

For immediate release

JUDGE TELLS SECRETARY OF STATE FOR JUSTICE IT WOULD BE 'WHOLLY UNFORGIVABLE' IF LESSONS WERE NOT LEARNED FROM DEATH OF GARETH MYATT IN SECURE TRAINING CENTRE

The Judge who presided over the inquest into the death of Gareth Myatt, the only child to die in custody following restraint, wrote today to the Secretary of State for Justice and Lord Chancellor saying that it would be 'wholly unforgivable and a double tragedy' if there was any delay in learning from and acting upon the lessons of Gareth's death.

His Honour Judge Pollard, sitting as Assistant Deputy Coroner for the County of Northampton, has used his power under r43 of the Coroners Rules 1984 to make a report to those authorities who have the power to take action to prevent the recurrence of similar fatalities. In a 17 page letter to Rt Hon Jack Straw MP, Secretary of State for Justice and Lord Chancellor, HHJ Pollard specified 34 preventative actions which range widely over the treatment of children, the use of restraint, monitoring, good practice, access for emergency vehicles, and inspection. He stressed to the Secretary of State the absolute need to 'listen to the voice of the child'. This is the underlying theme emphasised by Gareth's lawyers throughout the inquest, one which unifies the deaths of Gareth Myatt (who died in Rainsbrook STC in April 2004) and Adam Rickwood (who died in Hassockfield STC in August 2004). Both deaths were needless and avoidable.

The rule 43 report follows on from the scathing narrative verdict reached by the inquest jury which devastatingly implicated Home Office/Ministry of Justice and Youth Justice Board failures in the death of this 15 year-old child.

INQUEST however remains extremely concerned that the YJB is still 'unfit for purpose' and that the government's abiding lack of will to engage with the real lessons to emerge from the tragic deaths of two children in Secure Training Centres (STCs) is reflected in its unjustified and undemocratic amending of the Secure Training Centre Rules,¹ a move which will broaden the circumstances in which children in the care of the state can be forcibly restrained. HHJ Pollard has already indicated his concern about the adequacy of the proposed joint review on restraint and its ability to 'deal with the clear and urgent issues raised by Gareth Myatt's death.'²

...continues

¹ Statutory Instrument 2007 No 1709 - changes to the Secure Training Centre Rules 1998 which came into effect on 6 July 2007.

² Page 5 rule 43 report

Inquest

Deborah Coles, Co-director of INQUEST said:

“We have no confidence that this detailed rule 43 report will be acted upon with the vigour and urgency required without further public scrutiny and examination of the broad range of issues Judge Pollard has identified require action. Without effective and transparent mechanisms to ensure that positive steps are taken, those actions and inactions of the government and YJB that contributed to Gareth’s death will prevail and an opportunity to prevent the further suffering and deaths of other children will be missed.”

We remain convinced that the only way to learn from and act on the lessons resulting from Gareth Myatt’s death is for there to be an independent, holistic inquiry in public of the juvenile justice system with the proper involvement of families, children and those working within it.”

Mark Scott of Bhatt Murphy solicitors said:

“My client will never recover from the death of her son particularly as it was so avoidable. Her only hope is that comprehensive changes will be introduced to safeguard the lives of children in custody. However presently she has little confidence that the Ministry of Justice and the Youth Justice Board are willing to address the serious and wide ranging failures identified at the inquest.”

Background

Gareth, 4 foot 10 and weighing 6 ½ stones, died at the privately-run Rainsbrook Secure Training Centre in 2004 following restraint by three adult officers. The incident began with Gareth’s refusal to clean a toaster having made a cheese toastie. The officers used the Seated Double Embrace hold on him, part of an inadequately tested system of restraint used on children called Physical Care in Custody (PCC). The inquest jury found that the Home Office and Youth Justice Board’s failure to test this system medically and their inadequate safety assessment of it caused or contributed to Gareth’s death.

In a detailed article 2 narrative verdict, the inquest jury found that Gareth’s death was caused or contributed to by: inadequate assessment of the safety of the restraint system used on children in Secure Training Centres; failure to undertake medical review of the system; the failure by the YJB to depute anyone with managerial responsibility for PCC; the inadequacy of the YJB’s response to the National Children’s Bureau recommendation that there was an urgent need for the medical review of PCC; the YJB’s inadequate response to information that children were vomiting and having difficulties breathing during restraint; the inadequate monitoring of PCC by the YJB. ³

INQUEST will also be seeking an urgent meeting with the Secretary of State for Justice to discuss the action that the government intends to take arising from this rule 43 report.

³ See INQUEST press release

In q u e s t

INQUEST has supported Gareth's mother since his death three years ago, with INQUEST Lawyers group members Mark Scott of Bhatt Murphy solicitors and barristers Dexter Dias and Brenda Campbell of Garden Court Chambers.

Detailed [briefings on the death of Gareth Myatt](#) and on the [restraint of children and the proposed changes to Secure Training Centre Rules](#) are available on the INQUEST website, as is a [full copy of the rule 43 report](#).

Further information	www.inquest.org.uk
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Notes to editors:

INQUEST is the only non-governmental organisation in England and Wales that works directly with the families of those who die in custody. It provides an independent free legal and advice service to bereaved people on inquest procedures and their rights in the coroner's courts.