Appendix C

Report to Youth Justice Board on the use of restraint in Lincolnshire Secure Unit

October 2022

Introduction:

This is a report to the Youth Justice Board (YJB) in line with requirements set out in Working Together to Safeguard Children 2018, in which it states,

"Where there is a secure establishment in a local area, safeguarding partners should include a review of the use of restraint within that establishment in their report, and the findings of the review should be reported to the Youth Justice Board."

Background Information

The Lincolnshire Secure Unit (LSU) falls within the Lincolnshire Safeguarding Children's Partnership. Although young people are placed at the unit from all over the country, it remains the responsibility of Lincolnshire. It has the facility to accommodate welfare placements as well as those funded by the YJB.

LSU accommodates young people on remand, sentenced by the courts and young people placed on welfare grounds. The unit accommodates both female and male young people up to the age of 18. LSU is a 12-bed unit.

As established since 2017, the LADO (Local Authority Designated Officer) service has been undertaking restraint reviews that are meant to be held quarterly. The purpose of this is to consider whether restraints are being undertaken appropriately and proportionally and to identify any learning for the unit.

Prior to the LADO undertaking a restraint review, Lincolnshire Secure Unit send a list of all restraints from the previous three-month period, and on the day, access is provided to the LADO to electronic recordings of the restraint and CCTV footage.

During the last year, LADO has undertaken two restraint reviews partly due to the Covid - 19 Pandemic and partly due to the pressures within the LADO Service. The two reviews were held on the 17/06/21 and 19/10/21.

Nevertheless, the LADO service as a whole has good oversight of the restraints, due to the fact that the service also undertakes the Reg 44 visits who dip sample restraints each visit. To maintain independence, the LADO undertaking the restraint reviews is always different from the one undertaking Reg 44 visits. Any learning or need for improvement is fed back not only to the Unit, but to the whole of the LADO service as well, informing each restraint review and Reg 44 visit.

Training:

LSU report that all care and education staff receive annual training on the use of restraint, via an internal trainer, as a minimum. LSU continues to use the Ethical Care and Control Technique (ECCR) in the event of the need for physical restraint. All care and education staff are trained in ECCR and there remains a strong focus on crisis intervention and de-escalation of potentially volatile situations to prevent the use of restraint in all matters. Restraint is used only when other methods have failed.

In the past year two LADOs have observed training, a refresher of the holds used within the Unit. During the training the LADOs present noted the emphasis that was put on consideration of the young person's experience during a restraint, and how each staff member can support the young person to minimise their distress and help them calm.

Number of restraints April 2021-March 2022

The LSU had 330 physical interventions in the last year, welfare children were involved in 191 restraints and YCS children were subject to 139 restraints. This was steep increase compared to the previous year. However, I firmly believe the increase was not down to the staff's attitude or change in practice, but it was due to the complexity of the young people placed into the unit.

During April 2021- October 2021, the unit had been very unsettled, experiencing a very high number of incidents and restraints, the majority of which involved 3 young people. During this period there was a temporary dip in July 2021 after the departure of one young person. Incidents rose again, mainly involving two young people until their departure from the Unit in October, when there was a marked reduction in restraint interventions. It was noted that during the most difficult day, a young person was involved in 22 incidents.

It is credit to the unit/staff that even through these very stressful and demanding times they maintained the professionalism and focus on the young people's wellbeing, and the Regulation 44 visits and restraint reviews have noted consistently good practice as far as restraint interventions where concerned.

Monitoring

The Secure Unit is subject to external restraint monitoring through the restraint reviews and reg 44 process. Each restraint is fully documented and both staff and the young person involved and are de-briefed after the event. During staff debrief, every incident of restraint is used as an opportunity to review and identify any potential learning for the staff, and to cross-reference with the young person's risk assessment. It focuses on de-escalation and alternatives to physical intervention. LSU continue to use the framework "Secure Stairs", multidisciplinary team meetings attempt to track the efficacy of risk assessments and behaviour management strategies to minimise the need for restraint.

Managerial oversight of the restraint logs is evident. During the period when the unit experienced very high number of restraints the management understandably had fallen behind in terms or reviewing and signing off these incidents. However, this was caught up immediately as soon as the unit has started to settle again.

The Unit readily reports to the LADO whenever there is a direct allegation in respect of inappropriate conduct by a member of staff and/or if a young person sustains an injury during use of restraint.

Practice:

The method of restraint used by the LSU ensures that there is no pressure on joints, fingers or the chest, and each young person's medical history, disability and needs are also reflected in their care plan.

The incident logs remain detailed and clearly document the grounds for restraints and holds being used. Staff debrief is routinely undertaken with focus on learning from each incident. The young people are offered medical assistance and a debrief after each restraint. If refused, another opportunity is given to the young person to access medical assistance. Debrief offered to young people

are meant to detail their experience of the restraint and what could be done to avoid such intervention in the future. It was noted that young people often refuse such debrief, which may come across in the records as a missed opportunity for the young person to have their voice heard. Nevertheless, their voice is also captured during their discussion with other professionals, such as health or psychologist. During the last restraint review the LADO proposed to the unit to consider the timing of debriefs being offered to young people and whether their interaction with health professionals/psychologist could be specifically utilised for this purpose as well.

The staff strives to use de-escalation as a first port of call, to avoid restraint whenever this is possible. This is working well, in vast majority of the cases, whenever this is appropriate, the staff appear to spend time in attempting to calm the young person down, through talking, change of face, distraction etc. However, the staff are the first to identify during the debrief, if they feel that they may have fallen short in terms of attempts of de-escalate and any learning from the debrief/review is readily applied to their future practice.

It is noted that when a restraint is required, staff act quickly, and young people are consistently released at what appears to be the earliest opportunity.

The LSU seeks advice from the LADOs where appropriate and readily invites open discussion on matters concerning the safeguarding and welfare of the young people who reside there.

Considering all the information checked during the reviews, information from Reg 44 visits and the insight provided by the LSU deputy manager during each review visit, we have no concerns about the culture and the practice related to restraints within the LSU.

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