

GARETH MYATT BRIEFING

1. INTRODUCTION

- 1.1 Gareth is the first child ever to die in a privately run Secure Training Centre (STC) and is the only child to have died following restraint. Custody staff used a method of restraint on him called ‘seated double embrace’ which, on police advice, was withdrawn from use following his death. It has not been reinstated. The inquest into Gareth’s death will scrutinise: what actual restraint was used by the custody staff on Gareth; how such a method of restraint was given ministerial and/or governmental approval to be used on children; and how its use on children in custody was monitored by the Youth Justice Board (YJB).

This briefing covers:

- A case summary and synopsis of the key issues arising;
- a history of restraint related deaths in custody;
- information about what will happen at the inquest;
- details about INQUEST’s call for a public inquiry into child deaths in custody.

2. CASE SUMMARY

- 2.1 Gareth Myatt was a 15 year old child from Stoke on Trent. He was small for his age, being only 4 foot 10 inches tall and weighing 6 ½ stone. Gareth’s mother is Pam. He had an older sister who was 16 and a younger brother who was 9 at the time of his death. In the family Gareth was known as ‘Gazza’. Gareth was mixed-race, his mother being white and his father black of Caribbean descent.
- 2.2 Gareth died after being restrained by three adult officers at the privately run Rainsbrook Secure Training Centre on 19 April 2004. He was three days into a 12 month Detention and Training Order when he died.
- 2.3 Gareth was restrained under a Home Office and YJB approved restraint technique known as the ‘seated double embrace’. This type of restraint was part of a series of techniques approved by Home Office ministers as part of the Physical Control in Care (PCC) system of restraint.
- 2.5 Gareth’s death gave rise to three separate inquiries. A police investigation by Northampton Police; a Part 8 statutory inquiry held into a death of a child by Stoke on

Trent area Child Protection Committee and a YJB-commissioned investigation. None of the findings from these inquiries have yet been publicly scrutinised.

- 2.6 In the immediate aftermath of Gareth's death, the YJB stated it was reviewing all PCC techniques. The police investigating Gareth's death recommended the technique be withdrawn after hearing from independent experts and the YJB subsequently withdrew the seated double embrace from use within the juvenile secure estate in June 2004.
- 2.7 An inquest into his death will now be presided over by HH Richard Pollard, a retired circuit court judge sitting as the coroner, along with a jury. The inquest is scheduled to last for four weeks and will be the first time Gareth's death will be subjected to public scrutiny. Evidence will be heard from amongst others: Gareth's mother; the officers involved in the restraint; those responsible for the introduction of PCC; senior management of the YJB and of Rainsbrook; medical experts; and other children held at Rainsbrook when Gareth died.
- 2.8 STCs are privately-run children's prisons. They are contracted and monitored by the YJB to safely supply secure accommodation for children. Rainsbrook STC was opened in July 1999 and is near Rugby, Warwickshire. It is run by Rebound ECD, a private company which is a subsidiary of Global Solutions Ltd, which at the time of Gareth's death was owned by Group 4 and was then sold in July 2004 to Englefield Capital and Electra Partners Europe.

3. RESTRAINT RELATED DEATHS IN CUSTODY

- 3.1 In Gareth Myatt's case we hope that the inquest investigates:
 - the type and prevalence of physical restraint used against children in custody;
 - the appropriateness of the force used on Gareth;
 - how the type of restraint used was originally approved and medically assessed;
 - the monitoring, auditing and reviewing of PCC and if potential risks were identified;
 - how the staff were trained in the use of restraint.
- 3.2 INQUEST has worked since 1990 on a number of restraint-related deaths in police, prison and psychiatric custody, many of which have generated high profile media coverage and public disquiet. A number of these cases resulted in unlawful killing and other critical inquest findings and led to coroners' recommendations to prevent future similar deaths. They have also generated significant parliamentary debate and inquiry. These deaths have resulted in enhanced awareness of the dangers of asphyxia associated with particular methods of restraint and led to changes in policy and practice.
- 3.3 In 2003, four months before Gareth died, INQUEST gave detailed written evidence to the Parliamentary Joint Committee on Human Rights Inquiry into Deaths in Custody. In evidence we raised our concerns about restraint-related deaths and the lack of joined-up thinking and learning between government agencies.

“For two decades we have documented our concerns about deaths where the use of restraint by state agents has either caused or played a significant contributory factor in the death of the deceased. Casework¹ in police prison and psychiatric custody has revealed concerns about the excessive use of force generally including the use of CS spray, US style batons, firearms, strip cells and medication as well as the use of dangerous 'control and restraint' methods such as body belts, 'neck holds, and other restraint techniques resulting in the inhibition of the respiratory system, asphyxia and death”²

“These deaths show a systemic failure to learn lessons: to review, revise and implement policies, instigate new training, to share and disseminate information and guidance across different state agencies.

