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December 2007

INQUEST's submission to the Ministry of Justice & Department for Children, Schools and Families on the 'Review of Restraint'

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1. INTRODUCTION

- 1.1. INQUEST was founded in 1981 and is the only charity in England and Wales that works directly with the families and friends of those who die in all forms of custody. It provides an independent free legal and advice service to bereaved people on inquest procedures and their rights in the Coroner's Court and the civil courts. It is consulted widely, by Government Ministers and Departments, MPs, lawyers, academics, policy makers, the media and the wider public. INQUEST possesses an unrivalled body of knowledge, experience and expertise on issues surrounding contentious deaths and their investigation.
- 1.2. Since 1990 INQUEST has been working on the issue of the deaths of children and young people in custody to identify trends and issues emerging. We have also been concerned with the effectiveness of the state's investigative processes for identifying and rectifying dangerous practices and procedures in order to ensure that lessons are learned and further fatalities prevented. We have worked on many child death cases and produced numerous documents on the issue and published a detailed analysis in the book *In the care of the state? Child deaths in Penal custody in England and Wales* by Barry Goldson and Deborah Coles (INQUEST 2005). It concluded that children should not be imprisoned save for in child centred Local Authority Secure Children's Homes.
- 1.3. Since 1990, thirty children have died in the custody and care of the state. Most recently Liam McManus a boy of 15, was found hanging in his cell in Lancaster Farms Young Offender Institution on 29 November 2007. Twenty-eight of these deaths were self-inflicted, one was a homicide and one restraint related. Two of the most recent deaths were in privately run Secure Training Centre's (STCs); all of the others were in prison service accommodation in Young Offender Institutions (YOIs). In the same period 201 young people aged 18 to 21 have died in custody including 178 self inflicted deaths and 5 homicides.¹

¹ INQUEST monitoring www.inquest.org.uk

- 1.4. Our monitoring of the investigation and inquest process following child deaths has revealed consistent and repeated features, illustrating that systemic failings are not being addressed but continue to be reproduced by the practices and processes of child imprisonment. The starting point is the very high levels of children being sentenced / remanded to custody (often at great distances from home) with no consideration by the court as to where the child will be detained. This is resulting in children who are often extremely 'vulnerable' being sent to institutions which do not have the resources, facilities or trained staff to deal with their needs.
- 1.5. INQUEST believes that this Review is an inadequate response and an inappropriate mechanism for meaningfully addressing the issue of the restraint of children in custody which has to be seen in the context of the general treatment of children in the juvenile justice system. There was no consultation about the terms of reference of the review and there is no mechanism and funding to allow for us or the families to participate in any meaningful manner.
- 1.6. The review is very limited in remit and resources and there are no proposals for public hearings and public scrutiny. There is no provision for an unedited version of the review to be made public at the same time that it is presented to Ministers and no provision or timetable for a public governmental response.
- 1.7. It is now essential for there to be a properly resourced, transparent and critical analysis of the defects of the custodial treatment of children in the form of a public inquiry in order to ensure that the deaths of the children of the families who we support are not to be entirely in vain.
- 1.8. We have worked with many families whose children have died in custody and have supported the families of 14 year-old Adam Rickwood and 15 year-old Gareth Myatt since the time of their deaths. Families bereaved by a death in custody are dealing with a traumatic event and also the fact that the death occurred in custody, behind closed doors, which adds further distressing practical and emotional

dimensions to their experience. Neither family was offered any support by any state agency following their child's death nor was there a protocol in place at the Youth Justice Board (YJB) to deal with such a situation. INQUEST was able to make contact with the families – on the first occasion through a sympathetic journalist and on the second after making a direct approach to the YJB for the family's contact details.

1.9. INQUEST's casework service was crucial in ensuring that each family was given information about the investigation and inquest process, where to go for emotional support and in facilitating a meeting with a specialist lawyer, Mark Scott, who has considerable experience of working with the families of children who have died in custody. We worked closely with the legal team in preparing for the inquests and providing ongoing support for the family over a period of three years due to delays in the investigation and inquest process. Our expertise and that of the lawyers² engaged to represent the families greatly assisted the investigation and inquest process and the coroner's ability to conduct a proper inquiry – and, indeed, was specifically commended by His Honour Judge Richard Pollard, the coroner conducting the Gareth Myatt inquest. During the preparation and the conduct of these inquests it was clear that relevant documentation was only disclosed by the state because the family's legal teams knew what questions to ask.³

1.10. This only underlines the importance of high quality legal representation for families which can only be guaranteed if families are put in touch with INQUEST and lawyers are then provided with appropriate resources to be able to effectively represent families. It also adds further weight to the recommendation of Baroness Jean Corston:

² The INQUEST Lawyers Group is a panel of 150 lawyers organised by INQUEST across England and Wales that provides preparation and legal representation at coroners' inquests for bereaved people; promotes and develops knowledge and expertise in the law and practice of inquests; provides training; and acts as a forum for the exchange of ideas and experience. INQUEST publishes the journal *Inquest Law* which informs practitioners about recent legal and policy developments relating to the inquest system and the investigation of sudden deaths.

³ For the assistance of the review we are sending from the families' lawyers under separate cover complete indices of documents from the inquests, to the extent that the review is not able to access any documents that they consider relevant they should not hesitate to contact us.

" Public funding must be provided for bereaved families for proper legal representation at inquests relating to deaths in state custody that engage the state's obligations under article 2 of the European Convention on Human Rights. Funding should not be means tested and any financial eligibility test should be removed whenever Article 2 is engaged. Funding should also cover reasonable travel, accommodation and subsistence costs of families' attendance at inquests" ⁴.

