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Medical Conditions and Risk Factors in the Use of Force – The British Approach to Ensuring Safety and Security in the Youth Social Rehabilitation Estate

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Abstract
The article presents the complex legal and medical issues related to the use of force in secure rehabilitation institutions in England. It discusses the regulations governing the use of force, including the necessity for its application and official statistics regarding such interventions. The text highlights the risks of injury, breathing problems, and other medical concerns that may arise during the use of physical restraint. Furthermore, it emphasizes the crucial role of healthcare in monitoring the health of individuals subjected to restraint and minimizing potential health consequences.

1. Introduction

When considering juvenile offenders, it is vital to remember that we are dealing with people at a critical time of development, somewhere between childhood and maturity. This time is marked by profound shifts in awareness, value systems, and interests. Juveniles create new relationships and circles of interests, which serve as the foundation for their system of values and motives. In traditional words, juvenile justice refers to the complete process of holding juvenile offenders accountable, including the use of appropriate means of influence (punishment, educational coercion, etc.). The first juvenile court was formed in 1899

in the state of Illinois, United States. Its main job was to enforce penalties. Later, a period of child-centered reforms started, during which the juvenile justice system acknowledged that criminal conduct is not biologically determined but rather the consequence of the effect of social and family circumstances, which may be changed via social rehabilitation. The goal of social rehabilitation is to restore an individual's human rights, social position, health, activity, motivation, and values. This approach aims to restore the person's functioning within the social context, and the notion of inclusion includes adjusting the social environment to match the individual's requirements.

At the declarative level, everyone values trust, a sense of security, love, compassion, kindness, humanitarianism, family, parents, and friends. This fact alone offers a foundation for organizing resocialization activities, since it enables for steering juveniles toward socially acknowledged valued goals and teaching them socially acceptable methods of achieving these goals. The most effective way is to cause cognitive conflict (cognitive dissonance) in the youngster, allowing them to establish new harmony (consonance). Juvenile social resocialization is developing situations and circumstances that enable adolescents to critically evaluate their conduct and question the efficacy of their attitudes and ideals. In this setting, the juvenile's interests alter, and they begin to regard themselves as an active and valuable member of society. The purpose of these resocialization attempts is to elicit internal discontent with their former worldview and provide opportunities for self-reflection. Offenders should be worried about their issues and failings, as well as critically assess their attitudes and needs. During this procedure, professionals monitor and assess the nature of the juvenile's values and motives by comparing them to their actual conduct. The main risk in resocialization work is the high probability of frustration and the juvenile's withdrawal from further cooperation with specialists. To mitigate this risk, it is essential to monitor the stability of the motivation developed throughout the entire re-education process and reinforce positive outcomes. It is also important to cultivate an emotional sense of success and appreciation for achievements in the juvenile during resocialization.

Safety for Children and Young People Secure Estate statistics collect information on assaults, self-harm, use of force, separations, and fatalities from all sectors of the Youth Custody Service, including Young Offender Institutes (YOIs), Secure Training Centres (STCs), and Secure Children's Homes.

The use of force in the context of young offender rehabilitation is a sensitive and complicated topic that necessitates a delicate balance between ensuring safety and protecting young people's rights and well-being. In the United Kingdom, dealing with foreign circumstances stresses the safety of personnel and the wider society, as well as offenders' health and rehabilitation. Medical conditions and individual risk factors are crucial in assessing how and when force should be used since they can considerably alter the requirement and possible impact of such treatments.

2. The Law Relating to Use of Force

In the United Kingdom, the use of force is governed by stringent legal and ethical norms that aim to protect the welfare of juvenile offenders while also ensuring the safety of staff and society. This strategy is founded on the understanding that many juvenile offenders have a range of medical diseases and risk factors, such as mental health issues, developmental problems, or trauma histories, which may impact their behavior and attitude to authority.

"Depending on the sector, the Criminal Law Act 1967, the Secure Training Centre Rules 1998, Young Offenders Institution Rules 2000, The Children's Home Regulations 2015 (and equivalent provisions in Wales), the Criminal Justice and Immigration Act 2008 and the rights and freedoms contained within common law and the European Convention on Human Rights (ECHR) form a set of statutory and non-statutory provisions which should be understood when considering the use of restraint and physical intervention in secure settings" (Use of Force, 2024, p. 5).

YOI: The Young Offender Institution Rules (2000)5 - Rule 44 (Maintenance of order and discipline) and Rule 50 (Use of force).

STC: The Secure Training Centre Rules (1998)6 – Rule 31 (Maintenance of order and discipline); Rule 37 (Use of force); and Rule 38 (physical restraint).

SCH: The Children's Homes (England) Regulations (2015)7 – Regulation 2 (Interpretation); Regulation 12 (The protection of children standard); Regulation 19 (Behaviour management and discipline); 20 (Restraint and deprivation of liberty); Regulation 35 (Behaviour Management policies and records)[1].

