The medical role in restraint and control: custodial settings

Guidance from the British Medical Association

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General principles

- Prisoners are entitled to the same standards of health care as the rest of society. This includes respect for the patient's dignity and privacy.
- Wherever possible, without compromising the quality of care, treatment should be provided within the prison. Conditions of privacy must be available.
- Outside prisons, there should be a presumption that prisoners are examined and treated without restraints, and without prison officers present, unless there is a high risk of escape or the prisoner represents a threat to him or herself, the health team or others.
- Discussions should take place between the health team and the prison officers to assess the level of risk in each particular case. If, after discussion, it is considered that the level of risk is low, the doctor in charge should request the removal of restraints.
- If agreement cannot be reached, the Chief Executive of the hospital or NHS Trust should discuss the case with the Governor of the prison.
- If a prisoner lacks the capacity to consent, treatment should be administered in accordance with the relevant legislation. Further guidance on the treatment of adults who lack capacity is available from the BMA's website.[1]

Introduction

This guidance applies primarily to people detained in prisons but may also be relevant to prisoners in police stations, young offenders' institutions and asylum seeker detention centres.

Doctors have a duty to provide for each of their patients the best possible care in the particular circumstances. This includes respect for the patients' dignity and privacy. These issues are equally as important when treating those detained in prison, whether convicted or on remand, as when treating any other patient. It is important that doctors try and ensure that prisoners have access to the same standards of health care as are available to the rest of society.

When prisoners are taken outside the prison grounds for medical care, the duty of the health care team to provide optimal care can conflict with the prison authorities' duty to ensure that appropriate levels of security are maintained. It is therefore necessary to reach a balance between the dignity of the patient and security needs. Where there is a serious risk of escape or the prisoner represents a threat to him or herself, the health team or others, safeguards are required. These safeguards, however, should be commensurate with the actual or perceived risk and should respect the patient's right to privacy to the maximum extent possible.

Background

Current Prison Service policy is to secure all prisoners under escort, usually with handcuffs or a chain. Medical staff have the right to request the removal of restraints while the treatment is carried out, but this is not widely known. With pregnant women, Home Office guidelines state that no woman who goes into hospital to give birth should be restrained from the time she arrives at the hospital and that women attending hospital for ante-natal checks should have restraints removed on arrival in the waiting room unless there is a particularly high risk of escape. The same issues of dignity, trust and confidentiality arise in the treatment of patients with other medical conditions.

Treatment in prison

Wherever possible medical care and treatment should take place within the prison where physical security measures are in place. Health professionals should visit the prisoner rather than vice versa provided this can be done without undermining the quality of care provided. However, if the circumstances are such that treatment standards cannot be maintained in the prison, or where specialised equipment or facilities are required, appropriate care must be provided elsewhere.

The medical role in restraint and control

Where restraint is essential in dealing with detainees' health needs, health professionals need to be involved. If, however, discipline or control measures are invoked for the purposes of maintaining order or discipline, this should not involve health staff. Restraint should only ever be used as an act of care and control, not as punishment or a convenience. The use of restraint can result in psychological morbidity, demoralisation and feelings of humiliation. In terms of chemical interventions to control patients, the Metropolitan Police has issued guidance specifically relating to rapid tranquillisation that other practitioners might find useful. It states that rapid tranquillisation should only be performed where equipment for cardiopulmonary resuscitation is present and there are trained staff to use it.[2] In prisons, the security rules set out the appropriate conditions in which restraint may be used and international guidance is available from the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT).[3]

Summary of CPT guidelines

The use of physical restraint against violent prisoners requires safeguards.
Prisoners under physical restraint should be kept under constant supervision, and restraint should be removed at the earliest opportunity.

- Restraint should never be prolonged or applied as a punishment.
- A record should be kept of every use of restraint or force against prisoners.
- Prisoners who have been subjected to force should be examined, and if necessary treated, by a doctor as soon as possible.
- If possible, medical examination should be conducted out of sight and hearing of non-medical personnel, a note should be made of findings and this should be available to the prisoner.
- Effective inspection and complaints procedures must be in place. Prisoners should be aware of the avenues of complaint open to them.

Restraint of detainees in NHS facilities

Detainees may need treatment in NHS hospitals and other health care facilities. From the perspective of prison staff, hospitals are sometimes seen as the weak link in the chain of secure custody where detainees may try to give a false impression of their medical condition in order to attempt to escape. The main risks are of escape or of violence. Steps should therefore be taken to minimise these risks wherever possible. A hospital that treats prisoners on a regular basis should consider whether minor alterations could improve security. For example, it might be possible for a treatment room without windows, or with windows that do not open, to be designated as a secure room for the treatment of prisoners so that a prison officer could be stationed outside the door if there is considered to be a high risk of escape. Similarly secure side-wards could be designated for treating prisoners as in-patients. In hospitals where prisoners are regularly treated, staff should be given training in preventing potentially violent situations developing.