1.11. In both the cases of Adam Rickwood and Gareth Myatt there was serious delay in the families receiving any information about what had happened to their child which adversely impacted on the bereavement process. Each of the boys who died had siblings greatly traumatised by what had happened and bereft of counselling and support. The circumstances of a custodial death mean that families are involuntarily engaged in the investigation and inquest system which is a deeply intrusive process that exposes them to considerable scrutiny. It is a testament to the tenacity of these bereaved families and to their determination that no other family should suffer the loss of a child in the same way that this issue has received such public and parliamentary exposure.

1.12. INQUEST has also worked on a significant 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 verdicts and other critical inquest findings and led to coroners' recommendations to prevent future similar deaths. They have also generated significant parliamentary debate and critical comment in the report of the parliamentary Joint Committee on Human Rights Inquiry into Deaths in Custody (2004) and a number of critical inquiries and reviews including the Independent Inquiry into the Death of David Bennett (Norfolk Suffolk Cambridgeshire Strategic Health Authority 2003). These deaths have resulted

⁴ Recommendation 6 - Baroness Corston Review of Women with Particular Vulnerabilities in the Criminal Justice System 'The Corston report Home Office March 2005

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in enhanced awareness of the dangers associated with methods of restraint - in particular the dangers of positional asphyxia - and led to significant changes in policy and practice. This enhanced learning and awareness was ignored by the YJB – and, for example, was found to be a contributory factor in the death of Gareth Myatt.

2. EXECUTIVE SUMMARY

- 2.1 It is a matter of the utmost concern that it took public hearings in the form of the inquests into the deaths of Gareth Myatt and Adam Rickwood for evidence of unlawful and dangerous practices to be exposed. Had mechanisms been in place - as they should have been - to effectively monitor, inspect and investigate the use of restraint used against children across the juvenile secure estate, death and suffering could have been prevented.
- 2.2 The current debate around the use of restraint against children in STCs needs to be placed in the wider context of the treatment of children and young people within the youth justice system. Increasing numbers of children and demonstrably vulnerable young people are being detained in manifestly unsafe environments and being subjected to bullying; degrading treatment such as strip-searching, segregation and restraint. This amounts to a failure by the state to fulfil its duty of care towards children in its custody and additionally is a significant and substantial breach of the UK's international Treaty obligations. However, the violation of the rights of this large body of children goes worryingly beyond inhumane and humiliating treatment. It has been proved forensically that it presents a persistent risk of injury, suffering or death to young people detained in child prisons.
- 2.3 The Government's abiding lack of will to engage with the real lessons to emerge from the tragic deaths of two children in STCs is reflected in its amending of the Secure Training Centre Rules in the immediate aftermaths of the inquests,⁵ disturbingly broadening the circumstances in which children in STCs can be forcibly restrained. The fact that this rule change was presented by the Government as being simply for "clarification" and was made with no consultation, save for with the private contractors who operate STCs and before

⁵ Statutory Instrument 2007 No 1709 - changes to the Secure Training Centre Rules 1998 which came into effect on 6 July 2007.

this restraint review has reported casts grave doubts on whether the Government is actually willing to listen to the evidence that emerged from the inquests or indeed will listen to the findings of this review. HHJ Pollard, the Coroner who conducted the inquest into Gareth Myatt, 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.'⁶

2.4 The inquests into the deaths of Adam Rickwood and Gareth Myatt revealed a youth justice system urgently in need of sustained and profound public scrutiny in order to investigate and make recommendations to address:

- The increasing numbers of children being sentenced /remanded and then detained in inappropriate institutions that are not able to cater for their complex emotional needs.
- The failure to listen to the voice of the child at all stages in the juvenile "justice" system;
- The inadequacy of staff training and the failures in the inspection and monitoring systems;
- The excessive - and potentially unlawful - use of dangerous restraint against children.

2.5 In our judgement, this Review has not been framed, funded or structured to address these issues adequately or at all. These considerations constitute a minimum requirement if the professed desire to safeguard children is to be (1) genuine as opposed to a hollow political gesture; (2) democratic and transparent as opposed to an exercise in administrative introspection; (3) a forum where the bereaved families of the children can meaningfully contribute as opposed to remaining alienated and effectively ignored – which on any reasonable analysis has been the lamentable treatment of them by the state historically.

⁶ Page 5 rule 43 report

- 2.6 There is – and can be – no rational justification for mounting an investigation into these pressing and important issues of child safety behind closed doors, where those entities and organisations which have been held to have been contributors to or causally responsible for the pain, suffering and deaths of children adjudicate imperiously upon themselves.
- 2.7 Our deep concern is that this approach precisely replicates the worst practices of the Juvenile Secure Estate. It has been proved past argument that it is only when the oxygen of open and democratic accountability is introduced into the closed and claustrophobic world of custodial institutions that the truth will emerge. This is not, we emphasise, a simply theoretical or dryly principled approach. There is an indisputable precedent.
- 2.8 The experience of the Prison Service and Zahid Mubarek Inquiry demonstrates the soundness of this proposition. The 'search for truth' by Mr Justice Keith and his team of expert advisers, assisted by legal representatives for the bereaved family, during a properly funded public inquiry provides the model. It shows us the way, should we as a community choose to follow. The Mubarek Inquiry exposed 186 serious failures in the Prison Service. It made 88 Recommendations for lasting and irreversible improvement to the standards of care and custody in adult prisons.
- 2.9 Would these critical proposals for change have been generated by an internal review? The answer is obvious. The Juvenile Secure Estate is in no less a need of such systematic, rigorous and democratic investigation. The children who have suffered needlessly because of it deserve and require nothing less. And as importantly, those thousands of our community's children which are passing or who will pass through our child prisons need a public inquiry to reduce the risk to their safety and their lives to an acceptable level for a modern, civilised society. Anything less constitutes a sub-optimal and inexcusable compromise. As His Honour Judge Richard Pollard concluding after conducting the Gareth

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Myatt Inquest, to ignore the lessons emerging from this child's death would be 'wholly unforgivable'.

