to approach from the rear of a young person whose focus of attention is to the front.

The staff will approach the young person in protective stances; they will be back to back.

The members of staff will have their hands and arms in position where they can safely and effectively block any deliberate or accidental strikes from the young person.

As they make contact with the young person the staff will use their forearms to initially block the upper and lower arm of the young person.

HAND POSITION FROM THE REAR

The member of staff's lead hand is then passed across the young person's back with the palm facing outward, thumb toward the floor. This will reduce the risk of the hand becoming caught in clothing. Taking hold of the young person's upper forearm from the inside, the member of staff will ensure that their thumb is on top of the young person's arm. They will then pull the arm into the young person's body just above the hip. The young person's hand should be palm down.

At the same time the member of staff will take hold of the young person's lower forearm of the other arm using a palm up grip. The young person's bent arms will be pulled backwards slightly and tucked tightly into their sides.
Both members of staff will carry this out simultaneously on each side. When both members of staff have control of the young person's arms they will position their hips alongside the young person with their heads held away from the young person to reduce the risks from head-butts.

Staff must take care not to place their hands on the young person's wrist.

FINAL POSITION

From this position staff can move the young person away whilst de-escalating the situation.

If they need to change direction one member of staff will give the command '***ON ME***', and at this point they will pivot on their inside leg with the other member of staff continuing to move in the direction required.

STUDENTS WILL PRACTICE THIS TECHNIQUE <u>ONE ON ONE</u> UNTIL THE INSTRUCTOR IS SATISFIED THAT ALL STUDENTS ARE COMPETENT.

STUDENTS WILL PRACTICE IN GROUPS OF THREE.

2.3 FIGURE OF FOUR ARM HOLD.

When it is not possible for two staff to approach from the rear, the next technique to achieve the Double Embrace Hold is:

- One member of staff in front.
- One member of staff from rear.

The member of staff at the front will take up a protective stance; this will dictate which arm they control. For example, if the member of staff's left leg is leading, then they will control the young person's left arm.

The member of staff at the rear will adopt a protective stance and control the opposite arm of the young person. The member of staff at the rear will be leading with the same leg as the member of staff at the front.

The member of staff at the rear will apply a Figure Four Arm hold in the following manner:

After blocking the young person's arm as previously described, the member of staff's outside hand secures the young person's lower forearm using a palm up grip. The member of staff's other hand passes between the young person's arm and body. The member of staff wraps their hand over the forearm of the young person. The member of staff's hand then secures their own outside forearm/ wrist. They will keep their hips in to the young person and their head angled away.

STUDENTS TO PRACTICE ONE ON ONE.

2.4 WRAP AROUND ARM HOLD.

Having described in the previous section the role of the member of staff approaching from the rear, we now concentrate on the role of the member of staff at the front.

From the protective stance the member of staff blocks the upper and lower arm of the young person using their own forearms.

The member of staff then wraps both their own arms over the young person's arm taking care that their own elbows avoid contact with the young person's head.

The member of staff hands will then grip the young person's arm above and below the elbow ensuring they do not place their hands near the young person's wrist.

The member of staff maintains an upright posture keeping their back straight and steps back slightly with their outside leg, into a side on stance. Their weight distributed evenly, wrapping the young person's arm across their body ensuring they do not block the young person's elbow. They then place their own elbow across the young person's shoulder.

STUDENTS TO PRACTICE ONE ON ONE.

STUDENTS THEN PROGRESS TO PRACTICE ONE FROM FRONT, ONE FROM REAR, APPLYING BOTH FIGURE FOUR-ARM HOLD AND THE WRAP AROUND ARM HOLD.

2.4.1 TRANSFER TO DOUBLE EMBRACE.

Once both members of staff are in control of their respective arms the holds need to be converted into a Double Embrace Hold.

The member of staff in the Figure Four Hold will take the lead, as they are in a better position to monitor and view both the young person and the other member of staff. They will give the following instruction:

On the command '***PRESENT***', the member of staff in the Wrap Around Arm Hold will move their hand on the young person's forearm to a position just above the young person's wrist. They will then allow the young person's arm to bend naturally at the elbow. They will push the young person's arm upwards and move to a position where they are standing at the side of the young person facing towards them. This will give the other member of staff the opportunity to access the

young person's forearm ready to apply their part of the Double Embrace Hold.

Once that part of the Double Embrace Hold is secure the member of staff that presented the arm will now bring their own inside hand to the lower forearm of the young person in a palm up grip. They will maintain a hold of the young person's arm with their other hand ensuring that they have a 'thumb to thumb' grip. At the same time they will pass their inside arm across the young person's back and apply their part of the Double Embrace Hold as previously learned.

THE STUDENTS WILL PRACTICE THIS ONE ON ONE FROM THE WRAP AROUND ARM HOLD.

ONCE THE INSTRUCTOR IS SATISFIED ALL STUDENTS ARE COMPETENT IN THE CONVERSION THEY WILL PRACTICE IN GROUPS OF THREE, ENSURING ALL STUDENTS PRACTICE BOTH ROLES.

2.5 DOUBLE WRAP AROUND ARM HOLD.

The Double Wrap Around Arm Hold is applied when it is not possible for staff to approach from the rear.

Two members of staff will approach from the front in protective stance ensuring they are back to back.

Both staff will apply a Double Wrap Around Arm Hold as previously taught.

It is important that both staff maintain an upright position to keep the young person's head between their backs. This will reduce the risk of injury to both the young person and staff.

Staff should move into the Double Embrace or to two Figure of Four Holds at the earliest opportunity, ensuring that the young person is constantly observed and monitored throughout.

STUDENTS TO PRACTICE THIS TECHNIQUE IN GROUPS OF THREE.

2.5.1. TRANSFER TO DOUBLE EMBRACE.

From this position one of the members of staff will convert their hold into a Figure of Four Arm Hold.

From the Wrap Around Arm Hold one of the members of staff will place the young person's arm into the side of the young person's body with the hand palm downwards and above the hip. They then move to the outside of the young person, placing their outside hand onto the young person's lower forearm, using a palm upwards grip they place their own hand next to their other hand before moving into the Figure of Four Arm Hold as previously described.

The technique is then completed by continuing into the Double Embrace Hold as previously described, one member of staff from the front and one member of staff from the rear.

STUDENTS TO PRACTICE THE CONVERSION ONE ON ONE

STUDENTS TO PRACTICE IN GROUPS OF THREE.