[1] https://www.legislation.gov.uk/uksi/2015/541/contents/made (accessed 16.09.24)

Criminal Law Act 1967 Section 3(1)

"Any person may use such force as is reasonable in the circumstances in the prevention of a crime, or in the effecting or assisting in the lawful arrest of offenders or suspected offenders unlawfully at large"

Common Law

In terms of the use of force, there is a well-established common law concept that states that a person has the right to defend oneself or others. Individuals can justify using force if they believe it was appropriate in the circumstances at hand.

Human Rights Act 1998

Article Two - The Right to life

Article Three- Prohibition from torture, inhumane or degrading treatment

Children Act 2004

The Children Act of 2004 established a national framework for providing children's services and designated the five outcomes of the Every Child Matters initiative for children and young people, towards which all professionals must work. People, which all professional must work towards: be healthy, stay safe, enjoy and achieve, make a positive contribution, achieve economic well being.

a) Section 10 of the Act (Section 25 for Wales)

Children's services must make arrangements to co-operate between services to address "well being" defined by the following outcomes: physical and mental health and emotional well being, protection from harm and neglect, education, training and recreation, the contribution made by them (the children) to society, social and economic well being.

b) Section 11 of the Act

All agencies working with children, young people, and their families take reasonable measures to minimize risks to their welfare. If there are concerns about their welfare, agencies address them appropriately (NOMS, 2014).

Safeguarding and promoting the welfare of children is defined for the purposes of this guidance as:

- providing help and support to meet the needs of children as soon as problems emerge;
- protecting children from maltreatment, whether that is within or outside the home, including online,
- preventing impairment of children's mental and physical health or development,

- ensuring that children grow up in circumstances consistent with the provision of safe and effective care;
- promoting the upbringing of children with their birth parents, or otherwise their family network through a kinship care arrangement, whenever possible and where this is in the best interests of the children;
- taking action to enable all children to have the best outcomes in line with the outcomes set out (Working Together to Safeguard Children, 2023, p. 8).

Within this boarder definition, safeguarding is about taking steps to ensure that children and young people are kept safe from harm. This includes protecting children and Young People from:

- Harm from self (self harm and suicide),
- Harm from peers who bully or are violent,
- Harm from adults.

Health and Safety at Work Act 1974

Members of Secure Care Officer (SCO) employed across the secure estate are entitled to the protection offered by the Health and Safety at Work Act 1974 and associated laws, and their employer is bound by specific statutory requirements.

3. Rules for Using Force in the Secure Estate

A) Young Offender Institutions (YOI)

The Young Offender Institution Rules 2000[2]

Rule 50: Use of Force

- An officer in dealing with a prisoner shall not use force unnecessarily and, when the application of force is necessary, no more force than is necessary shall be used.
- No officer shall act deliberately in a manner calculated to provoke a prisoner.

B) Secure Training Centres (STC)

The Secure Training Centre Rules 1998, Rules 37 and 38[3]:

Rule 37: Use of Force

- 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] https://www.legislation.gov.uk/uksi/2000/3371/article/5/made (accessed 16.09.24)
[3] https://www.legislation.gov.uk/uksi/1998/472/contents (accessed 16.09.24)

- No officer shall act deliberately in a manner calculated to provoke a trainee.

Rule 38: Physical restraint

- No trainee shall be physically restrained save where necessary for the purpose of preventing him from: escaping from custody (a), injuring himself (b) or others, damaging property (c); or 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.
- 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.
- 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.

Prisons and secure educational centers follow the same legislative framework and health and safety rules. There are, however, various laws controlling the use of force in secure training facilities. The phrase 'Use of Force' refers to 'any sort of physical action' employed by one person against another.

1. The use of force by one person against another without agreement is illegal unless it is carried out in accordance with the legislation controlling the use of force in specific scenarios.
2. There is no one standard by which the lawfulness of a specific use of force may be assessed. The legality of an activity is always determined by the circumstances at the time.
3. Staff must comprehend the various statutory frameworks and broad principles of the law governing the use of force. That understanding should influence decisions on how to use force appropriately.
4. Never forget that everyone, whether in custody or not, must follow all provisions of the law. Acting against the law is illegal and can result in criminal charges.

The youth justice system in England and Wales works to prevent offending and reoffending by children. It is different to the adult system and is structured to address the needs of children. The interpretation of reasonableness is a fundamental issue in the application of force. Reasonableness is a factual question that must be answered in every sce-

nario. Each set of circumstances is unique and must be evaluated on its own merit. The size, age, gender, and history of both the Young Person and the staff person in issue should all be considered. Factors such as the presence of weapons, the physical actions performed, and the Young Person's mental, emotional, and psychological health should all be examined when assessing whether the use of force or a certain sort of limitation is reasonable.