3 CONTEXT: THE TREATMENT OF CHILDREN IN CUSTODY

- 3.1 The use of restraint on children cannot be isolated from the context of the general treatment of children within the juvenile secure estate. Children are placed in custody and are being treated there in ways which compromises their human rights.
- 3.2 Before addressing in detail the specific concerns about the use of restraint arising from the Adam Rickwood and Gareth Myatt inquests, we will attempt to depict the overall experience of children in custody.
- 3.3 In England and Wales more children are imprisoned, at a younger age, for more minor offences than in almost any other European country. This is an adult-centric approach towards child custody with a focus on heavy punitive measures and degrading treatment as opposed to child-centric approach with a focus on welfare and protection.
- 3.4 This has resulted in a system which fails to recognise and address the fact that children in all forms of custody are some of the most vulnerable and socially disadvantaged. This is particularly so of children in STCs. Recent reports and debates on young offenders have highlighted the following:
- England and Wales imprison more children than most industrialised democratic countries in the world.
 - The UK is incarcerating twice as many children as 10 years ago.
 - Half have been in care.
 - Most have been excluded from school.
 - 84% of young offenders are on remand and 88% sentenced have a personality disorder.

- Levels of sexual abuse, domestic violence and physical and emotional violence are significantly higher than in children in the general population.
- Levels of self harm within secure training centres rose by 803% between 2001 and 2004.
- The risk of suicide for incarcerated teenage boys is 18 times higher than those within the community.
- Almost a third of all children in STCs are over 50 miles away from home.
- 35% of males and 49% females of in secure establishments reported themselves as dependent on drugs.⁷

Given this context, the routine use of violent and in some cases dangerous restraint against children is particularly disturbing.

Degrading treatment

3.5 Whilst the use of force remains, quite rightly, the most controversial aspect of the regimes operating in the juvenile justice estate, vulnerable children are often subjected to other inhumane treatment such as strip searching and segregation. High levels of self harm and suicide attempts prevail.

3.6 Her Majesty's Chief Inspector of Prisons (HMIP) Annual Report 2005/2006 found that:

"A second joint chief inspectors' report on safeguarding in 2006 expressed concern about behaviour management, and the over-use of physical control, strip searching and segregation. We remain extremely concerned about these processes. Inspections rarely find comprehensive behaviour management policies, in which all methods of managing this

⁷ Sir Al Ainsley Green (the Children's Commissioner)'s CCJS lecture 27 November 2007; Nacro Mental health and crime policy briefing; *Community Care* article 7 August 2007; Baroness Linklater of Butterstone, Lords Debate 8 March 2006; Standing Committee for Youth Justice briefing December 2006; YJB press release 27 March 2007

*challenging and sometimes volatile population are coordinated, and subject to appropriate safeguards and procedures.*⁸

*"In our survey, 27% of boys and 11% of girls said that they had been physically restrained. Injuries sustained during restraint are often the highest single category of child protection referrals in an establishment; but few properly monitor the injuries that arise from use of force. Nor do the Youth Justice Board or Prison Service, in spite of Inspectorate recommendations."*⁹

- 3.7 HMIP inspection of HMYOI Werrington in April 2007 highlights a strip search of a boy disturbingly reminiscent of the evidence heard at the inquests about the culture within these institutions:

"2.176 We examined the video recording of one of the incidents where a young person had his clothes cut off and was strip-searched under restraint.

X had destroyed furniture in his cell, caused a good deal of structural damage (broken his sink and toilet) and smashed the glass observation panel in his cell door. After he had calmed down, it was decided to relocate him to one of the safer cells on C1 landing. Although the young man was verbally abusive and threatening, his behaviour was not violent and he showed no resistance to the control and restraint team involved in the planned removal. The young person was restrained all the way to the safer cell. On arrival, officers found that the cell had not been prepared and the young person was held for an unreasonable amount of time bent over, still restrained, outside the cell while the supervisor searched for a towel to carry out a strip-search. Upon entering the cell, the young man lay on the floor when directed to do so. He was told that he was to be

⁸ HMIP Annual report 2005/2006 Published January 2007

⁹ Op cit

strip-searched. He asked why and was told, 'Because the governor says so'. He continued to question the need for the strip search, interspersed with more verbal abuse. Though clearly angry, he then said he would comply, and was adamant that he did not want to be forcibly stripped. The supervisor instructed the search to begin. The young man, still held down, muttered something inaudible, possibly further verbal abuse, at which point the (female) supervisor shouted at him: 'You're not complying. Unlucky – the officers will search you' and immediately left. The camera was then moved away, leaving only audio evidence.

Inside the cell the young man was held down by three staff while another began to forcibly remove his clothes and he began to scream in distress. At one point, he said something inaudible, which can be assumed to be an indication that he would comply, as one of the officers responded 'We've gone past that now ... We'll do it my way'. The screaming intensified and we assumed that his clothes were being cut off at that point. Later, when the officer said that the team were going to remove his boxers, the young man said he would do it himself. He was told that he could have done so if he had complied and had stood up, to which he again replied 'I will comply. I'll stand up'. However the search continued under restraint. At no point during the incident did the duty governor or supervisor check on the welfare of the young person, who was held on the floor for around eight minutes, while his clothes were cut off and he was re-dressed in tracksuit bottoms. The team then withdrew, leaving the young man crying on the floor. There had been no attempt to de-escalate the situation throughout the removal. No one properly explained to the young man why it was thought necessary to strip-search him or help him to calmly reflect on it to secure his compliance. No consideration was given to isolating the young man and leaving him to calm down.