2.6 DOUBLE EMBRACE LIFT.

INSTRUCTORS NOTES:

Before allowing students to practice this technique the instructor must explain correct lifting technique utilising kinetic lifting techniques, i.e. keep back flat, using legs to lift. Keep a good firm base with the feet.

Anyone with existing injuries to back, knees, shoulders, etc. are NOT to participate in this session.

This technique is only to be used as a last resort and only over a short distance.

Both members of staff must be in agreement prior to the lift and will only use it if confident of its success.

Never attempt this if the disparity in size and strength between the staff and young person is too great.

Split the working groups into equal size/strength and avoid performing too many lifts.

From the Double Embrace it is possible to lift a young person if: -

- They are continually dropping their body weight thereby hindering the movement process.
- Hooking their legs around furniture/fixtures.
- Preventing staff moving them through narrow doors/corridors.
- Or, in any way compromising the safety of themselves or staff.

If left with no alternative option then the Double Embrace Lift will be used in the following way:

The inside leg will step back allowing the staff to be facing inwards towards the young person. The outside hand will be removed from the young person's nearside arm, at this and all subsequent times, the inside arm will maintain contact across the young person's back onto the far arm. The member of staffs outside arm will be placed behind the young person's knee.

On the command '***LIFT***', both members of staff will lift the young person using correct lifting skills.

They link hands avoiding interlocking the fingers.

From this position the young person can be carried over a short distance or until the lift can be safely released

This technique can be used several times if necessary. However it may be necessary to replace staff as this technique can be physically demanding.

STUDENTS TO PRACTICE IN GROUPS OF THREE.

INSTRUCTORS NOTE:

ENSURE THE MEMBERS OF EACH WORKING GROUP ARE OF SIMILAR BODYWEIGHT AND SIZE

2.6.1 DOUBLE EMBRACE LIFT ESCALATION.

If the young person continues to be disruptive then the hold can be escalated to include a third and fourth member of staff. This will only be used when releasing the hold could result in further escalation of the incident or injury to the young person or staff.

THIRD MEMBER OF STAFF.

From the Double Embrace Lift position the third member of staff can take control of the young person's head in the following way:

The third member of staff designated to control the young person's head approaches from behind in a protective stance. Their lead hand will be placed on the young person's forehead, palm down. The trail hand will be placed on the back of the young person's head supporting it, palm up. This prevents the young person's head from snapping back and also reduces the risk of the young person head-butting staff.

The use of the head support should be carefully monitored. It is the responsibility of the person controlling the head to ensure that the spinal column is maintained in a straight line and that breathing is not impaired.

The young person should be constantly monitored by Health Care Staff and the restraint risk assessed to ensure that it is safe for the restraint to continue. If breathing is compromised the situation ceases to be a restraint and becomes a medical emergency, and all holds must be released.

STUDENTS TO PRACTICE IN GROUPS OF FOUR.

FOURTH MEMBER OF STAFF.

If required a fourth member of staff can support the lift by controlling the young person's legs in the following manner:

The member of staff will approach safely in a protective stance from the side of the young person's legs. The member of staff will ensure that they are facing towards the young person's feet. The member of staff's lead arm will pass over the young person's legs then back under to interlock their hands to prevent the young person's legs from kicking out.

The leg member of staff can now guide the team as they are in the best position to evaluate any hazards.

STUDENTS TO PRACTICE IN GROUPS OF FIVE.
DE-ESCALATION OF DOUBLE EMBRACE LIFT.

If at any time the young person begins to calm and it is safe, then the additional staff release their hold of the legs and their support of the head.

Remember this technique is a last resort, and is only to be used over a short distance.

When the lift is no longer required then the young person is placed back on the ground and the Double Embrace Hold re-applied.

2.6.2 HOLD RELEASE OPTION

At any time should the situation deteriorate to such an extent that the continued application of any of the previously described holds represent an unacceptable risk to the young person or staff then the holds should be released.

Communication between the staff is important to affect a simultaneous release of the holds.

On the command ***'RELEASE'*** **,**both members of staff will release their holds and move away from the young person while maintaining a protective stance.

While maintaining a reactionary gap staff will continue their dialogue with the young person. Should it be necessary staff will re-engage the young person using the Two from the Front technique previously described. The reactionary gap will be between 1½ and 2 arms length distance away from the young person thereby allowing the member of staff sufficient time to react to any physical threat from the young person.

STUDENTS TO PRACTICE IN GROUPS OF THREE.

2.7 DE-ESCALATION

At all times the objective for staff is to de-escalate the situation, this can be done in a number of ways, and staff should use all of their skills to achieve the objective.

If this proves successful, then staff should look to release any holds and resolve the situation without the use of force.

If at any time a member of the Health Care assessors deems that the continued use of holds presents a medical risk, then all holds will be released immediately.

If the situation initially requires a hold that requires more than one member of staff, then staff should at all times look to de-escalate to a lower phase of hold. This will be dependent on the level of resistance offered by the young person and with the full agreement of the staff involved following a dynamic risk assessment.

2.7.1 DE-ESCALATION

Option 1:

When a young person has been removed in the Double Embrace and is safely relocated into their room, staff then have two options as to the de-escalation method to be used.

If the situation requires the staff to be present elsewhere within the establishment then once inside the room the young person will be placed in a position facing the far wall.

On command **'*RELEASE*', ** both staff will release their holds and withdraw from the room in a protective stance back to back facing the young person. Staff will secure the door and return to the young person at the earliest opportunity.

STUDENTS TO PRACTICE IN GROUPS OF THREE.

2.7.2 DE-ESCALATION

Option 2:

If there is adequate time and resources to allow the staff to fully de-escalate the situation then once they are in a suitable position the Double Embrace will be converted into two Figure of Four arm holds. The young person will then be sat down onto either a chair or their bed. As the young person is sat down their legs will be eased forward by the member of staffs inside leg, the young person will be kept upright throughout.

As the situation calms down then the hold can be further de-escalated to one member of staff. This will depend on who is nearest the exit. The non-door side staff will exit first, prior to leaving the door side staff will change their outside hand from an underhand to overhand grip and move their inside arm from the upper forearm to the young person's shoulder.

At this point the non-door side staff will release their hold and move around the young person in a protective stance and position themselves at the door as a safeguard should the situation deteriorate and holds need to be re-applied.

Maintaining the dialogue the remaining member of staff releases their hold and continues dialogue until it is suitable to exit the room.

STUDENTS TO PRACTICE IN GROUPS OF THREE

SECTION 3: PHASE III.

