A child's death in custody
Call for a public inquiry

INQUEST's campaigning, political lobbying and work with individual family campaigns, has placed the issue of deaths in custody and their investigation firmly on the political agenda. INQUEST was set up in 1981 following a number of controversial deaths in police and prison custody and is the only non-governmental organisation that works directly with bereaved people following a death in custody.

INQUEST
89-93 Fonthill Road, London N4 3JH
Tel 020 7263 1111 Fax 020 7561 0799
www.inquest.org.uk

Inquest is a registered charity
Registration no. 1046650

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Nacro
169 Clapham Road, London SW9 0PU
Tel 020 7582 6500 Fax 020 7735 4666
www.nacro.org.uk

Nacro is a registered charity
Registration no. 226171

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A child dies in prison: who is responsible?

INQUEST and Nacro are calling for a public inquiry into the death of Joseph Scholes. The narrow remit of the inquest cannot possibly address all the issues that have arisen from Joseph's case.

'The day he was sentenced I knew he was going to die. You don't get a death sentence for murder. Why should a child get one for robbery? How could they have locked up my ill, abused boy?'

Yvonne Scholes, Joseph Scholes's mother

'This case raises fundamental questions about the increasing use of prison for children. The fact that this is one of 26 deaths of juveniles in custody since 1990 must disturb anyone who cares about the protection of some of society's most vulnerable and damaged children. The call for a public inquiry is motivated by the urgent need to address what is a serious human rights issue – the deaths and suffering of children at the hands of the state.'

Deborah Coles, Co-director, INQUEST

'This shocking case clearly demonstrates why a vulnerable child like Joseph should never have been held in prison service accommodation. The death of any child in the care of the state should raise deep concern. There are profound flaws in this country's system for dealing with children in trouble. The time has come for a fundamental examination of how future tragedies can be avoided.'

Paul Cavadino, Chief Executive, Nacro

'Joseph's death is obviously a personal tragedy for my client Yvonne Scholes but his death also starkly highlights failings in the system of care of children in the criminal justice system which the state urgently needs to acknowledge and address in order to avoid the unnecessary suffering and death of other children in the future.'

Mark Scott, Bhatt Murphy solicitors

Introduction

INQUEST and Nacro have joined forces with Yvonne Scholes to call for a public inquiry into the circumstances surrounding the death of her son Joseph.

Joseph was a deeply disturbed boy who had been repeatedly sexually abused from an early age. On 24 March 2002 he hanged himself in his cell at Stoke Heath Young Offender Institution (YOI) in Shropshire. His death occurred just nine days into his two-year sentence for street robbery.

Joseph's death raises serious issues that question the ability of the state agencies responsible for the care of children to carry out their role in providing a safe environment for society's most vulnerable young offenders. His death also raises questions about the procedures for holding these state agencies to account when they fail. The need to identify these systemic failings is highlighted by these tragedies and it is imperative that we learn from them.

INQUEST, Nacro and Yvonne Scholes believe that the seriousness of this particular case, and the wider policy issues that it raises, warrants an independent and open judicial inquiry.

The death of Joseph Scholes

Joseph Scholes hanged himself from the bars of his cell in Stoke Heath YOI a month after his 16th birthday, just nine days into a two-year sentence for street robbery.

He had an unsettled childhood and became a disturbed young boy. His parents had gone through an acrimonious divorce in 1997 and there had been a bitter custody battle. From the age of six he had allegedly suffered repeated and severe sexual abuse by a member of his father's family. At the time of his arrest he had been seeing a psychiatrist for some months and had been prescribed medication. He was exhibiting clear signs of depression, periodic suicidal thoughts and had begun to self-harm.

Joseph had one previous conviction for affray in November 2001. This was the result of an altercation with ambulance staff when he was disorientated and disturbed and had tried to kill himself by taking an overdose and jumping from a window. On this occasion he was sentenced to a community sentence.

Through the later months of 2001 Joseph became more disturbed and on 30 November he was taken into the voluntary care of social services and was placed in a children's home.

Six days later, on 6 December, he went out with a group of boys and girls from the children's home, and was involved in a series of mobile phone robberies. He pleaded guilty to robbery. There was no suggestion that Joseph had used or threatened violence, and his involvement was accepted by both the victims and other witnesses as peripheral.

As the trial date drew nearer, Joseph became increasingly depressed and agitated. Two weeks before his court appearance he disappeared into his room at the children's home and, taking a knife, slashed his face more than 30 times. The deepest wound, across his nose, cut right down to the bone. The walls in his room had to be completely repainted as they were covered in blood.