There was no entry in the governor's journal about this incident. The deputy governor had not seen the documentation, and we were unable to find any authorisation for this extreme procedure to take place.¹⁰

- 3.8 Far from being an isolated incident, the above exemplifies the unnecessarily punitive measures applied to children. Control and restraint was used on 146 occasions during strip searching in 11 Young offender institutions.¹¹ A quick examination of a number of HMIP reports into YOI's provides repeated examples of similarly disturbing practices. HMIP inspectorate report of HMYOI Warren Hill an inspection that took place from the 31 October – 4 November 2005, found that all young people were routinely strip searched when arriving into custody and when coming back from court. Searches were conducted in the view of another officer with the effect of humiliating and lowering the self worth of already damaged children. The same report notes that a third of the staff had not completed the suicide and self-harm prevention training and not all the staff knew where the first aid equipment was kept¹².
- 3.9 The HMIP report into their inspection of HMYOI Glen Parva on 25-27 June 2007 highlighted that the previous year's recommendations to stop the routine strip searching of children without it being confirmed as necessary through risk assessment, had not been implemented on children and young people who were kept in the segregation unit and that in fact levels of force were higher than the year before¹³.
- 3.10 Concern over the rising use by staff of restraint in Oakhill STC led to a new Director being appointed in July 2007 after two unpublished inspection reports showed that painful distraction restraint techniques were used on 110 occasions in 2006 in a centre which holds only 80 trainees. 'Non painful restraint' was used

¹⁰ HMIP, *Report on an unannounced short follow-up inspection of HMYOI Werrington 16-20 April 2007*, p45

¹¹ *Hansard* House Of Lords written answer 8/1/07

¹² HMIP, inspection of HMYOI Warren Hill 31 October – 4 November 2005 p19 & 30

¹³ HMIP, inspection report of HMYOI Glen Parva on 25-27 June 2007 p46-47

921 times.¹⁴ In Oakhill handcuffs were used on 8 occasions while in Hassockfield STC, they were used on children on 36 occasions.¹⁵

Joseph Scholes

3.11 The psychological impact on already vulnerable children of such degrading treatment cannot be underestimated and is illustrated by the case of Joseph Scholes, who died aged 16, at Stoke Heath YOI in 2002.

"Joseph Scholes had an unsettled childhood and became a disturbed young boy. He had allegedly been sexually abused from an early age and at the time of his arrest he was seeing a psychiatrist and taking medication. Joseph was depressed, had begun to self-harm and have periodic suicidal thoughts. Joseph was in voluntary care of social services and was placed in a children's home.

Six days into his time there he went out with a group of children from the home and was involved in a series of mobile phone robberies. He was subsequently arrested and charged with robbery. Both victims and other witnesses accepted that Joseph's involvement in these incidents was peripheral; there was no suggestion that he had used or threatened violence. As his trial date drew nearer, Joseph became more depressed and agitated and two weeks before his court appearance he slashed his face with a knife over 30 times. When Joseph was found guilty he was sentenced to a two-year detention and training order for robbery. The judge made clear that he wanted the warnings about Joseph's self-harming and history of sexual abuse "most expressly drawn to the attention of the authorities". After sentencing, the YJB was urged to place him in local authority secure accommodation where intensive care and support would be available. They said that there was no

¹⁴ The Guardian, 13 July 2007

¹⁵ Hansard House of Lords written answer 10/1/07

accommodation available and placed Joseph in Stoke Heath YOI instead. Yvonne Scholes phoned the health care nurses at Stoke Heath personally to warn of her son's vulnerability.

When Joseph arrived at Stoke Heath, he was stripped of his clothing, including underwear, and placed in a garment like a horse blanket with stiff Velcro fastenings. Joseph was kept in virtual seclusion in an unsafe cell. He was offered no meaningful activity. He was told that he would be put on the main wing with other prisoners, a prospect that horrified him because of his history of sexual abuse. Nine days into his prison sentence, Joseph was found by a maintenance worker hanging from a sheet tied to the bars of his window¹⁶

- 3.12 Joseph's death raised extremely serious concerns including sentencing policy and practice and inter-agency failings in the protection and safeguarding of vulnerable children as well as the adequacy of practices, procedures and facilities for vulnerable children, particularly those at risk of suicide and self-harm in custody.
- 3.13 INQUEST was concerned from the outset of its work with Joseph's family that the inquest into his death - however well conducted - would not be an effective form of inquiry. As a result prior to the inquest taking place INQUEST, together with Nacro (National Association for the Care and Resettlement of Offenders) and Joseph's mother Yvonne Scholes called for a public judicial inquiry into his death which was supported by over 100 MP's and Peers, many other individuals in public life and a range of penal reform, child welfare and human rights organisations and agencies. Since then support has grown to include more Parliamentarians, officials from the General Synod of the Church of England and by the Joint Committee on Human Rights.