'No more force than is necessary' can be seen as proportionate. SCO should establish a fair ratio of proportionality between the methods used and the goal sought. Any use of force should be kept to a minimum and completed as quickly as feasible. When there are less harmful but equally effective alternatives, the action performed is unlikely to be considered proportional. Using more force than is necessary is illegal; personnel must demonstrate that the intervention is proportionate to the goal (for example, you should not use a sledgehammer to shatter a nut).

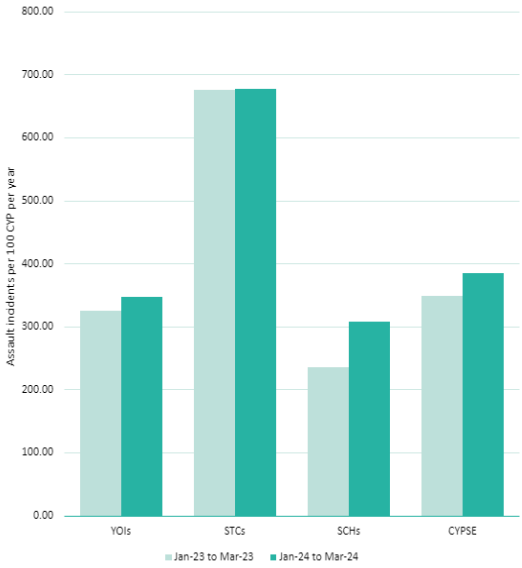
4. Why Use of Force is needed? Official Statistics

The youth justice system in England and Wales seeks to prevent children from offending and reoffending. It varies from the adult system and is intended to satisfy the needs of children. The report looks at statistics from the youth justice system in England and Wales for the fiscal year ending March 2023. It considers the number of minors in the system (ages 10-17), the offenses they committed, the outcomes they received, their demographics, and long-term trends.

Between January and March 2024, the annualized rate of assault events on staff per 100 children and young people was 169.0, representing a 6% rise over the same period in 2023. The rate of self-harm occurrences also increased dramatically, reaching 420.9 per 100 children and young people, a remarkable 119% rise over the prior year. During this time, the number of unique children and young people who engage in self-harm grew by 7%, from 83 to 89. Furthermore, the use of force episodes increased by 16%, reaching an annualised incidence of 882.6 per 100 children and young people. The number of persons involved in such occurrences increased by 6%, from 381 to 403. In Secure Children's Homes, the rate of separations per 100 children and young people

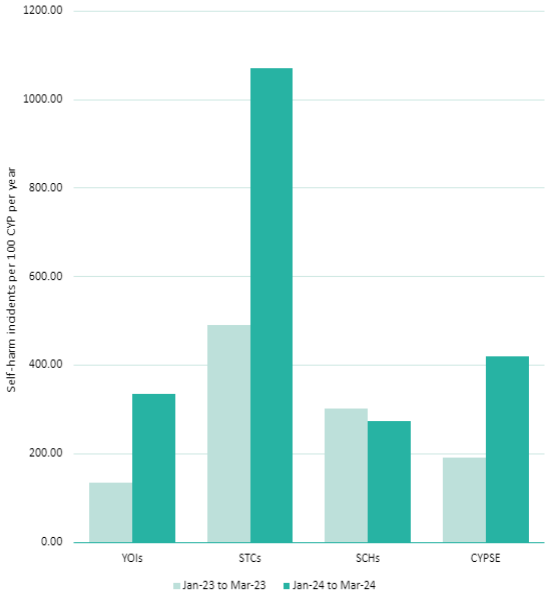
increased by 25% to 691.1. The number of unique children being separated climbed by 69%, from 29 in early 2023 to 49 in 2024. Similarly, at Secure Training Centres, the separation rate increased by 34%, with an annualized rate of 748.4. The number of people segregated in these centers has grown by 31%, from 35 to 46. In Young Offender Institutions, the separation rate increased by just 11%, to 312.4 separations per 100 children and young people. The number of unique persons enduring separations remained largely consistent, with 197 children and young people separated in early 2024, compared to 195 the previous year[4].

Figure 2: Rate of assault incidents per 100 Children and Young People per year from January 2023 to March 2023 and from January 2024 to March 2024[5]



[4] Safety in the Children and Young People Secure Estate: Update to March 2024, https://www.gov.uk/government/statistics/safety-in-the-children-and-young-people-secure-estate-update-to-march-2024/safety-in-the-children-and-young-people-secure-estate-update-to-march-2024 (accessed 19.09.2024).
[5] Ibidem.

Figure 4: Rate of self-harm incidents per 100 CYP per year from January 2023 to March 2023 and from January 2024 to March 2024[6]



5. Risk of Injury

The techniques in Physical Restraint have been designed for use on young people aged 12 to 17; it is recognised that within this age group there is a wide range of physical sizes and strengths that can influence how staff gain and maintain control during physical restraint incidents. Techniques should not be chosen arbitrarily, but rather after careful analysis of the effect variables listed above, as well as the nature of the occurrence and the Young Person's competence. These considerations may impact staff members' decision to use a certain method, but the goal should always

[6] Ibidem.

be to decelerate to the lowest degree of restraint possible, and any reason for technique selection should be documented in the Use of Force report. When force is used or is likely to be used to control a violent or disturbed Young Person, a member of health care professionals must attend every incident as soon as reasonably possible.