Phase 3 involves the introduction of a third member of staff. Any Phase 2 hold can be escalated into a Phase 3 hold. This will normally only be required if the young person is so violent that a Phase 2 hold is deemed to be inadequate, and the safety of the young person or staff is at risk If this is the case a third member of staff will be used to control and protect the young person's head until de-escalation becomes possible.
The member of staff protecting the young person's head will become the Number 1 of the team. The other two members of staff become the Number 2 and Number 3 of the team, as designated by the Number 1.

3.0 RESPONSIBILITIES OF THE MEMBER OF STAFF PROTECTING THE HEAD (THE NUMBER 1 OF THE TEAM)

a) In charge of the team.

b) Responsible for the control and protection of the young person's head, and for observing the head and neck.

c) To monitor the condition of the young person, to ensure that it is safe to continue with the restraint.

d) To monitor the condition of the staff.

e) Maintain dialogue with the young person throughout, explaining what is happening and trying to calm the young person down.

f) To instigate any movement of the young person by the team during the holds.

ROLE OF THE HEAD SUPPORT OFFICER

The member of staff approaches in a protective stance and being aware of the young person's legs. The leading hand is placed on the rear of the young person's neck and the young person's head is lowered forward and downwards. The head will be lowered to

comfortable position for the head support officer. This may result in the head being in a position that is lower than the recommended guidelines i.e lower than the heart. If this is the case then the head support officer and any medical staff in attendance should closely monitor the young person. Where practicable the incident supervisor must give due consideration to replacing the head support officer with a member of staff with less size disparity to the young person.

Consideration must be given to the potential breathing problems related to the head support position as outlined in the Medical Advice section of this manual.

The application of the head support position will have the effect of restricting the young person's ability to kick forward.
The member of staff's trailing hand will remain in a protective position until the danger from the young person's head has passed. The trailing hand will then adopt a head support position for the head.

The member of staff index finger, second finger and thumb will cup the young person's chin. Care should be taken that the remaining fingers do not come into contact with, or apply pressure to the throat area of the young person. The member of staff's forearm should be extended down the side of the young person's nose.

To control and protect the young person's head it should be kept in close proximity to the body of the head support officer.

N.B. **THE YOUNG PERSON'S HEAD SHOULD REMAIN IN AS NATURAL A PLANE AS POSSIBLE. IT MUST NOT BE TWISTED OR TURNED.**

THE USE OF THE HEAD SUPPORT SHOULD BE CAREFULLY MONITORED. IT IS THE RESPONSIBILITY OF THE PERSON CONTROLLING THE HEAD TO ENSURE THAT THE SPINAL COLUMN IS MAINTAINED IN A STRAIGHT LINE, AND THAT BREATHING IS NOT IMPAIRED. THE YOUNG PERSON SHOULD BE OBSERVED CONSTANTLY BY STAFF WHO SHOULD CONTINOUSLY RISK ASSESS THE INTERVENTION IN ORDER TO ENSURE THAT IT IS MEDICALLY SAFE FOR THE RESTRAINT TO CONTINUE.

IF BREATHING IS COMPROMISED THE SITUATION CEASES TO BE A RESTRAINT AND BECOMES A MEDICAL EMERGENCY.

In exceptional circumstances a member of staff may make a decision to take control of the young person's head prior to the application of controlling holds to the arms. This may be due to a perceived imminent threat to there personal safety and therefore the safest option.

THIS OPTION WILL ONLY BE USED IF RESPONSE STAFF ARE IN CLOSE PROXIMITY IN ORDER TO APPLY CONTROLLING HOLDS TO THE ARMS.

3.1 MOVEMENT

The young person should be moved in the Double Embrace Hold with the No 1 supporting the young person's head.

The No 1 must ensure that they maintain dialogue with the young person. They must also continue to monitor the condition of the young person and the other team members.

3.2 YOUNG PERSON ON THE GROUND.

Prone position.
If during the restraint a young person deliberately takes themselves to the ground, the staff will maintain the holds and the No. 1 will protect the young person's head. If the young person is already on the ground and restraint is necessary then the following techniques will be used.

Once on the ground staff must be particularly aware of the heightened risk to the young person of positional asphyxia and medical distress. Staff must avoid placing any weight on the young person's head, neck or torso. Refer to Medical Advice section.

UNDER NO CIRCUMSTANCES WILL STAFF INITIATE THE TAKING OF A YOUNG PERSON TO THE GROUND

3.2.1 ROLE OF THE NUMBER 1

Young Person On The Ground

If the Young Person initiates movement that results in themselves and the staff going to the ground:

The role of the No 1 during this movement is to control and protect the young person's head. This will be achieved by maintaining the head support position, ensuring that the No 1's forearm makes contact with the ground first, protecting the young person's face. Once the No 1's forearm has made contact with the ground, the young person's head will be turned to one side. To control and protect the young person's head on the ground, the No 1 will position their knees, one to the rear of the head and one alongside the forehead of the young person.

Note. A pregnant young person must not be held face down on the ground.

THE KNEE THAT IS POSITIONED ALONGSIDE THE FOREHEAD OF THE YOUNG PERSON MUST NOT PROTRUDE PAST THE FOREHEAD AS THIS COULD INTERFERE WITH BREATHING.

The No 1's hands, without undue pressure, should assist in securing and protecting the head against injury.

Care should be taken to ensure that the No 1's hands do not interfere with the young person's hearing**.**

STUDENTS WILL PRACTICE THIS TECHNIQUE ONE ON ONE.

3.2.2 THE ROLE OF THE NUMBERS 2 and 3

If either or both of the two members of staff have a securing hold on the young person's arm they will convert it to a Figure of Four hold. If they do not have a secure hold they will control the arm until they can convert it to a Figure of Four Arm hold by using their knee beneath the young person's elbow in order to secure the arm.

This is achieved by keeping the young person's arm held to the floor. The young person's lower arm is then moved so that it is at an approximate right angle to the young person's upper arm.
The member of staff's outside hand takes a palm up grip of the young person's lower forearm. The member of staff's inside hand is passed under the young person's shoulder and across the young person's forearm into a Figure of Four Arm hold. To strengthen the hold where necessary the members of staff will draw the young person's bent arms back slightly.

STUDENTS TO PRACTICE ONE ON ONE.

STUDENTS TO PRACTICE AS PART OF A THREE OFFICER TEAM.

Once control of the young person's arms is gained the No's 2 and 3 will inform the No. 1 that they have control of their respective arm. At this point the No. 1 will

- Check the condition of the young person.
- Check the condition of the staff.