¹⁶ INQUEST, 'Why are children dying in custody?' pamphlet, July 2006

Coroner's call for a public inquiry

- 3.14 The inquest into Joseph's death was held in April 2004 and significantly, at its conclusion, the Coroner as part of his duty to prevent further fatalities, also recommended to the Home Secretary, using his rule 43 powers under the Coroners Rules, that a public inquiry should be held into Joseph's death. The inquest did not hear any evidence, save for the fact of the sentence itself, or make any inquiry into the sentencing policy and practice which led to Joseph receiving a custodial sentence. Indeed as previously indicated, at no inquest into the death of a child has the sentence or the policy and/or practice which led to the sentence ever been considered. Nor were wider policy issues concerning the allocation process canvassed. The Coroner's recommendation was rejected and an application has now been lodged with the European Court of Human Rights.
- 3.15 One of the central findings of the inquest jury was that a vulnerable 16 year-old was, for reasons of policy, not placed directly into a local authority secure unit, and that "*there are just not enough LASCH's*". They also returned a finding that extremely vulnerable children should not be placed in Prison Service accommodation. Notwithstanding this, vulnerable children are still being placed in Prison Service and other unsuitable accommodation unable to cope with their complex needs. There has been no increase in the provision of LASCH's, but instead a significant decrease with a number of local authorities expressing concerns about the future viability of their Secure Units given the short term contracts that have been awarded by the YJB. Consequently, there is the real prospect that beds in LASCH's will be even further reduced. It has also been demonstrated that a national shortage of available places in LASCH's, particularly for 15-16 year-old boys, has contributed to deaths in custody and wholly unacceptable conditions of confinement for vulnerable children.

Deaths of children in penal custody

- 3.16 Lessons have not been learned from Joseph's death and dangerous practices have not been rectified. Of the 30 deaths of children in penal custody in England and Wales since 1990, six of these occurred since the death of Joseph Scholes. 15 year old Liam McManus, the most recent child to die was serving a six week sentence of breach of a supervision order. An inquest into his death is not expected to take place until April 2009.
- 3.17 Our monitoring of the investigation and inquest process following child deaths has revealed consistent and repeated features, illustrating that systemic failings are not being addressed but continue to be reproduced by the practices and processes of child imprisonment. The starting point is that the judiciary sentence children on the theoretical basis that they will be detained in institutions that can cater for their needs whereas in practice this can never be achieved and leads to extremely 'vulnerable' children being placed (often at great distances from home) in institutions which do not have the resources, facilities or trained staff to deal with their needs.
- 3.18 What the inquests held into child deaths in custody have uncovered is that the juvenile justice system urgently needs profound public scrutiny, investigation and review significantly wider in scope than the inquest process or the present review permits.

4 THE INQUESTS INTO THE DEATHS OF ADAM RICKWOOD AND GARETH MYATT

- 4.12 In 2007 inquests were held into the deaths of Adam Rickwood and Gareth Myatt who both died in STCs in 2004 and exposed graphic evidence about the routine and unlawful use of restraint in STCs.
- 4.13 The inquests offered a rare opportunity for scrutiny - through detailed examination of documentation and individual witnesses - into the treatment of children in STCs. They exposed dangerous practices that had not been highlighted or acted on by the monitoring and inspection process.
- 4.14 We should commend the approach taken by HH Judge Pollard in his conduct of the inquest of Gareth Myatt where he endeavoured to hold as broad as inquiry as possible within the confines of the inquest process. It indicated how an inquest could be conducted in a properly resourced system and information gained at this inquest greatly assisted the conduct of the inquest into Adam Rickwood's death which was conducted in a more traditional manner.

Brief facts – Gareth Myatt

- 4.15 Gareth Myatt, a mixed race fifteen year old boy from Stoke on Trent was detained at Rainsbrook STC on 16 April 2004. This was his first time in custody. He was small for his age, being only 4 ft 10in tall and weighing 6 ½ stone. The restraint that led to Gareth's tragic and untimely death arose following a dispute over the cleaning of a sandwich toaster. It is deeply disturbing that a trivial dispute of this nature led to the death of a child and must lead to serious questions about the motivation, training and values of those working in STCs.

- 4.16 During the reception process on arrival to Rainsbrook, Gareth had been subjected to restraint after he refused to be strip searched and was regarded by staff as being verbally abusive and non compliant. He was taken to his room using a Physical Control in Care' ["PCC"] technique – the same 'seated double embrace' (SDE) hold that would be deployed on him the day he was killed. Gareth had complained of difficulty breathing saying that his chest hurt and that he felt sick. The nurse described Gareth as being '*bent over with his head below his groin*'.
- 4.17 The next day at his vulnerability and risk assessment Gareth was not resistant and happy to be assessed. He stated that he did not often become aggressive but that if he did it was best for staff to leave him alone and let him go to his bedroom to calm down. This risk assessment was on his file and available to all unit staff to read. The three custody staff who dealt with Gareth on the day of his death were neither aware of the previous restraint incident nor did they know or had read anything about him.
- 4.18 On 19 April Gareth became involved in an argument with a member of staff over the question of whether he should clean a sandwich toaster. Gareth refused to clean it and was told to go to his room. He complied immediately with this request, went to his room and was locked in. Shortly afterwards two staff members (one male and one female) went to his room to talk to him about his behaviour. It is said that Gareth responded defiantly, that he asked the staff to leave his room and, as a result of his attitude, the staff took a decision to 'single separate' him i.e. to remove him from association. They then began to remove his property from his room.
- 4.19 One by one, the few personal possessions of Gareth were removed from his room. Gareth did not react until a small scrap of paper was removed which contained his mother's mobile telephone number. At this point the officers allege that Gareth said "You're not fucking taking that" and "Don't take my mum's phone number". Gareth, a 28.5kg (6½ stone) boy, who was 4ft 10in

tall, is then said to have clenched his fist and swung it at the male officer, David Beadnall who stood at over 6 ft tall and at the time of this incident, weighed over 16 stone.