"No restraint is 100% safe. As many of those who have contributed to the review have acknowledged, it is an area of controversy and competing claims and there is little consensus among medical experts about the causes of injury and death associated with restraint use or the relative risk associated with alternative methods of restraint" (Smallridge, Williamson, 2008, p. 32).

It is critical that all personnel participating in restraining a Young Person understand that using techniques in certain postures may enhance the danger to the Young Person during restraint (especially prone). A restraint with the Young Person sitting requires extra consideration since the angle between the torso and lower limbs is already reduced. Compression of the torso against or towards the thighs limits the diaphragm and reduces lung inflate. The following variables contribute to the elevated hazards of restricting young people in a sitting position:

- Increased risk of compromising breathing.
- Duration of restraint can be unspecified/lengthy.

Over more, all SCO must be made aware of the following medical concerns that may occur during restraint: airway blockage, breathing difficulties, circulation anomalies, fracture/dislocation, nerve injury, ligament/tendon damage, soft tissue swelling, muscle damage, and bruising. Whenever possible, SCO should avoid having a young person sit. If employees are constrained in a sitting posture, they should look for another work as soon as feasible. A young individual should never sit while wearing a head support. All SCO must be aware of the medical signs, indicators, and procedures to follow, and an event may be characterized as a medical emergency rather than a Use of Force incident.

6. Airway and breathing issues

Problems with any component of the airway can limit or prohibit oxygen and carbon dioxide from entering and exiting the lungs. This might result in a fast drop in blood oxygen levels, causing substantial in-

jury. Any restraining technique that confines the airway or causes the rib cage or diaphragm to inflate might severely limit a young person's ability to breathe, perhaps leading to asphyxiation. Covering the mouth and/or nose, as well as exerting pressure to the neck area, can restrict or obstruct the airway. This can soon result in asphyxiation. Any covering of the airway (nose/mouth), such as clothing or towels, can have an impact; for example, if the Young Person is supine (face up) and spits at staff, there may be a tendency to cover the face with towels, clothes, and so on. This must be avoided since it reduces the young person's ability to breathe. A safer method is to supply staff with full-face visors and protective clothing.

Any restraining technique that restricts the airway or causes the rib cage or diaphragm to expand may severely impede a Young Person's capacity to breathe, perhaps leading to asphyxiation. The airway can be constricted or blocked by covering the mouth and/or nose, or applying pressure to the neck area. This can quickly lead to asphyxiation. Any covering of the airway (nose/mouth), such as clothing or towels, can have an effect; for example, if the Young Person is supine (facing up) and spits at staff, there may be a propensity to cover the face with towels, clothes, and so on. This must be avoided since it impairs the young person's capacity to breathe.

Breathing can also be limited by restrictions on chest wall and diaphragm mobility. When the abdomen is squeezed, the stomach and its contents constrain the rib cage and diaphragm's movement. This can occur while the Young Person is in sitting, kneeling or prone (face down) constraint postures (Parkes, 2002). When restraining a young person laying face forwards on the ground (prone posture), caution must be shown. The individual's body weight (and any additional weight from restraining personnel) restricts mobility of the rib cage and diaphragm, resulting in breathing issues (Parkes, Carson, 2008). Restraint grips around the neck can be particularly effective and hence appealing to staff in dangerous situations. However, they have a lengthy history of causing abrupt death when under restraint due to airway obstruction. As a result, no neck restraints should be employed. For all of the reasons stated above, no weight should be placed on the Young Person's chest wall, belly, or neck (Reay, Eisele, 1982, p. 254).

7. Medical issues

Other medical issues can influence and raise the risk of complications related to airway, breathing, and circulation difficulties. It should be noted that the start of a major medical condition following the use of physical restraint is exceedingly unusual; nonetheless, persons in custody have died as a result of restraint, and this has nearly always been due to a failure to follow proper protocols. In a few cases, the constraint exacerbated an undiagnosed health issue.

Hence staff should be aware, whenever possible, of any associated health conditions that the Young Person may have which can affect how the body responds to increased exertion. These include: medical conditions that may affect airway, breathing and circulation; asthma, sickle cell thalassaemia, diabetes, epilepsy, obesity, drug or alcohol withdrawal /intoxication, pre-existing heart conditions, pregnancy.

Other risk factors include size disparity between the staff and the Young Person

- Restraint of an individual of small stature
- Prolonged restraint, where the person violently resists for an extended period of time. (This has been identified as the single greatest risk factor)
- A combination of chest-wall or abdominal restriction in a seated, kneeling or leaning forwards position (this is particularly dangerous). The Young Person must be kept as erect as possible when they are being restrained in a seated position (MMPR, 2014, p. 91).