If any staff received any injuries or are showing signs of fatigue they can be replaced at this stage. If the young person shows any sign of injury or restraint related distress, then the holds are to be released and medical assistance sought.

3.2.3 YOUNG PERSON TO STANDING

The young person should not be held in this position for any longer than necessary. While in the prone position the young person must be constantly observed and risk assessed. Staff must be aware of the medical implications outlined in the previous section and follow the guidelines. The young person will be brought to their feet under the direction of the No. 1 of the team.

When both the No's 2 and 3 are in a Figure of 4 Arm Hold, the No. 1 will turn the young person's head and place the young person's forehead, supported by the No. 1's hand, onto the floor. The No 1's other hand will control the back of the young person's head. The

young person will then be instructed to draw their knees up to their chest. The young person will then be instructed to kneel up. After ascertaining that the No's 2 and 3 are well balanced, the young person and team will rise to a standing position. The No's 2 and 3 will assist by supporting the young person with their forearms under the young person's armpits. The No 1 will place the young person's head in the head support position.

STUDENTS WILL PRACTICE AS PART OF A THREE OFFICER TEAM WITH THE N0. 1 IN CHARGE.

IF THE YOUNG PERSON REFUSES TO BRING THEIR KNEES UP, THE No. 1 WILL INSTRUCT THAT THE YOUNG PERSON IS MOVED REARWARD. THE No. 1 MAY INSTRUCT A SUPPORT MEMBER OF STAFF TO BLOCK THE YOUNG PERSON'S FEET. THE No's 2 AND 3 WILL DROP THEIR WEIGHT REARWARD AS THE No. 1 MAINTAINS CONTROL OF THE YOUNG PERSON'S HEAD. THE YOUNG PERSON IS BROUGHT TO A KNEELING POSITION AND STOOD UP, AS PREVIOUSLY TAUGHT.

3.3 YOUNG PERSON ON THE GROUND

Supine position:

If a young person is on the ground and restraint is required to prevent self-harm, damage to property, risk of harm to others, or to prevent the situation escalating, then the following holds can be used.

3.3.1 ROLE OF THE NUMBER 1

The No. 1 will position their knees either side of the young person's head above the young person's ears. The No. 1's hands, without undue pressure, will assist in securing the head. Care must be taken to ensure that the No 1's hands and knees do not interfere with the young person's breathing or hearing.

STUDENTS TO PRACTICE ONE ON ONE.

3.3.2 ROLE OF THE NUMBER'S 2 and 3

Initially the staff will block and secure the young person's arms using their own body weight.

TRANSFER TO FIGURE of 4 ARM HOLD OPTION

Under the direction of the No. 1, the No's 2 and 3 will carry out the following movement. The members of staff controlling the young person's arms will keep the young person's arms on the floor, maintaining control by placing weight over the arm.

The No's 2 and 3 will, one at a time, then take a hold of the young person's lower forearm with their outside hand, in a palm down grip, with their own thumb pointing towards the young person's head. The member of staff's inside hand will take hold of the young person's upper arm. To strengthen the transfer of the hold the member of staff will move the young person's whole arm away from themselves so that it is at an angle of approximately 45˚ to the young person's body.

While keeping the young person's arm held to the floor the member of staff will rise to their knees ensuring the young person's arm is held securely, applying body weight to the arm if necessary, ensuring that no undue or unnecessary pressure is applied.

The member of staff's inside knee will be placed below the young person's elbow to block the arms movement. The member of staff will then pivot on this knee and allow the young person's forearm to lift from the floor in a natural movement.

As this is carried out the member of staff will bring the hand that was holding the upper arm to the floor alongside their other hand on the young person's lower forearm. The young person's forearm will be in a near vertical position, angled back slightly towards the member of staff. The member of staff will now be in a position looking down the young person's body towards the young person's feet.

With the young person's lower forearm still held, the member of staff's inside hand moves down to the young person's upper arm and secures it. The young person's hand will be then be lowered towards the floor.

The member of staff's inside hand will move from the upper arm and pass under the young person's shoulder (palm down initially to avoid

any possible injury to the back of the hand from debris), and the Figure 4 arm hold then applied. Care should be taken not to place undue strain upon the young person's shoulder cradle throughout.

Under the direction of the No. 1 the No's 2 and 3 will carry out the following movement. The member of staff will keep the young person's arm flat on the floor, maintaining control by placing body weight over the young person's arm.

The member of staff will then take hold of the young person's lower forearm with their outside hand, thumb pointing towards the young person's head. Whilst keeping the arm pinned to the floor the member of staff will come to their knees ensuring their body weight is supported on the young person's upper arm. The member of staff's inside knee will block the young person's elbow. The member of staff will then pivot on their knee; they will now be in a position looking down the young person's body towards the young person's feet. With the lower forearm held by the member of staff hand the member of staffs hand moves down to the young person's upper arm. The young person's hands, fingers pointing down will be lowered towards the foot.

The member of staff's hand will be passed under the young person's shoulder, palm down and the Figure 4 arm hold applied.
The member of staff will then bring that outside leg up, foot placed firmly on the ground.

STUDENTS TO PRACTICE ONE ON ONE.

STUDENTS TO PRACTICE AS PART OF A THREE OFFICER TEAM

3.3.3 YOUNG PERSON TO SEATED

The No. 1 will maintain control of and support the young person's head. The No's 2 and 3 will maintain their respective holds and assist the young person into the seated position by supporting under the young person's armpits with their inside forearm. The young person will be instructed to keep their legs flat on the floor throughout this phase. As the young person is sat up the No. 1 will move to a standing position ensuring that they maintain control of the young

person's head without undue pressure being applied. The side of the No. 1's lead leg will support the young person's back in the seated position

INSTRUCTORS NOTE: ONCE COMPETENT WITH THE VARIOUS ELEMENTS STUDENTS WILL PRACTICE THE TRANSFER OF THE HOLD IN ONE COMPLETE MOVEMENT.

3.3.4 YOUNG PERSON TO STANDING

The No's 2 and 3 will ensure their inside shoulder is placed behind the young person to prevent any backward movement. The No 1 will then instruct the young person to draw their knees towards their chest, feet placed on the floor as near to their backside as possible. The No 1 will place one hand on the top of the young person's head to support the head and will move around to the front of the young person. To prevent the young person from kicking the No 1 will place one of their feet in front of the young person's feet.

Under the direction of the No. 1 the No's 2 and 3 will assist the young person's to a standing position by rolling the young person's body weight forward and lifting on their inside forearms under the young person's armpits. Throughout this move the No. 1 will maintain control of the young person's head, one hand on the back of the head and the other hand protecting the No. 1's face, taking no active part in the lifting process. When the young person is in the standing position the No 1 will adopt the head support position.