- 4.20 The staff member who Gareth allegedly swung at claimed that this behaviour amounted to a threatening situation and as such warranted using a restraint technique on Gareth. The staff members and Gareth ended up lying on his bed, with one staff member holding his legs and the other holding his upper body. A third officer then came into the room and then Gareth was placed in an approved, PCC hold, known as the SDE. This involved two staff members holding his upper body and pushing his torso forward towards his knees with one officer holding his head.
- 4.21 During the course of the restraint Gareth complained that "*I can't breathe*" and Mr Beadnall responded "*if you can talk then you can breathe*". Gareth then complained that he was going to defecate and was told "*you are going to have to shit yourself*" and the restraint continued. Gareth did then defecate and the restraint continued. Gareth then vomited and the restraint continued. In describing finding vomit on her trouser one of the officers said she had thought "*Dirty bugger, he's been sick on me*". The restraint was continued even when Gareth slumped forward and when the restraint was stopped several minutes later, Gareth was found to be unconscious. Attempts to resuscitate him failed and he died as a result of asphyxia resulting from a combination of inhalation of gastric content and his body position during the period of physical restraint. One member of staff stated afterwards; "*I should never have PCC'd; he was half my size. It was rather like having run over a cat and then thinking...if I hadn't gone down that street, it wouldn't have happened*". Following a police investigation into Gareth's death the SDE technique was removed from use and has never been re-instated.

Culture at Rainsbrook

- 4.22 At the inquest evidence emerged of PCC being used to gain compliance and representing a significant part of the prevailing culture at Rainsbrook. The YJB Monitor David Tuck had himself expressed concerns report that there was a danger of Rainsbrook becoming "*reliant on PCC.*" Two of the three restraining officers accepted that PPC had been used at Rainsbrook to gain compliance.
- 4.23 Gareth's failure to comply with the request to clean the toaster was a pivotal factor in the subsequent decision to restrain him. Instead of action being taken to de-escalate the situation, moves were made which positively provoked Gareth, exacerbating a situation and then punishing him physically for his behaviour. "Single separation" was a practice used at Rainsbrook whereby the entire child's property was removed from the room, including magazines, pencils and paper – effectively leaving the child devoid of anything and in virtual isolation. For Gareth, who had only been in Rainsbrook for two days, his only personal possession was his piece of paper with his mother's new mobile phone number on it. Evidence from the YJB Monitor at Rainsbrook, unchallenged by both the three officers and Rebound was that removing items from children's rooms was '*a bit of an excuse, a bit of punishment, it was a way to establish authority...it was a good way to escalate it into a PCC*'. He accepted in questioning that it was a concern of his that there was a culture of the staff exerting their authority early on and showing them who was boss and if he had been able to prove it he would have raised it with the Director at Rainsbrook.

Evidence of children subject to restraint while detained at Rainsbrook

- 4.24 It became clear in inquest evidence that the SDE had become the default restraint technique used at Rainsbrook. A boy who had been in Rainsbrook when Gareth died told the inquest about how '*being PCC'd*' was part of the culture and vocabulary of the institution and how "*you could get PCC'd for not*

going into your room'. He also demonstrated the application of the SDE and how his body had been bent double and his head had been forced down towards his knee and that when he was PCC'd he couldn't breathe "...your head is below your knee, whoever is on your head is leaning on your head. It's not nice."

Other statements given to the police as part of their investigation and disclosed at the inquest described further the effects of the restraint used on the children *"—head shoved so far down that it banged on the bed", " being pushed so far down that it seemed to be touching my arse", " being pushed between knees, there was no way that I could get it down that far on my own".*

- 4.25 These accounts of body and head position during restraint were reiterated in the evidence given by a qualified nurse who had been the HealthCare manager at the centre. She had expressed healthcare concerns to Rainsbrook management about the way in which children were being restrained – particularly their heads being pushed too far down.
- 4.26 Other evidence emerged illustrating the macho culture at Rainsbrook where internal staff training documents for restraint described staff being involved in PCC as being on '*active duty*' with nicknames such as '*Clubber*', '*Crusher*' and '*Mauler*'. The child restrained the most was known as the '*Winner*'. One of the officers involved in the restraint against Gareth had one of the highest numbers of restraint incidents to his name amongst staff and had been specifically monitored for excessive use of pain compliance. Children also seemed to be viewed as undeserving and not to be trusted by some staff as demonstrated by a comment about why children had Sony Playstations as entertainment given their offending background. A duty manager at Rainsbrook on the night Gareth died also stated at the inquest that the reason why staff may not have reacted to stop the restraint when Gareth said he couldn't breathe was because Gareth could have been "*faking it*" and that children often lied in situations such as this.
- 4.27 Such attitudes demonstrate a wider cultural problem at the institution where staff with no childcare or social work experience – often not many years older

than the children themselves- are hired and can be given only seven weeks training to look after vulnerable children and are effectively given the green light to treat them in whichever way they seem fit. In Gareth's case, questions are raised about how fair or reasonable it was for Gareth's possessions to be taken away from him in the first instance. Any responsible adult should be aware that taking away a 15 year old child's mothers new mobile phone number from him in his first days in custody would be traumatic and would provoke him. It is clear that Gareth was not seen as troubled young child who needed care but rather as someone who needed to be punished to teach him a lesson.

Brief facts – Adam Rickwood

- 4.28 Adam Rickwood, at 14, is the youngest child ever to die in penal custody in England and Wales. He had a history of suicide and self-harm and between November 2001 and October 2003, he had had seven admissions to hospital following the deliberate ingestion of alcohol and drugs. On 29 June 2004, Adam had been remanded in custody by Burnley Magistrates Court and on 10 July 2004, when a place became available he was taken to Hassockfield STC, some 150 miles from his home and family. He had previously been in a secure children's home where he had settled in well. At an initial assessment at Hassockfield, Adam was noted to be very vulnerable and a 'High Risk Assessment Team' ["HRAT"] was opened in respect of him with a recommendation that he be closely observed.
- 4.29 On 8 August 2004, at about 5.50pm Adam was in his House block with two other trainees. One trainee was locked in his room as a result of rudeness to a member of staff. That trainee then passed a note under his door and asked Adam to give it to the staff member in question. Adam handed the note to a staff member who then told him to go to his room. Adam refused and was then subjected to physical restraint in order to force his compliance with the order that he be removed from association. There has, at no time, been any suggestion that the criteria contained in the contract between the Home Office

and the STC nor the STC rules 36 (removal from association) and/or rule 38 (use of force) were satisfied. A situation involving adolescent boys misbehaving escalated into a violent restraint incident within a matter of minutes. This was Adam's first experience of restraint.