The steps listed below will lower the risks associated with certain diseases and risk factors:

- Ensure that medical treatment is delivered as quickly as feasible.
- Minimize the duration of any unavoidable constraint.

Now, let's see more details about few medical conditions issues:

1) Asthma

As Gabriela Harvanová and Silvia Duranková (2022) pointed out Bronchial asthma is currently one of the most common chronic diseases of the respiratory system worldwide. The immune and respiratory systems regress to seemingly innocuous stimuli such as pollen, animal hair, dust, dust mites, or psychological stress. Subsequently, patients develop symptoms characteristic of bronchial asthma: shortness of breath, wheezing, chest tightness, and coughing. The disease has an impact on the patient's

psychological state, where in many cases it can be the cause of depression, anxiety, or a reduction in self-control. Bronchial asthma is a lifelong disease, but under the control of medical treatment, patients can live a good quality and fulfilling life. Treatment of bronchial asthma is a lifelong process, but the prognosis is excellent. It is very important that it is diagnosed early and that the subsequent treatment is set up correctly. Also, the use of medications should be regular and accompanied by the use of relaxants and oral corticosteroids during anxiety states.

Young people with asthma have wheezy episodes that can be induced by effort, as well as shortness of breath and the need of an inhaler to ease their symptoms. They will increase their breathing rate and effort, employ 'accessory muscles of ventilation', and may complain of being unable to breathe. They need to get access to their drugs as quickly as possible. If the inhaler does not help their health or they grow increasingly wheezy or unable to communicate, they should be handled as a medical emergency.

2) Sickle cell anaemia and thalassaemia

Some people have inherited difficulties with the red blood cells they manufacture. Red blood cells deliver oxygen from the lungs throughout the body and transport carbon dioxide from the body's cells to the lungs, where it is eliminated. Many of these young people have less severe versions of these disorders, such as sickle cell trait, which arises when only one of the two genes is faulty. The severe type of sickle cell anaemia develops when both genes are defective, resulting in sickle cell disease. These people usually experience complications because their red blood cells grow stiff in small blood veins and obstruct them, producing agony (a sickle cell crisis). This obstruction increases their susceptibility to infections. Young people with sickle cell trait are typically free of crises, especially in cases of extreme oxygen deficiency. Sickle cell crises can result in catastrophic consequences including heart attacks, strokes, or even death. Sickle cell disease is more frequent in black Africans, the Mediterranean, and some regions of India (and their descendants) (Dyson, Boswell, 2009).

Blood disorder types characterized by low levels or missing normal globin chains in the normal red blood cell protein hemoglobin are now characterized as thalassemia (Shafique et. al., 2023, p. 2). Thalassemia1 is a genetic blood disorder. People with Thalassemia disease are not able to make enough hemoglobin, which causes severe anemia. Hemoglobin is found in red blood cells and carries oxygen to all parts of the body. When

there is not enough hemoglobin in the red blood cells, oxygen cannot get to all parts of the body. Organs then become starved for oxygen and are unable to function properly (Prathyusha et. al., 2019, p. 186).

The majority of young people with sickle cell anemia or thalassaemia are aware of their disease, and whatever information they provide should be taken carefully. There is no reason why people with these genetic conditions should not be confined as long as they employ and use recognized techniques and procedures effectively. However, the hazards of restricting people with these disorders highlight the need of all workers being aware of and ensuring that the airways and breathing of everyone who is being restrained are maintained at all times. Any of the following symptoms may signal a significant worsening of sickle cell anaemia, sometimes known as „sickle cell crisis". This is more likely to occur with sickle cell disease, but can occur with sickle cell trait, particularly if there is significant effort. Thalassaemia also has the disadvantage of enlarging the spleen, which might rupture with trauma. A person with severe sickle cell anemia or thalassaemia will need medical treatment. There have been cases where untreated patients have died in detention. Staff should avoid restraining postures that might impede respiration or compress the abdomen.

3) Diabetes

Diabetes mellitus is a metabolic disorder characterized by the presence of hyperglycemia due to defective insulin secretion, defective insulin action or both. The chronic hyperglycemia of diabetes is associated with relatively specific long-term microvascular complications affecting the eyes, kidneys and nerves, as well as an increased risk for cardiovascular disease (Goldenberg, 2013). There is a rise in the number of young people who use insulin to regulate their blood sugar levels. They may rapidly reduce their sugar level with effort and require immediate medical treatment because if the level falls too low, they may complain of dizziness, drowsiness, loss of consciousness, or even fit.

4) Epilepsy

In 2005, the International League Against Epilepsy (ILAE) defined epilepsy as "a disorder of the brain characterized by an enduring predisposition to generate epileptic seizures, and by the neurobiologic, cognitive, psychological, and social consequences of this condition" (Fisher, et al. 2005). An epileptic seizure, on the other hand, refers to "a transient occurrence of signs and/or symptoms due to abnormal excessive or synchro-

nous neuronal activity in the brain.