STUDENTS TO PRACTICE AS PART OF A THREE OFFICER TEAM

NB: IN THE CASE OF AN EXTREMELY HEAVY YOUNG PERSON, AN EXTRA MEMBER OF STAFF CAN BE EMPLOYED TO ASSIST GETTING THE YOUNG PERSON TO A STANDING POSTION.

3.4 DOORWAY NEGOTIATION

Whilst moving the young person it may be necessary to negotiate doorways or gates. If this is the case, on reaching the doorway the member of staff supporting the young person's head will maintain the head support position. The No. 1 will instruct the No's 2 and 3, who will be applying the Double Embrace Hold, to proceed through the doorway first. Deciding who goes first will depend upon the direction to be taken once through the doorway. For example, if the member of staff controlling the left arm places their left shoulder into the doorjamb, and initiates the spin out movement, then the team having passed through the doorway will be facing to the left. The member of staff controlling the head will be the last person to pass through the doorway.

Every effort will must be made to protect the young person's head from contacting the door frame. The No 1 of the team may have to adjust the head support position and use their arm to protect the young person's head.

STUDENTS TO PRACTICE AS PART OF A THREE OFFICER TEAM.

Whilst a young person can be moved using the phase three-method de-escalation would make movement far easier.

3.5 STAIRWAY NEGOTIATION MOVING DOWN STAIRS

Ideally the team and the additional member of staff will take up the following positions away from the top of the stair area.
When approaching the stairs, the team will turn sideways so that the No's 2 and 3 applying the Double Embrace Hold have their backs to the wall. A fourth member of staff will take up a position at the side of the member of staff nearest to the stairs acting as an anchor for the team. This member of staff will grip the handrail of the stairs to stabilise the team. The member of staff controlling the head will dictate the rate at which the stairs are descended.
If at any time a member of staff feels that their hold is insecure, the command "DOWN" is given. Staff will sink down into a kneeling position and adjust their holds, before standing back up and continuing their movement.

STUDENTS TO PRACTICE AS PART OF A 3 OFFICER TEAM AND A SUPPORT OFFICER.

MOVING UP STAIRS:

Ideally the team and the additional member of staff will take up the following positions away from bottom of the stair area.
When approaching the stairs the team will turn sideways so that the No's 2 and 3 applying the Double Embrace Hold have their backs to the wall. The extra member of staff will take up a position directly behind the team acting as an anchor by gripping the handrail. The member of staff controlling the head will dictate the rate at which the stairs are ascended.

If at any time a member of staff feels that their hold is insecure, the command "*DOWN*" is given. Staff will sink down into a kneeling position and adjust their holds, before standing back up and continuing their movement.

STUDENTS TO PRACTICE AS A 3 OFFICER TEAM AND A SUPPORT OFFICER

3.6 HOLD RELEASE OPTION

Should the situation deteriorate to such an extent that the continued application of holds represents an unacceptable risk to the young person and/or themselves, staff should release the holds.

Staff should move away from the young person and where appropriate continue their dialogue with the young person from a safe distance.
Communication between members of staff is extremely important to ensure that the holds are released simultaneously.

Staff must be prepared to re-engage the young person physically if necessary to ensure the safety of the young person or others.

STUDENTS TO PRACTICE AS PART OF A THREE OFFICER TEAM.

DE-ESCALATION

Whilst the young person is being held by the staff dialogue with the young person should continue. The No. 1 of the team should adopt the role of team leader to co-ordinate the de-escalation of the holds.

The No. 1will be the first person to step away allowing the head to come up.

3.7 RELOCATION PROCEDURES

How the young person is relocated will depend on:

- The level of co-operation of the young person.
- The risk posed by the young person.
- The availability of staff.
- Other activity within the establishment.

The supervisor must follow the guidelines for a young person being relocated as previously described.

3.7.1 Co-operative

If the young person is showing signs of calming then staff will endeavour to de-escalate the situation and relocate as per de-escalation of Phase 2 holds.
If the young person is to be seated with the holds still applied then the No 1 of the team will release the young person's head before the young person is sat down.

3.7.2 Non Co-operative

If de-escalation is not effective or the level of violence or non co-operation offered is too great then a full relocation will take place. In preparation of this the young person's room will be checked prior to relocation and all unauthorised or hazardous items removed in accordance with local policy.

The staff will maintain the Phase Three Holds and move through the doorway as previously described. They then move into the room clear of the door. The young person is knelt down with their back to the door. Once in position the No. 1 places a hand on top of the young person's head and moves to the rear of the young person. The No 1 then places their hands on the young person's shoulders giving a command to the No's 2 and 3, who are applying the Double Embrace Holds, to release their holds and step rearwards towards the door. At this point the No 1, standing side on will bring the young person's back onto the side of the thigh of their lead leg, pushing through the shoulders of the young person they will step rearwards towards the door.

The dialogue will continue with the young person from the doorway, with the door closed if necessary.

STUDENTS TO PRACTICE AS PART OF A THREE OFFICER TEAM

Section 4: SPONTANEOUS INCIDENTS

4.0 Introduction

Many of the incidents that occur in establishments are spontaneous, they can happen without any indication or prior warning.

The types of incidents likely to be encountered are:

- Fights.
- Assaults on other young people.
- Assaults on staff.
- Young person(s) denying access to staff
- Attempted escapes.
- Young people damaging property or the fabric of the establishment.

Before dealing with the incident staff must assess the situation and not put themselves in a position of danger. If possible they must wait until sufficient staff arrive to safely resolve the situation.

However, there are times when staff will be required to intervene as a duty of care or to ensure the safety of both young people and other members of staff. In these situations staff may have to use whatever force is necessary, provided it is reasonable and proportionate in the circumstances as they see them.

In the case of a young person denying access to staff it may be necessary to use force to prevent any of the circumstances as described in STC Rule 38.

The following techniques are to assist staff to either separate or distract young people and before possibly applying the previously taught techniques.

4.1 PHASE 1.

Phase 1 holds are only used during a spontaneous incident where it is necessary to intervene in order to prevent circumstances arising as described within STC Rule 38.

Phase 1 holds are not to be used on a planned removal, although Phase 2 holds can be de-escalated to a Phase 1.

Phase 1 holds require only one member of staff to apply a hold. They are low-key holds and should only be used if the member of staff has assessed the situation and is happy to control a young person on their own. They must consider the level of risk to themselves and the young person. If they consider the risk to be too high then assistance should be summoned and a Phase 2 or Phase 3 hold considered applied.