- 4.30 Four members of staff (all male) were involved in restraining him. One member of staff held his head and two others held his arms. Pressure was applied to Adam's nose in purported application of the 'nose distraction' technique, which is designed to inflict pain on the subject and to distract and confuse them. Its use caused Adam to bleed from the nose for approximately an hour and he suffered facial abrasions. Another member of staff then picked up Adam's legs and he was carried face down to his room and locked in. Adam was extremely distressed: he kicked his door, threw objects at the door and requested to be taken to hospital. This was refused. He later had telephone calls with his solicitor where he complained about the restraint. He was also told that no bail application was being made on his behalf the following day.
- 4.31 The members of staff on duty that night were not told of Adam's earlier restraint. Despite a policy of checking on all children every 15 minutes the evidence of the two officers on duty was that Adam was not checked on between 9.45pm and 11.15pm. At approximately 12.00 midnight, Adam was found hanging in his room. The member of staff on duty had not been informed about the use of force on Adam.
- 4.32 After his death a "statement" was found in Adam's room in which he described in his own words his experience of being restrained:

"My Statement [to the authorities]

On the 8th August at aprox 6.50pm, I was sat at the table on the wing 2 Bravo. And my friend was messing about, so he was put in his cell for 30 minutes (time out). When my friend was in his cell he asked me to go

over to his door. When I went over he slid a piece of paper under the door and asked me to give it to a female member of staff.

When I gave the paper to her she told me to get in my room. I asked why and she said 'Just go in' then at that point I refused because there were no explicit reason for this. Then she called for first response (assistance from other staff). When the other staff came they all jumped on me and started to put my arms up my back and hitting me in the nose. I then tried to bite one of the staff because they were really hurting my nose. My nose started bleeding and swelled up and it didn't stop bleeding for about one hour and afterwards it was really sore. When I calmed down I asked them why they hit me in the nose and jumped on me. They said it was because I wouldn't go in my room so I said what gives them the right to hit a 14-year-old child in the nose and they said it was restraint."

The trauma, humiliation, anger and fear this experience had on Adam is hinted at in this letter. He was plainly angry at what had happened and his history of self harming when angry and upset emerged from the evidence at the inquest and in the documentation held by Hassockfield.

- 4.33 Evidence was heard that Adam had been a model trainee and that the incident prior to his death was his first episode of non-compliance. It was also his first experience of being restrained. Although he was reported to have acted aggressively resulting in the restraint there was video evidence that Adam did not respond in an overly aggressive manner. The CCTV also showed how, contrary to PCC methods, he was carried upside down to his room.
- 4.34 The Lancashire Safeguarding Children's Board published its findings and recommendations in September 2007 and found that Adam was seen by the criminal justice system as "*a child solely in need of custody rather than a*

*vulnerable child also in need of care and safeguarding*¹⁷. Like Gareth, Adam was let down by a culture in juvenile custodial settings that resorts too quickly to the use of force. Adam Rickwood's family are currently involved in judicial review proceedings¹⁸ as to the failure of the inquest to properly investigate Adam's death by the Coroner not ruling on whether the use of force against Adam before he died was unlawful.

Themes emerging from both inquests

4.35 The themes which emerge from the evidence heard at both inquests paint a disturbing picture of the history of restraint, its use in STC's and repeated systemic failures of statutory agencies to monitor its application. The key findings from the inquests relevant to this review are noted below:

Restraint is routinely used in STC's

4.36 It appears from the outset the intention has been that the use of force should be a rare occurrence. The formal position presented to the public and parliament was that there was absolute clarity in relation to the limited criteria that were to be applied in the use of restraint. However during the inquest preparation and at the inquests it became clear that contrary to what was being presented to parliament and the public, restraint was being widely used by staff for purposes outside these criteria and in particular in order to gain compliance with staff instructions.

4.37 Answers to written parliamentary questions found that restraint was used 2988 times in 2006, 4285 times in 2005 and 3727 times in 2004¹⁹. These figures are

¹⁷ LSCB Press release, Report into death of Adam Rickwood, September 2007

¹⁸ For the assistance of the review we are sending from the families lawyer's a copy of the judicial review application and indices to documents, to the extent that the review is not able to access any documents that they consider relevant they should not hesitate to contact us.

¹⁹ *Hansard*, Written parliamentary question, 19 Feb 2006

high given the numbers kept in STC's - in September 2007, there were 256 children detained in the four STC's²⁰.

- 4.38 It also became apparent that the practice of using restraint to gain compliance with staff instructions was in fact known to the YJB and had been from at the latest in October 2004, some two years, four months prior to the commencement of the inquests. In October 2004, David Waplington, who came from a prison service background had been asked to carry out a review of restraint techniques. He reported that PCC was routinely used to gain compliance, was used too often and that there needed to be improved methods of behaviour management and staff training, primarily in dealing with adolescents and their challenging behaviour.

STC's operate in isolation from other custodial institutions.