Seizures can include loss of consciousness, collapsing to the floor, and tensing of the entire body followed by rhythmical muscular twitching (a „tonic-clonic seizure"). Other young people may have seizures in which they appear to be absent and unresponsive but may not lose consciousness completely. There are also seizures that affect only a portion of the brain ('partial seizures'), which can result in strange sensations (such as seeing or hearing things) and aberrant behavior, depending on which section of the brain is involved. Epilepsy is a prevalent condition that is not often linked to violence. However, the following considerations are significant in the context of safe management for young people:

- If a young person discloses epilepsy, medical attention and access to prescribed medicines are critical. Seizures (and other dangerous responses) may occur if antiepileptic medication is quickly discontinued
- A person recuperating from an epileptic seizure may be disoriented, but this should not be misinterpreted as deliberate refusal to follow directions. A young person may be resistant to interventions at this time if they do not grasp what is going on. It is typically best to wait until complete responsiveness returns (assuming no imminent risk is present). If the Young Person is unconscious, get medical attention and place them in the recovery position.
- A young person having a 'absence' type seizure may appear to be conscious and capable of responding. However, this is not the case, and it is critical not to misinterpret the seizure for a deliberate inability to follow instructions. Allow the Young Person to act in a safe environment whenever feasible. Move everyone who may be in danger out of the area. However, cautious restraint may be required if the Young Person puts themselves in danger.
- Seizures can be caused by a variety of conditions. The Young Person may be aware of triggers that are important to them. A tiny proportion of young people will have seizures in reaction to flashing lights (photo-sensitive epilepsy), and they should not be intentionally exposed to strobe-type lighting.

5) Obesity

According to the World Health Organization (WHO), obesity and overweight are defined abnormal or excessive fat accumulation that may impair health. The imbalance between excess calorie intake and relatively less energy expenditure causes obesity. Obesity is a growing medical and

socioeconomic problem, which WHO defined as the epidemic disease of the new age world called globosity (Sümer, 2016, p. 57).

In 2022, an estimated 37 million children under the age of 5 years were overweight. Once considered a high-income country problem, overweight is on the rise in low- and middle-income countries. In Africa, the number of overweight children under 5 years has increased by nearly 23% since 2000. Almost half of the children under 5 years who were overweight or living with obesity in 2022 lived in Asia. Over 390 million children and adolescents aged 5–19 years were overweight in 2022. The prevalence of overweight (including obesity) among children and adolescents aged 5–19 has risen dramatically from just 8% in 1990 to 20% in 2022. The rise has occurred similarly among both boys and girls: in 2022 19% of girls and 21% of boys were overweight (WHO, 2024)

Obese Young people are susceptible to airway blockage, particularly when constrained in prone or sitting positions. The stomach and abdominal contents, like those of any prone or sitting individual, inhibit diaphragm mobility. Furthermore, obesity limits the diaphragm and rib cage's range of movement. In the prone or sitting posture, the rib cage has a much more difficult time moving upwards and outwards, as in inspiration, and fat within the belly hinders the diaphragm's downward migration.

6) Drug or alcohol withdrawal/ intoxication

Alcohol and various other substances can impair the brain's control of respiration. The body's responses can be affected, and a sudden collapse may occur. Drugs like cocaine, methylamphetamine, or crack function as stimulants, so the young person may look hyperactive, impatient, anxious, and their speech may be nonsensical or difficult to comprehend. The heart and respiration rates may accelerate, and it may be difficult to decelerate the condition since the person may not listen. Restraint should not be continued since it might cause irregular cardiac rhythms. Any such individual experiencing chest pain should seek immediate medical assistance as this might be a heart attack.Ecstasy is related with high temperatures, disorientation, increased water consumption, fainting, and collapse. The heart and respiration rates rise, and thirst may increase. Alcohol withdrawal can range from psychological dependence to physical symptoms including sweating, tremors, fits, hallucinations, nausea, and vomiting, and it is considered a medical emergency (MMPR, 2024).

7) Heart Conditions

Heart disease describes a range of conditions that affect the heart. Heart disease includes: Blood vessel disease, such as coronary artery disease; Irregular heartbeats, called arrhythmias; Heart conditions that you're born with, called congenital heart defects; Disease of the heart muscle; Heart valve disease[7]. Anything that strains the heart or damages heart tissue can increase the risk of sudden cardiac death. Some conditions that can lead to sudden cardiac death in young people are:

- *Thickened heart muscle, also called hypertrophic cardiomyopathy***.** This genetic condition is the most common cause of sudden cardiac death in young people. It causes the heart muscle to grow too thick. The thickening makes it hard for the heart to pump blood. This can cause fast heartbeats.
- *Long QT syndrome***.** This heart rhythm condition can cause fast, chaotic heartbeats. It›s linked to fainting for no reason and sudden death, especially in young people. If you are born with it, it›s called congenital long QT syndrome. If it is caused by a medicine or health condition, it is called acquired long QT syndrome.
- *Other heart rhythm conditions***.** Other irregular heart rhythms can cause sudden cardiac death. These include Brugada syndrome and Wolff-Parkinson-White syndrome.
- *Forceful hit to the chest***.** A blunt chest injury that causes sudden cardiac death is called commotio cordis. Commotio cordis may occur in athletes who are hit hard in the chest by sports equipment or by another player. This condition does not damage the heart muscle. Instead, it changes the heart's electrical signaling. The blow to the chest can trigger ventricular fibrillation. The hit must occur at a specific time in the heart signaling cycle.
- *Heart condition present at birth, also called a congenital heart defect.* Some people are born with changes in the heart and blood vessels. These changes can reduce blood flow and lead to sudden cardiac death[8].