4.1.1 SINGLE EMBRACE HOLD

The member of staff approaches from the side and adopts a protective stance as proximity to the young person is made. The member of staff's lead hand is passed around the young person's back and takes hold of the young person's upper forearm, palm down. The member of staff's trailing hand is placed on top of the young person's lower near arm, palm down. The young person's near arm is pulled in and folded. It is then placed between the young person and the member of staff's body with the young person's palm

facing down. The member of staff remains in a side on stance with their hip in and head out of the way.

TURNING

If it is necessary to turn the young person the member of staff moves the outer leg rearwards and maintaining hip contact with the young person. The young person is turned on the hip of the member of staff .

MOVING

The member of staff maintains hip and body contact with the young person and moves forward purposefully.

DE-ESCALATION

The member of staff should continue to talk to the young person throughout the use of the Embrace Hold. As the young person calms and co-operates the member of staff should seek to release the hold when in their assessment the situation is safe to do so.

HOLD RELEASE

Should the situation deteriorate to such an extent that the continued application of the Single Embrace Hold represents an unacceptable risk to the member of staff or the young person the hold should be released. The member of staff should move away to a safe distance summon assistance and attempt to continue their dialogue with the young person.

4.1.2 SIDE HUG HOLD

The member of staff approaches from the side of the young person facing the opposite way to the young person and adopts a protective stance as proximity to the young person is made.

The member of staff's leading hand is passed across the front of the young person's abdomen palm outwards, taking hold of the young person's lower far forearm. The member of staff's hand will be palm down.

The member of staff's trailing hand blocks the young person's arm and is then passed across the young person's back to take hold of the young person's upper arm.

BODY POSITION

The member of staff's body is sideways on to the rear nearside of the young person. The member of staff maintains hip contact, and the side of their head is placed on the young person's back. The member of staff's rear foot is moved backwards to create and maintain a strong stance.

TURNING

It is possible to maintain the hold should the young person move around. The member of staff continually adjusts the placement of their rear foot to retain the 'T' shape formation of the hold.

MOVING

As the situation improves it is possible for the member of staff to change the Side Hug Hold into an Embrace Hold, and so make it possible to move the young person away.

DE-ESCALATION

If appropriate, convert the Side Hug Hold to Single Embrace Hold. Step forward so that the member of staff is to the far side of the young person. The hand on the young person's shoulder moves down to the lower forearm in a palm down grip. The hand that was on the young person's forearm moves across and is placed on the young person's opposite upper arm/shoulder.

HOLD RELEASE

Should the situation deteriorate to such an extent that the continued application of the Side Hug Hold represents an unacceptable risk to the young person and/or the member of staff, the hold should be released.
The member of staff should move away to a safe distance, summon assistance and continue their dialogue with the young person if appropriate.

4.1.3 SIDE HUG HOLD ESCALATED TO SINGLE BASKET HOLD

This technique, and subsequent basket holds, are not to be applied to young people who are known to have any breathing related medical conditions or who are known to be pregnant. If applicable staff should consult any local PCC handling plans.

It may be possible for the young person held in the Side Hug Hold to get the arm held down by their side free. In these circumstances the member of staff holding the young person may attempt to block and trap the arm as it comes across the young person's body. Once held the member of staff simply places the arm below the elbow of the arm already held, thus having both the young person's arms crossed across their midriff area.

The member of staff then steps from behind the young person and stands to the same side as the arm that they have just blocked and held. The member of staff is then holding the young person in a Single Basket Hold.

HOLD RELEASE OPTION

Should the situation deteriorate to such an extent that the continued application of the Single Basket Hold represents an unacceptable risk to the young person and/or the member of staff, the hold should be released.
The member of staff should move away to a safe distance, summon assistance and continue their dialogue with the young person if appropriate.

DE-ESCALATION

As the young person calms down and regains self control, the Single Basket Hold can be phased down to a Single Embrace Hold and the young person led away.

4.1.4 SIDE HUG HOLD ESCALATED TO DOUBLE EMBRACE HOLD

If another member of staff is available they may be able to assist if the arm comes free from the Side Hug Hold. The second member of staff adopts a protective stance and moves towards the young person's free arm blocking it with their forearms.

Having controlled the arm the member of staff will move the young person's arm into their body and apply a figure of four arm hold. The member of staff in the side hug hold will move around the young person whilst still controlling the arm and apply a figure of four arm hold. From this position they will decide as to whether to apply a double embrace or remain in two figure of four arm holds.

4.2 TANTRUM HOLD

The Tantrum Hold is only to be used to prevent an act of self-harm by a young person. It will normally be applied when there is only one member of staff available to manage the young person and then only when:

- Further staff assistance has been summoned
- A dynamic risk assessment has been carried out
- It is deemed safe for them to physically engage the young person

As with all physical interventions staff should use all possible options before applying physical force. In this instance the use of loud verbal commands and clear instructions to cease their actions should be the first option.
Staff must be aware of:

- Potential weapons (sharps)
- Body fluid (blood, risk of contagious diseases)
- Trip hazards
- Electrical, structural risks
- Possible distraction

The preferred option for dealing with this situation is for three staff to engage the young person as per a young person in the supine position, and only then when a dynamic risk assessment has been carried out.

APPROACH

The member of staff approaches the young person on the floor and kneels down facing the upper body/head of the young person.

HANDS/ARMS

The member of staff's lead hand pushes the young person's near arm across the young person's body. The member of staff's lead hand continues its move across the young person's body and travels between the young person's arms to cradle the far side of the young person's head.

The member of staff's near hand maintains the position of the young person's near arm across the body and assists with rolling the young person onto their side. The young person is now facing away from the member of staff. Having rolled the young person onto their side the member of staff's trailing hand cradles the near rear side of the young person's head.

BODY POSITION

The member of staff facing away from the young person adopts a seated position. The member of staff makes and maintains contact with their near hip and lower back with the young person's rear upper back/shoulder area.

The members of staff's legs are bent in a forward running position with the lower leg leading.

The member of staff's head is lowered onto the young person's near shoulder and upper arm to complete the hold.

MOVING

If the young person moves around on the floor, the member of staff retains the hold and moves systematically with the young person and continuously checks medical signs and symptoms of the young person.

DE-ESCALATE.

As the young person regains self-control and the member of staff assesses that it is appropriate the hold can be released and the young person can be sat up and then moved away.

HOLD RELEASE.

