Restraint Related Deaths in the UK

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Cold Facts

- 41000+ Assaults in MH 2011/2012 NHS Protect
- Three quarters involving medical factors
- 55,000 in total
- 38 Restraint related deaths (Reported)
- 5th and final Count Me in Census in 2010 found that 12% of pts had experienced restraint

- Huge variation
- One Trust reported 38 incidents and another over 3000 incidents
- Last year 1000 incidents of physical injury following restraint
- Face down was used over 3000 times
- Some Trusts have put an end to this

MIND 2013
Systematic Reviews


- Manual restraint is used up to 5 times per month on an average ward
- Lasts for about 10 mins
- Mostly face down
- Young, male, detained under MH Act
- Not about efficacy

Salias and Fenton (2000)

- 2,155 articles, no controlled studies
- S/R efficacy and therapeutic value not established
- Serious adverse effects cited
A Review of Restraint Related Deaths

INCLUSION:

- Age 14 upwards,
- Mental health, custodial settings, or whilst being arrested by officers, secure young people’s estates and immigration removal services.
- Studies were published between 1st January 1992 and 1st June 2010.
- Cases in the UK were there was a report of, or comment on death relating to physical restraint;
  - during, or after a short time period,

EXCLUSION:

- elderly mentally ill,
- intensive care medicine,
- military,
- use of Tasers,
- door security
Specific Case Characteristics

- 16 out of the 38 cases had a history of mental illness, specifically psychosis.
- 3 had a learning disability.
- 15 were of Black or Minority Ethnic origin.
- 15 were males in the 30-40 yrs age group.
- 2 were noted as being obese.
- Time held prone before collapse ranged from 2 to 12 minutes. Average time 5.6 minutes.
- More likely to be prolonged, severe struggle before collapse under restraint.
- Laboured breathing and cessation of resistance may demonstrate this collapse and indicate a medical emergency rather than cooperation from the individual.
- The number of staff involved in the restraint was between 2 and 15 staff;
- The length of restraint was between 10 mins and 1 hr 40 minutes.
- Police were involved in the restraint incident for 29 of the deaths.

■ 30 of the 38 therefore fall into one or more of the vulnerable populations.
15 cases involved drug/alcohol misuse

Verdicts of fatal excited delirium were given for 5 deaths.

Accounts described the individual as being restrained in a prone position, either flat or over a mattress/chair.

The deceased who had a history of mental illness may have been receiving neuroleptic medication which can have life-threatening adverse effects.

6 of the 38 had pre-existing conditions that may have increased the risk of cardiac arrest: one had ischemic heart disease, one had diabetes and four had epilepsy.
Vulnerable Groups

- Individuals with serious mental illness
- Individuals with learning disabilities
- Black and Ethnic Minority groups
- Individuals with high BMI
- Men 30-40yrs
David “Rocky” Bennett, 38

Died in restraint in a UK hospital in 1998. He was racially-abused by a white consumer in the hospital and lashed out at a nurse. He was held in a prone restraint by 5 staff for 25 minutes and died.

An inquest into his death found significant “institutional racism” in the NHS.


**Daniel**

Daniel suffered with Schizophrenia. He died in 2002 whilst being restrained by 5 nurses in a UK hospital. He struggled excessively for 6 minutes and then collapsed. He had been restrained in the prone position.

**Kurt**

Kurt died whilst being restrained in the prone position for 55 minutes by four members of staff. He suffered 17 injuries. The jury found excessive prolonged restraint was one of the factors causing death.
Potential Consequences

- People who are secluded and restrained experience vulnerability, neglect and a sense of punishment.

- It has been reportedly used for non violent behaviour:

- Power - Going in strong:
  - Whittington

- Negative psychological and physical impact:
  - Moran et al 2009, Paterson 2002
WORSE CASE SCENARIO

http://www.bbc.co.uk/i/b01nqn4d/
Intrinsic factors: vulnerabilities, e.g. serious mental illness, pre-existing conditions. Alcohol/drug abuse

Extrinsic factors: organisational culture/attitudes to vulnerable groups. Under-reporting.


Fatal collapse

Changes to policy, practice, training and culture

PREVENTION

Organisational governance and learning
“The message is that there are known knowns - there are things that we know we know. There are known unknowns - that is to say, there are things that we now know we don’t know. But there are also unknown unknowns .... things we do not know we don’t know. And each year we discover a few more of those unknown unknowns.”
Issues

- Non standardised approach
- Non regulation/accrediation
- Poor reporting
- Accountability
- LAST RESORT
- Organisational models – multimodal causation
- Attitudes – Trauma informed
- Presentation versus self preservation
- What do we do with the information we collect?
- Varied strands of work
Way forward

- Standardised and Monitored Reporting
- NICE Update 2015
- DH Update 2014
- RCN resolution re training
- Change in thinking about last resort
- Summit
- Feasibility work on organisational approaches