Every year, a few young people collapse and die as a result of an undetected cardiac problem, such as when participating in sports or physical exercise. It is therefore necessary to be prepared to administer basic life support in this circumstance as well as any other situations when any individual may have collapsed.

[7] https://www.mayoclinic.org/diseases-conditions/heart-disease/symptoms-causes/syc-20353118 (accessed 26.09.24).
[8] https://www.mayoclinic.org/diseases-conditions/sudden-cardiac-arrest/in-depth/sudden-death/art-20047571 (accessed 26.09.24).

8) Use of restraint or physical intervention involving a child who is pregnant

In any incident involving someone who is pregnant every effort should be made to deescalate and ensure that restraint or physical intervention is only used where it is absolutely reasonable, necessary and proportionate, and if it is being used to prevent harm to the child themselves, the harm to their unborn child should also be considered. 4.68 In all planned or unplanned instances where the use of restraint or physical intervention involving someone who is pregnant, members of staff must ensure that detailed planning or dynamic assessment is undertaken and the very specific risks to the mother and their unborn child are considered. Healthcare staff must be present from the start of the response unless the incident is spontaneous or unplanned[9]. Occasionally, it may be required to restrain a pregnant person; if the female falls on the ground, she must be shifted from the prone or supine position to the recovery posture, with the left side of her body on the ground and the right side uppermost. This is to prevent the uterus (with the fetus within) from compressing the big vein that drains back blood from the body, the inferior vena cava.

9) Unconsciousness

In all of these situations, such as drug or alcohol withdrawal/intoxication, low sugar as in insulin-dependent diabetes, cardiac difficulties, and so on, unconsciousness may develop, followed by aspiration of vomit into the lungs/compromise of the airway. This is life-threatening. The unconscious Young Person should be placed in the recovery posture as soon as feasible. Medical assistance is necessary.

10) Weight and height disparity

For each restraint method or operation that involves constraint, especially if it is planned, members of the team performing the restraint must consider their weight and size. A team of huge, powerful persons can do harm when restraining a much smaller individual; nevertheless, if the Young Person is considerably larger than the member(s) of staff, care should be taken to avoid injury to staff members. Height might be an essential aspect since a tall employee may apply a hold from a different angle than a smaller employee. This must be carefully studied by staff personnel so that their own restraining method does not

[9] Youth Custody Service, https://assets.publishing.service.gov.uk/media/64de3b25c8dee4000d7f1e6f/use-force-restraint-restrictive-practices-pf.pdf (accessed 26.09.24).

cause unwanted and accidental suffering to the Young Person. Under no circumstances should the personnel place any body weight on the neck, chest or abdomen. This is such a crucial lesson since many fatalities have happened as a result of either airway blockage or preventable respiratory issues. When the member of staff is removing their hold on a Young Person, it must be done in such a way that no significant force is used on that part of the body to remove him/her self from that hold, e.g. to come off the arm hold from the Young Person in the supine position, the member of staff must not push him/her self off that arm by pushing down onto the arm, otherwise there is the potential for ligament, tendon or nerve damage at the elbow, muscle damage in the lower or upper arm and bruising at the site of maximum application of force (MMPR, 2014).

11) Psychosis/ disturbed behaviour

Most people suffering from mental illness 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. Psychosis is a set of symptoms related to mental health issues that occurs in a range of psychotic disorders, to include Schizophrenia Spectrum Disorder, Bipolar Disorder, Posttraumatic Stress Disorder and Major Depressive Disorder (Doherty, Owen, 2014, p. 29).