Should the situation deteriorate to such an extent that the continued application of the Tantrum Hold represents an unacceptable risk to the young person and/or the member of staff, the hold should be released.
The member of staff should roll away and stand at a safe distance, summon assistance and continue their dialogue with the young person if appropriate.

4.2.1 ESCALATION.

If a tantrum hold has been applied and the young person responds adversely, a staff member can secure the young person's legs to further protect the young person from injury with the support of other staff.
Normally approaching from the rear of the young person's legs the member of staff will protect themselves by ensuring they block the young person's legs.
They will drop onto their knees and encircle the young person's legs with their arms, above the young person's knees at the same time they will sit down and push their own legs out for stability.
They will face towards the young person's head.

When staff assess it is safe to do so the situation can be de-escalated by initially removing the Leg Hold. The member of staff will ensure that they protect themselves when they release the young person's legs.

Should the Leg Hold and the Tantrum Hold fail to resolve the incident, staff must always be prepared to use the Hold Release Option. This is especially important if in their assessment the continued application of the holds is likely to result in injury to the young person or themselves. Staff should release the holds and move away to a safe distance from the young person and consider their options.

4.3 SEPARATION TURN.

This technique is to be used when two young people are involved in a dispute but have not engaged in a fight, and where the dispute needs to be resolved quickly to prevent further escalation or risk of harm.

The two members of staff need to position themselves to the rear of each young person. Both must be in a **left leg lead protective stance** and will move toward the young people at the same time.

As they approach their lead hand is placed onto the young person's hip and their trail hand is placed on the young person's shoulder.

From this position the lead hand pushes on the hip and the trail hand pulls on the shoulder ensuring that they avoid grabbing the young person's clothing.

As the push/pull movement is affected the young person involved will be turned to the right. This allows the staff to create a substantial gap between the young people and position themselves between them.

Once separated, the staff can apply the Single Embrace Hold by sliding the trail hand from the shoulder to the lower forearm in a palm down grip and moving the lead hand from the hip to the upper arm. From here the young people can be moved away and de-escalation technique utilised.

STAFF TO PRACTICE ONE ON ONE.

WHEN COMPETENT, TO PRACTICE IN GROUPS OF FOUR, EMPHASISING THE INITIAL POSITIONING AND COMMUNICATION PRIOR TO AND DURING THE SEPARATION.

4.4 RIB DISTRACTION.

There may be occasions when trying to separate young people where staff have to use a distraction technique, one of which is the Rib Distraction. An example might be where a young person has physically grabbed hold of another young person or a member of staff with the intention of causing them significant harm. The following

techniques can be applied to quickly gain initial control. The member of staff will then assess and decide whether there is a requirement for a further use of PCC.

The Rib Distraction is an extreme measure and can only be used if fully justified.

The guidelines previously described in the Policy on The Use of Force must be adhered to when using the Rib Distraction technique. Once separation has been achieved then the member of staff will then assess and decide whether there is a requirement for a further use of PCC.This will depend on the level of violence offered and the staff available.

If two trainees are involved then ideally two members of staff will work simultaneously to separate the trainees

Approaching the young person in a protective stance from the rear, take hold of the young person's clothing around the rib cage area with both hands.

The member of staff will give a clear verbal instruction that a technique involving the use of pain will be applied.

With an inverted knuckle drive sharply inward and upward to distract the young person and effect a separation by turning the young person away from the incident. At the same time clear instructions must be given to the young person on what actions they must stop doing i.e let go, release etc.

STUDENTS MUST PRACTICE ONE TO ONE.

REMEMBER GIVE CLEAR VOCAL COMMANDS PRIOR TO APPLYING THE RIB DISTRACTION.

ONLY USE IN SHORT, SHARP BURSTS AND ONLY WHEN NECESSARY TO PROVIDE A DISTRACTION OR TO ACHIEVE SEPARATION OF THE YOUNG PERSON.

4.5 FIGHT ON THE FLOOR.

ONE MEMBER OF STAFF.

If a member of staff is faced with two young people on the floor fighting or a young person on top of another young person, or a member of staff, they may have no option but to intervene and should consider the following techniques.

Prior to any physical intervention the staff must assess the situation and use any other means to resolve the incident for example verbal commands, or waiting for assistance.

Before attempting to intervene, assess whether or not it will be possible to safely separate the young person, bearing in mind the member of staff needs to be aware of their own self-protection. If they are to intervene then they must utilise correct lifting skills.

4.5.1 OPTION ONE.

The member of staff will approach the young person from the side in a protective stance facing the same direction as the young person. Take hold of the clothing on the young person's shoulders with both hands, taking care to avoid taking hold of the skin.

The member of staff will bend their knees and keep their arms straight and step rearwards pulling the young person off the other person. They will continue to pull the young person away until there is sufficient distance between them and the other person. The member of staff will then release their grip and position themselves in between both parties, so as to deter any further incident and begin to attempt to de-escalate the situation.

If the young person has a strong grip on the person on the floor, then the member of staff may need to first break the grip and balance of the one on top. They should place their hand on the inside of the young person's elbow joint and pull the arm outwards so that the young person's balance is broken. Then they should continue the technique as described above.

STUDENTS TO PRACTICE ONE TO ONE.

INSTRUCTOR'S NOTES:

ENSURE STUDENTS PRACTICE ON SOMEONE OF SIMILAR WEIGHT. CHECK FOR ANY INJURIES BEFORE PRACTICE COMMENCES.

4.5.2 OPTION TWO

It may be possible for the member of staff avoid pulling the young person away by using a pushing technique. This can only be used if there is sufficient space to the side and there is minimal risk of injury to the young person.

The member of staff will approach in a protective stance from the side of the young person, when in position the member of staff will push the young person off the other person, and then position themselves between both parties to deter any further incident and attempt to begin to de-escalate the situation.

STUDENTS TO PRACTICE ONE TO ONE.

4.5.3 FIGHT ON THE FLOOR.

TWO MEMBERS OF STAFF

If two members of staff are available to separate either two young people or a young person with a member of staff pinned to the floor, then the following technique can be used:

When practicing this technique staff must use correct lifting skills.

Instructors must check for injuries prior to practice.

Ensure staff practice on students of a similar size and weight.

The members of staff will approach the young person from the rear and either side in a protective stance. The members of staff should be back to back, that is, the staff on the young person's right side in the left leg lead, and the staff on the left with the right leg lead.

Both members of staff will apply a Figure of Four Arm Hold to affect a release and to gain initial control of the young person.

Once the young person's arms are secure the young person can be moved by using a Scoop Lift.