On 26 February 2002 he pleaded guilty to three offences of street robbery. The judge deferred sentence for 19 days while he read the case file. Joseph was unfortunate to have been tried at a time of heightened public anxiety, and political posturing over street crime, and he was sentenced to a two-year detention and training order. During the sentencing hearing on 15 March 2002 the Manchester Crown Court judge stated in open court that he wanted the warnings about Joseph's self-harming and history of sexual abuse 'most expressly drawn to the attention of the authorities'.

On sentencing, responsibility for Joseph's care transferred from the local social services to the Youth Justice Board (YJB).[1]

The YJB was informed of Joseph's vulnerability, his history of anxiety and depression and, importantly, his attempted suicide and self-harming behaviour. A number of people who had worked with Joseph urged the YJB to place him in local authority secure accommodation, where the facilities and staffing levels were more conducive to the provision of the care he needed. Despite this and despite the concerns expressed by those who had the most knowledge and information about Joseph, the YJB placed him in Prison Service accommodation at Stoke Heath YOI.

Upon arrival at Stoke Heath Joseph was initially put in strip clothing and placed in a cell with a surveillance camera, reduced ligature points, and high levels of observations. His mother, Yvonne, telephoned Stoke Heath YOI to ensure that they were aware that Joseph had been a victim of rape and to inform them that he was depressed and unstable with a history of self-harm and suicidal behaviour.

But within days of his arrival, and without consultation with Yvonne, Joseph was moved to a single cell with no surveillance camera, normal ligature points and put on reduced observations. He was also deeply anxious of the imminent prospect of being moved onto one of the main wings. Given his history of sexual abuse, not wanting to be in the close proximity of other young men was hardly surprising.

On 24 March 2002 Joseph retired into his cell where he was later found dead, hanging from a sheet attached to the bars of his cell window.

The case for a public inquiry

Joseph's death raises a number of questions about the treatment and care of children in the criminal justice system and the accountability of those agencies responsible, in particular the YJB, the Prison Service and social services departments.

If his death were a one-off it would still be tragic but would not necessarily suggest a wider malaise in the system of dealing with and caring for vulnerable young offenders. However, Joseph's death was anything but a one-off. Since 1990, 25 young people aged 15-17 years old have killed themselves in prison service custody (see appendix).

During 2002, 12 young people under 20 killed themselves whilst in Prison Service custody.

Throughout the 1990s the Prison Inspectorate reports became increasingly critical of institutions holding some of society's most vulnerable and damaged children. This has persisted despite the establishment of the YJB, which has provided increased resources to improve regimes for juveniles in custody. This history of concern from the Prisons Inspectorate was summarised in 2002 in an important report by the Children's' Rights Alliance for England, *Rethinking Child Imprisonment*.

More recently Judge Mr Justice Munby, delivered his judgement in the Howard League's successful challenge over the treatment of children in YOIs. He said that conditions in such institutions should 'shock the conscience of every citizen'.[2]

But the problem extends beyond the conditions in YOIs to encompass the investigation of deaths such as that of Joseph. INQUEST and Nacro believe that the current inquest system is incapable of dealing with the systemic issues highlighted in cases such as Joseph's and consequently fails victims, their families and the wider public interest in seeking to ensure that lessons are learnt to avoid future fatalities.

To reduce the risk of future suffering and deaths of children in state custody, a public inquiry into Joseph's death, the circumstances that led up to it, the role and responsibility of individual agencies, should be established so that the wide-ranging matters of concern can be properly examined.

The following issues are highlighted by the decision to place Joseph in Prison Service accommodation despite his recognised vulnerability and risk of self-harm. Any effective inquiry into Joseph's death will need to explore a number of issues including these:

- the methods of communication for placing children in suitable accommodation as opposed to the only available accommodation
- the methods for grading the risk of suicide and self-harm and the reason why a child such as Joseph Scholes who was recognised as a risk of self-harm/suicide was placed on his own in a cell with ligature points
- the roles and responsibilities of the local authorities for vulnerable children such as Joseph Scholes
- the treatment and care of prisoners at Stoke Heath and the identification of any systemic failings
- whether any steps were taken by Stoke Heath YOI to request the YJB reallocate Joseph Scholes to non-Prison Service accommodation
- the decision to sentence an extremely vulnerable 16-year-old to a two-year detention and training order
- changes in legislation and sentencing practice that have led to the imprisonment of more children.

In order to identify failings in the youth justice system and to learn the lessons the inquiry should also review all deaths of juveniles since the introduction of the YJB in April 2000, to identify common themes and share learning and understanding. This should involve the families of those who have died.