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

- Acute and chronic organic brain syndromes (Cognitive Disorder): Such as delirium and dementia with psychotic features, some toxic or pathological basis can often be defined. Prominent features are confusions, disorientation, defective memory, disorganized thought and behaviour.
- Functional disorder: No underling cause can be defined, memory and orientation are mostly retained but emotion, thought, reasoning and behaviour are seriously altered.
- Schizophrenia (Split Mind): Schizophrenia is characterized by delusion, hallucination and lack of insight. Acute schizophrenia may also present with disturbed behaviour, disturbed thinking, or with insidious social withdrawal and other so called negative symptoms and less obvious delusion and hallucination (Bangwal, Bisht, Saklani, Garg, Dhayani, 2020, p. 164).
- Mania: An extremely disabling and potentially harmful behavioral syndrome that indicates an underlying central nervous system disorder. Mania can lead to harm to self or others, and

- may be accompanied by features of psychosis. Hypomania is a less severe form of mania,
- see later on in the text how to differentiate between the two. Usually, by definition they denote affliction by one of the various forms of Bipolar Disorders or 'Bipolar Spectrum' of disorders[10].
- Drag Induced Psychosis is defined as a condition in which psychotic symptoms are caused by a psychoactive substance and resolve within a set time period (Weibell, Velden Hegelstad, Johannessen, 2016, p. 52).
- Attention Deficit Hyperactivity Disorder (ADHD) is one of the most prevalent mental health problems among children and adolescents, with a rising trend. ADHD is a neurodevelopmental condition related to deficient brain and nervous system functions that usually start in early childhood and follow a persistent trait-like course into adolescence and adulthood. Children with ADHD may have behavioral problems such as inattention, hyperactivity, and impulsivity (Khamenkan, Homchampa, 2024, p. 1).
- Externalizing problems include rule-breaking actions, aggression toward others, and delinquency. Longitudinal research shows that adolescent externalizing behaviors are a major risk factor for a number of negative outcomes, such as juvenile delinquency and future crime and violence, as well as decreased educational and occupational attainment in adulthood (Georgiou, Charalampous, 2024). However, while some children uniquely exhibit externalizing problems, for a sizable proportion of children, these problems co-occur with internalizing problems (i.e., behavioral symptoms that are focused 'inwards' such as depression, social withdrawal, and anxiety) (Boutin et al., 2020).
- Oppositional defiant disorder (ODD) is one of a group of behavioral disorders called disruptive behavior disorders (DBD). These disorders are called this because children who have these disorders tend to disrupt those around them (Rocque, 2016, p. 493).
- Conduct disorder (CD), primarily characterized by aggression toward people and animals, property destruction, theft, and serious rule violations, is a problematic psychiatric disorder that generates significant impairment of daily functioning (Doucet, Azar, Doucet, Luke, 2021).

[10] Bipolar Disorder Mania and Hypomania, http://thehub.utoronto.ca/psychiatry/wp-content/uploads/2014/05/Bipolar-Disorder-Handout.pdf, (accessed 27.09.24).

8. Role of Healthcare during all instances where restraint or physical intervention is used

The safety, health and wellbeing of staff or children involved in any incident where restraint or physical intervention is used is a key priority. Training for staff in secure settings about their response to incidents where restraint or physical intervention is used must include: - Recognition of distress or deterioration of a child's physical condition and the warning signs and symptoms associated with medical distress45, including: - airway obstruction. - respiratory issues or breathing difficulties. - circulatory or cardiovascular problems. - articular or bony injury, including fracture or dislocation. - nerve injury. - damage to ligaments or tendons. - soft tissue swelling. - muscle damage. - Bruising. - Understanding of the physiology of breathing. - Airway management and how to undertake resuscitation. - Understanding of physiological or psychological conditions which might increase the risk of an adverse outcome.

9. Conclusion

The medical safety of both workers and young people is a top responsibility. According to the Independent Review of Restraint guidelines, providers must guarantee that they may call for prompt medical help for young people, including getting a paediatric report if hospital care is necessary. Any injuries should be treated appropriately and recorded on a body map. Providers may want to acquire photographic proof of the injuries, but this may not always be appropriate given the history of abuse that some young people in the secure estate have.

Both young people and staff should have a distinct debriefing procedure. The consequence should be an agreed-upon action plan to support positive conduct in the young person, reducing the chance of future behaviour degrading to the point where force is required. All young people should get support following a use of force event, especially throughout the debriefing phase. Some young people may benefit from having advocates present throughout the debriefing process, while others may choose to speak with their key worker, personal officer, social worker, or Independent Monitoring Board. Young people should always make the decision to seek support services themselves.

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Stan zdrowia i czynniki ryzyka a użycie siły – brytyjskie podejście do zapewnienia bezpieczeństwa i ochrony w procesie resocjalizacji nieletnich

Słowa kluczowe

czynniki ryzyka, nieletni, problemy zdrowotne, resocjalizacja

Abstrakt

W artykule zaprezentowano złożone kwestie prawne i medyczne związane z użyciem siły w zamkniętych instytucjach resocjalizacyjnych w Anglii. Omówiono przepisy regulujące stosowanie siły, w tym jej konieczność oraz oficjalne statystyki dotyczące takich interwencji. W tekście podkreślono ryzyko obrażeń, problemy z oddychaniem oraz inne kwestie medyczne, które mogą wystąpić podczas stosowania przymusu fizycznego. Ponadto zwrócono uwagę na kluczową rolę opieki zdrowotnej w monitorowaniu stanu zdrowia osób poddanych restrykcjom i minimalizowaniu potencjalnych skutków zdrowotnych.