STUDENTS PRACTICE IN GROUPS OF THREE.

4.6 SCOOP LIFT

From the Figure of Four Arm Hold the member of staff removes their inside arm from their outside forearm and takes hold of the young person's forearm with both their hands, thumb to thumb palms up.

The young person's arm is lifted upwards towards their shoulder.

The member of staff releases their outside hand and turns to face the opposite direction to the young person.
The member of staff drives the now inside hand under the young person's armpit and places their own hand palm down onto the young person's shoulder. The member of staff now removes their other had from the young person's lower forearm and uses it to push down on the young person's elbow trapping it between their young person's body and their own.

THIS MUST BE PERFORMED SIMULTANEOUSLY BY BOTH MEMBERS OF STAFF.
When both members of staff are ready and in position, they will step forward on their inside leg at a 45º angle. As the members of staff step forwards direction the young person will be moving backwards and be off balance.

The members of staff will continue to move the young person until they are clear of the other person. The young person will then ideally be placed in a seated position and, if necessary, the staff will then

reverse the previous conversion back into a Figure of Four Arm Hold prior to standing the young person up and re-applying the Double Embrace Hold.

If this is not possible then the young person will be placed onto the floor and all holds released.

Staff must then position themselves between both parties involved in the incident and attempt to resolve the incident.

STUDENTS WILL PRACTICE IN GROUPS OF THREE.

If a third member of staff is available, then they can control the other young person on the floor by applying the Tantrum Hold if needed, or by moving them away from the scene in a Phase One Hold.

4.7 THUMB DISTRACTION

If the Figure of Four Arm Holds cannot release the young person's hands or arms then the staff can use a Thumb Distraction to effect release.

As with all distraction techniques the Thumb Distraction is an extreme measure and can only be used if fully justified.

PRINCIPLES OF THE THUMB DISTRACTION

- Block the base of the thumb.
- 'Cock' the thumb.
- Apply pressure between the base and tip of the thumb.
- To be used only when necessary.
- Report reasons for use.
- Use in short sharp bursts.
- Use in conjunction with verbal commands

STUDENTS TO PRACTICE ONE TO ONE.

From the Figure of Four Arm Hold place the inside hand onto the young person's thumb and apply the Thumb Distraction. Be aware that the young person's arm may react quickly to the technique and staff to exercise care from flaying arms.

Staff should also practice the giving of clear instructions to their partner during this session as they would to a young person when applying this technique within the operational environment.

STUDENTS TO PRACTICE IN GROUPS OF THREE.

Once the arms are released staff then perform the Scoop Lift as previously described if necessary.

SECTION 5: THE USE OF HANDCUFFS

5.0 INTRODUCTION

The use of handcuffs on a young person must only be in exceptional circumstances.
Examples might be;

- A long or difficult route to escort the young person.
- Staff unlikely to be able to maintain PCC holds.
- Exceptionally strong / violent young people.
- An aid to de-escalation.

Only the approved model is to be used:

HIATT HANDCUFF MODEL 2015

Prior to using handcuffs, staff will attempt to de-escalate the situation with interpersonal skills and or approved PCC techniques. If handcuffs are deemed necessary then their use will only be as a temporary measure, and they are to be removed as soon as the threat has receded.

THE USE OF HANDCUFFS MUST BE AUTHORISED BY THE DUTY DIRECTOR.

The medical staff will examine any young person that has had handcuffs applied. They will record details of any injuries consistent with the use of handcuffs. The Use of Force report must state the reasons for applying handcuffs.

5.1 APPLICATION OF HANDCUFFS

When the authority for handcuffs has been authorised they will be applied in the following manner.

From a Phase 3 hold, the No. 1 will instruct the young person to adopt a kneeling position; the members of staff will at this time be applying Double Embrace Hold. When the young person is taken to their knees, the two staff applying the holds will kneel down on their inside leg. The No. 1 will instruct the two staff to convert into Figure of Four arm Holds. The supervisor will instruct a support member of staff to support the young person's head from the rear.

The support staff will approach the young person in a protective stance from the rear and place the side of the lead leg alongside the young person's back.
They will take control of young person's head by placing their trail hand across the nape of the young person neck. Their lead hand will cup the young person's chin as previously described in the head support position.
The No 1 will then apply the handcuffs to the front of the young person. When the handcuffs have been applied the No. 1 will re-take control of the young person's head and the support member of staff will move away.

From the kneeling position the two staff will assist the young person to their feet by passing their inside arm underneath the young person's armpit and helping them to their feet. Once in a standing position the No 1 in consultation with the supervisor will decide as to whether or not restraint holds are necessary.

STUDENTS TO PRACTICE AS A THREE OFFICER TEAM.

5.2 MOVING A YOUNG PERSON IN RATCHETT HANDCUFFS

If the young person responds to staff instructions but it has been decided to maintain the use of handcuffs for other reasons (as described in Para 6.0), then the young person will be moved in the following manner.

In these circumstances the young person will not normally be in the head support position but allowed to stand and walk upright. The two staff controlling the young person's arms will place their outside hand on the young person's shoulder. Their inside hand will be placed on the young person's forearm. The No 1 will be positioned to the front and slightly to the side of the young person, at a distance of approximately two to three metres.

STUDENTS TO PRACTICE AS A THREE OFFICER TEAM

5.2.1 NON CO-OPERATIVE

Should the young person be actively resistant and a risk to staff throughout the escorting procedure the No 1 will maintain the head support position.
The other team members will maintain the Figure of Four Arm Hold. Staff should be aware that it is possible to cause discomfort to the young person if the arms are pulled outwards, therefore the holds will be sympathetic to the degree of movement in the arms.

STUDENTS TO PRACTICE AS A THREE OFFICER TEAM.

5.2.2 MOVING A YOUNG PERSON AGAINST THEIR WILL

If the only option available to staff is to carry the young person then an assessment is required prior to attempting the lift - as described in Double Embrace Lift section.
From the Figure of Four Arm Holds the member of staff's inside arm will extend through between the young person's arm and torso, the members of staff's outside hand will be placed behind the young person's knee.
On the command '*LIFT*', both staff will lift the young person using correct lifting skills, once lifted both staff will clasp their hands together with each other.

STUDENTS TO PRACTICE.

5.3 REMOVAL OF HANDCUFFS

Option 1:

Allow the young person to remain in an upright position with a member of staff removing the handcuffs from the young person in a controlled manner and with regard for their own personal safety.

Option 2:

Handcuffs should be removed within the prescribed techniques as described in section 6.2.1 non co-operative.