Given the pattern of deaths of children in prison, the number of different state agencies involved in Joseph's care, the systemic and wide-ranging issues involved, and the narrow confines of the coronial system, any inquest into Joseph's death will not be able to fulfil the state's obligations under Article 2 incorporated by the *Human Rights Act 1998* to identify faults in the system that might have led or contributed to the death and to enable steps to be taken to prevent the recurrence of such deaths in the future.

Conclusion

The most appropriate course is for the state to hold a public inquiry into Joseph Scholes's death, conducted or chaired by a senior judge with adequate powers and resources to consider matters including those identified above. The call for a public inquiry is motivated by the urgent need to address what is a serious and deeply disturbing human rights issue – the suffering and deaths of children while in the custody of the state.

1 The Youth Justice Board established by the *Crime and Disorder Act 1999* is the state body responsible for making decisions about, amongst other things, the placement of young people subject to detention and training orders. They consider that children assessed as being vulnerable should if at all possible be placed outside Prison Service accommodation.

2 Howard League for Penal Reform v Sec of State for Home Department and the Department of Health.

Juvenile deaths in prison: 1990-date

Name	Sex	Ethnicity	Age	Status	Date	Cause	Classification	Establishment	Verdict
Ian Powell	M	UK white	17	Convicted	06/10/02	Hanging	Self-inflicted	HMP Parc	Awaited
Joseph Scholes	M	UK white	16	Convicted	24/03/02	Hanging	Self-inflicted	HMYOI Stoke Heath	Awaited
Kevin Jacobs	M	UK white	16	Convicted	29/09/01	Hanging	Self-inflicted	HMYOI Feltham	System neglect
Mark Dade	M	UK white	16	Convicted	27/07/01	Hanging	Self-inflicted	HMYOI Wetherby	Suicide
Anthony Redding	M	UK white	16	Convicted	14/02/01	Hanging	Self-inflicted	HMYOI Brinsford	Accidental death
Kevin Henson	M	UK white	17	Remanded	06/09/00	Hanging	Self-inflicted	HMYOI Feltham	Suicide
Philip Griffin	M	UK white	17	Convicted	01/08/00	Hanging	Self-inflicted	HMYOI Wetherby	Misadventure
David Dennis	M	UK white	17	Remanded	30/05/00	Hanging	Self-inflicted	HMYOI Brinsford	Suicide
Anthony Howarth	M	UK white	17	Convicted	29/08/99	Hanging	Self-inflicted	HMYOI Hindley	Suicide
Kirk Edwards	M	UK white	17	Convicted	30/05/99	Hanging	Self-inflicted	HMYOI Wetherby	Suicide
John Keyworth	M	UK white	17	Remanded	10/11/98	Hanging	Self-inflicted	HMYOI Hindley	Accidental death
Nicholas Whelan	M	UK white	16	Convicted	09/07/98	Hanging	Self-inflicted	HMYOI Glen Parva	Suicide
Colin Scarborough	M	UK white	17	Remanded	17/04/98	Hanging	Self-inflicted	HMP Doncaster	Suicide
Lee Wagstaff	M	UK white	17	Remanded	17/01/97	Hanging	Self-inflicted	HMYOI Hindley	Suicide while balance of mind disturbed
Ryan Winter	M	UK white	17	Convicted	13/08/96	Hanging	Self-inflicted	HMYOI Lewes	Open
Mark Weldrand	M	UK white	16	Convicted	03/12/95	Hanging	Self-inflicted	HMP Doncaster	Accidental
Chris Greenaway	M	UK white	16	Convicted	02/10/95	Hanging	Self-inflicted	HMP Stoke Heath	Self-inflicted *
Andrew Batey	M	UK white	17	Remanded	08/08/94	Hanging	Self-inflicted	HMP Low Newton	Suicide
Joseph Stanley	M	Irish white	17	Convicted	10/05/94	Hanging	Self-inflicted	HMP Cardiff	Suicide
David Stewart	M	UK white	17	Convicted	13/09/93	Hanging	Self-inflicted	HMP Exeter	Open
Patrick Murphy	M	UK white	16	Convicted	02/05/92	Hanging	Self-inflicted	HMYOI Deerbolt	Suicide
Jeffrey Horlver	M	UK white	15	Convicted	22/09/91	Hanging	Self-inflicted	HMYOI Feltham	Accidental death
Craig Walsh	M	UK white	15	Convicted	26/10/90	Hanging	Self-inflicted	HMYOI Glen Parva	Open
Simon Willerton	M	UK white	17	Remanded	12/08/90	Hanging	Self-inflicted	HMP Leeds	Open
Philip Knight	M	UK white	15	Convicted	12/07/90	Hanging	Self-inflicted	HMP Swansea	Open

* Iinitial verdict was self-inflicted death but this was later changed to homicide.