Evidence of dangerous practice and culture has emerged but the lessons to be learned have not been applied to the range of organisations that are increasingly involved in restraining people:

- *police and prison officers and those working in psychiatric custody;*
- *immigration officers;*
- *private security firms detaining asylum seekers;*
- *security guards;*
- *and those working in care homes for children, people with learning disabilities and older people.*

In the majority of restraint-related deaths, coroners have reiterated their concerns about restraint training and made recommendations but there is no mechanism for monitoring such recommendations and their communication and subsequent implementation across relevant Government departments

In our view this failure to act and ensure inter-agency communication and collaboration in terms of policy and practice around restraint has resulted in more deaths and serious injury.”³

- 3.4 We raised similar points in our oral evidence to the JCHR inquiry on 12 January 2004 and in our written evidence to the inquiry in September 2004 we raised our concerns about Gareth Myatt’s case - in particular what medical input and advice was taken before the introduction of PCC and the treatment of Gareth’s family by the authorities following his death.

¹ This means working closely with family members very soon after the death, referring them to appropriate lawyers, working with the legal team, attending the inquest, raising the issues with relevant agencies and government departments and with MPs and other interested organisations. This gives us a unique body of knowledge from which to comment on the deaths and the issues they raise.

² INQUEST submission to the Joint Committee of Human Rights, JCHR Deaths in Custody: Interim Report and Findings, 2003 p105

³ *ibid* p107

- 3.5 It is well-documented that there are high levels of restraint used against children in STCs and Young Offender Institutions⁴
- 3.6 Recently, on 5 February 2007, the House of Lords debated the Corporate Manslaughter Bill 2006-07 and the government was defeated over its exclusion of deaths in custody from prosecution. During the course of this debate issues around deaths of children in penal custody were discussed.

5. CHILD DEATHS IN CUSTODY – PUBLIC INQUIRY CALL

- 5.1 There have been 29 deaths of children in penal custody in England and Wales since 1990. There has never been a public inquiry following any of these deaths. Collectively they raise thematic issues that need to be addressed in a joined-up manner through a properly resourced inquiry so that appropriate recommendations are made to ensure that lessons are learned and safeguards put in place to protect the lives of children in the future.
- 5.2 INQUEST has been campaigning for a public inquiry into child deaths in custody⁵ since the death of Joseph Scholes, a deeply disturbed young boy who hanged himself in his cell at Stoke Heath Young Offender Institution in Shropshire in 2002. Joseph's death raises serious issues about the ability of the state agencies to provide a safe environment to care for society's most vulnerable young offenders. His death also raises questions about the procedures for holding these agencies to account when they fail. In Joseph's case, the coroner who presided over the inquest into his death recommended a public inquiry – but this has been repeatedly turned down by the Home Secretary and his family are now appealing the decision to the House of Lords. INQUEST's casework has highlighted that child deaths are too often linked to failings in the community, the inappropriate use of penal custody for vulnerable children, inadequate treatment whilst in custody whereby the institutions are unable to care for the vulnerabilities of those that they detain.⁶
- 5.3 Since the launch of the campaign in November 2003, backing for the public inquiry into Joseph's death has snowballed with key children's charities, penal reform groups, leading members of the legal establishment, peers and MPs supporting the call. More than 100 MPs signed an EDM (1423) in support of the call, and a second EDM (2410) tabled by the Scholes family MP Chris Ruane has received renewed support. Child deaths in custody have been debated extensively in parliament, most recently at the debate on the Corporate Manslaughter Bill 2006-07 in the Lords.

⁴ i) *The Carlile Inquiry*, Howard League for Penal Reform, 2006 ii) House of Lords debate on the treatment of children in custody since the Carlile report, Hansard, 29.01.07 iii) Annual report of HM Inspectorate of Prisons 2005-2006 published on 30 January 2007

⁵ 'Why are Children dying In Custody' – available from www.inquest.org.uk

⁶ In 2005 INQUEST published *In The Care Of The State? Child Deaths in Penal Custody in England and Wales* by Barry Goldson and Deborah Coles, the first detailed analysis of child deaths published.

6 About INQUEST

- 6.1** INQUEST has worked with the family of Gareth Myatt since his tragic death in April 2004. We were put in contact with his family via a journalist and the family has received no support from any of the statutory agencies. We are working with the family lawyers who are members of INQUEST’s lawyers group and have extensive experience in representing families of those who have died in custody.⁷
- 6.1** INQUEST is the only charity in England and Wales that provides an in depth casework service directly to the families and friends of those who die in custody. This includes deaths at the hands of state agents and in all forms of custody; police, prison, young offender institutions, secure training centres and immigration detention centres. It also provides a free, confidential advice service to all families who go through the inquest process including those families whose relatives have died at work or following major disasters.
- 6.2** Through our casework over the last 25 years, INQUEST has a unique overview of how the inquest system operates from the perspective of bereaved families and their advisors. Our casework service informs our research, parliamentary and policy work and we are widely consulted by government ministers and departments, MPs, lawyers, academics, policy makers, the media and the general public.

For more information about any of the issues contained in this briefing please contact Deborah Coles at inquest@inquest.org.uk or 020 7263 1111

⁷ Mark Scott from Bhatt Murphy solicitors represents many families of those who have died in custody and is the solicitor for the family of Joseph Scholes. Dexter Dias from Garden Court Chambers represented the family of Zahid Mubarek at the public inquiry into his death and the family of Alton Manning who was unlawfully killed in Blakenhurst prison