Health professionals are often unsure as to whether they are entitled to ask for handcuffs to be removed during assessment and treatment and whether they can ask accompanying guards to leave the room. They should certainly do so if the method of restraint interferes with treatment or if the detained person is clearly too incapacitated either to threaten others or to abscond. The general advice given to prison staff around the UK is to comply where feasible with such requests. (Advance risk assessment procedures should have already clarified the potential threat of escape or violence.) In England and Wales, the Prison Security Manual makes it plain that physical restraints should normally be removed if health professionals request it.[4] Sometimes terminally ill patients have been handcuffed to a hospital bed when clearly unfit to escape although, again, the Prison Security Manual stipulates that restraints must not be used to attach any prisoner to furniture, fixtures or fittings.[5] Whether or not

restraint is advisable should be discussed between health professionals and the detaining authorities and judgements made on a case-by-case basis. In some cases, it is unnecessary and humiliating for the detainee to be shackled and closely attended by guards. As previously mentioned, restraints should be removed from pregnant women attending hospital for antenatal care and those in labour. Where there is a risk of escape or violence to others, the safeguards employed should be commensurate with the risk. The Prison Security Manual sets out the rules that should be observed by all prison staff.

Prison Service rules on restraint in NHS facilities

- Risk assessment must be carried out prior to a prisoner going to hospital.
- Assessment determines the degree of supervision.
- Assessment includes the prisoner's condition, any medical objection to the use of restraints, nature of the prisoner's offence, security of the consulting room and the risk of violence or hostage taking.
- Where escape is unlikely, escort and bedwatch by one officer is sufficient, without restraints.
- Prison governors must establish good working relations with hospitals and agree the arrangements within which prisoners will be seen.
- Prisoners should have a single room with bathroom to avoid disruption to other patients.
- Hospitals should be informed in advance about the levels of escort and restraint envisaged and hospital staff should have an opportunity to discuss when use of restraint is clinically unacceptable. In those cases, prison management should consider alternative security arrangements.

In addition, Prison Service Order 1600 emphasises:[6]

- force is a measure of last resort when alternatives (persuasion or negotiation) are ineffective
- only minimum force for the minimum amount of time to ensure safety can be used
- there should be safe and supervised use of control and restraint techniques and equipment
- the use of force or restraint should be justified and records kept
- there is a requirement to seek immediate advice from health professionals when restraint is used.

Restraint in transit

Any means of restraint can be dangerous if improperly applied. Methods whose level of risk have not been thoroughly investigated should not be used. In 1998 the BMA objected to the use of CS spray in confined spaces such as police vans. It argued that there was a lack of data about the full effects of the interaction of the CS and the carrier spray, especially on people who were already taking medication. In March 2000, a report by the Police Complaints Authority noted that a third of public complaints about CS resulted from police officers squirting the spray at near point-blank range in breach of guidelines. Health professionals need to speak out if they are aware of any such breaches of established guidance.

In the event of disagreement

If, after discussion, agreement cannot be reached between the medical staff and the prison staff on appropriate levels of restraint, the Chief Executive of the hospital or NHS Trust should be asked to discuss the case with the Governor of the prison. In extreme cases, where agreement or compromise cannot be reached, the Chief Executive retains the right to refuse to treat the patient in the hospital. However, in an emergency situation, where treatment cannot be delayed, appropriate treatment must be provided.

Restraint in non-medical settings

These guidelines focus on treatment for physical disorders but similar issues need to be considered in other circumstances where there is a serious risk to the psychological welfare of prisoners. For example, attending the funeral of a close relative can play an important part in the grieving process and help the individual to come to terms with bereavement. Whether restraints are essential for a

prisoner attending a funeral or other emotional event should be a matter for negotiation. In considering such requests from prisoners, the actual or perceived level of risk should be assessed and, wherever possible, attendance without the use of restraints should be permitted.

Further reading

BMA (2004) (2e) *Health care of detainees in police stations*. London: BMA.
BMA (2004) *Medical ethics today: the BMA's handbook of ethics and law*. London: BMA.
BMA (2001) *The medical profession and human rights: handbook for a changing agenda*. London: BMA.
European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (2002) *The CPT standards*. Strasbourg: Council of Europe. (CPT/Inf/E (2002) 1.)

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References

1 BMA (2007) *The Mental Capacity Act 2005 – guidance for health professionals*. London: BMA. BMA (2007) *Medical treatment for adults with incapacity: guidance on ethical and medico-legal issues in Scotland*. London: BMA. Both available from: www.bma.org.uk/ethics
2 Police Complaints Authority (2001) *Policing acute behavioural disturbance*. London: PCA. See also: Herring J (2001) Fitness to be detained. In: Stark MM, Rogers DJ, Norfolk GA, (eds) *Good practice guidelines for forensic medical examiners*. London: Metropolitan Police.
3 European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (2002) *The CPT standards*. Strasbourg: Council of Europe. (CPT/Inf/E (2002) 1.). Accessed 23 Jan 04.
4 HM Prison Service. Prison Security Manual (1998) *Prison Service Order 1000*. London: HM Prison Service. 37.92 (v) (updated 9/99); 37.133 and 37.144 (both updated 12/2000).
5 Ibid: 37.135.
6 HM Prison Service (1999) *Use of force. Prison Service Order 1600*. London: HM Prison Service. (PSI 38/1999.) The Order applies only in England and Wales.

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