- 4.39 STCs are private child prisons that are run for profit and operate in isolation from other custodial institutions. INQUEST prepared a chronology of restraint related deaths from 1990 to 2004 (up to time of Gareth's death) which showed that in the period leading up to the restraint related deaths in STCs there was a growing body of knowledge and scientific literature highlighting the risk of death from restraint. However, the YJB failed to consult anyone with this knowledge and expertise, even after the death of Gareth Myatt, until December 2007. Their complacency and inaction on this resulted directly in the death of Gareth.
- 4.40 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 and our concerns about the risk of deaths occurring of children.²¹

²⁰ Ministry of Justice, monthly custody tables October 2007

²¹ INQUEST Evidence to JCHR December 2003

The development of PCC was inadequate

- 4.41 Both Gareth and Adam were subjected to 'approved' PCC techniques. PCC came to be named in 1998 following ministerial approval and was developed from an earlier system of restraint called Protecting Rights in the Care Environment (PRICE). This was developed by the Prison Service Training College for use in children's homes following a number of bone injuries at Aycliffe. PCC was subsequently approved for use in STCs by a Ministerial authorisation of February 1998.
- 4.42 PCC is disingenuously described as being a non pain compliant form of restraint. Albeit that particular wrist locks were not approved due to the fact that they were pain compliant forms of restraint, it is clear that pain compliance is used in PCC with the form of "distraction" techniques to the ribs, thumb and nose as used on Adam.
- 4.43 During the development of PCC a panel of "experts" which had two sessions in 1995 and in January 1998 advised on PCC before it was subsequently sent for approval to the Secretary of State. At no time during this period did the panel have any appropriate expert on restraint asphyxia or deaths in custody despite the growing information and knowledge base within the Prison Service. The focus of the panel's work appears to have been concerns that restraint should be used that would risk breaking bones as opposed to any damage done to a child's mental health by using pain compliance techniques or whether the methods could be dangerous. The warning of the need for monitoring and review by the 1998 panel is naturally because of the special dangers to children from physical restraint techniques.

There were serious failings by the YJB to manage and review the use of PCC

- 4.44 On 1 April 2000 the YJB took over responsibility for the juvenile secure estate and PCC. Although they had a duty to review PCC they did not do so. As a consequence there was no safety or medical review of PCC from its introduction in 1998 until after Gareth Myatt's death in April 2004. This was despite growing evidence of worrying outcomes for children as a result of PCC techniques.
- 4.45 As part of the Northamptonshire police investigation into Gareth's death the police collated information concerning other children who had been restrained in the 12 months prior to Gareth's death. This together with the material that they obtained was then sent to an Accident and Emergency expert, Dr Bleetman, who conducted an analysis of the 52 incident reports. In his report of 24th August 2004, he concluded:
- a) There is a striking rate of subject injury from PCC holds at Rainsbrook;*
 - b) The majority of untoward medical reports followed the application of the seated double embrace;*
 - c) The potentially lethal effects include vomiting, airway compromise, interference with the mechanics of breathing, neck injury, vagal stimulation, reported difficulty in breathing and restriction of the blood flow from the head and neck;*
 - d) From the incident reports with which I was provided, it is possible to conclude that of the 52 reported PCC incidents:34 involved clear signs of potentially lethal events. This indicates a wholly unacceptable safety profile for the restraint skills employed in a secure training centre.*

Although the SDE was ultimately completely withdrawn on medical advice from use within the juvenile estate we have not been able to establish if the 'seated figure of four' and 'double basket hold' has also been withdrawn. We would

also urge the review to examine randomly selected CCTV video evidence of recent PCC incidents.

No YJB management lead on PCC

- 4.35 No one at the YJB had the management lead or responsibility with regard to the use and safety of PCC and it was clearly not on the YJB's radar. Nor did anyone in the YJB senior management have or take management lead responsibility for the health and safety of children in STC. Without anyone in senior management "owning" the issue, no one managed the risk – exposing children to more harm. Prison Service trainers told the inquest that when they tried to contact the YJB to communicate the need for a review of PCC they found that it was 'pot luck' contacting any individual.
- 4.36 In June 2002 the YJB monitor copied a letter to the YJB expressing concern about instances of the dangerous use of restraint. In November 2002, YJB head office officials failed to attend a workshop on the PCC system arranged by Prison Service trainers. There was continuing failure to act upon reports emanating from the YJB monitor at Rainsbrook and evidence from the YJB regional manager was that such material was put on the 'F Drive' on the YJB computer system; effectively a dusty shelf with no proactive response.
- 4.37 When the National Children's Bureau (NCB) offered to prepare a report for the YJB including 'qualitative analysis' including interviews with 'medial and psychiatric experts' HMIP Inspectors etc the YJB refused to take up the offer opting instead for a report without such analysis and expert input – for a financial saving of £1500.
- 4.38 The NCB review which was completed between January and April 2003 was presented to YJB management and recommended an '*urgent need*' for sound evidence to be collected focusing on '*medical safety, psychological and emotional impact and effectiveness*'.

Monitoring failures

- 4.39 It was quite clear from the inquests that STCs were using restraint and removals from association on many occasions where they were not permitted to and yet this was not acted upon either by the YJB or the inspectorate.
- 4.40 The failures arose as the YJB did not effectively monitor the terms of the contract between the Home Office and the private contractors who run the STCs on the criteria about when restraint could be used. The YJB failed to ensure that children were restrained in accordance with the law and failed to pick up on evidence emerging from Rainsbrook and Hassockfield about the use of restraint on children and its effects.
- 4.41 It is also clear that YJB's failures are in so sense purely "historic". Evidence emerged at the Adam Rickwood inquest that Jon Collier the lead instructor on PCC at the Prison Service training college was under the impression that injuries from the use of the nose distraction were rare, as if not he would have expected to have been informed by the YJB. He was visibly shocked when shown in 2007 for the first time (by counsel for the family) the injuries actually suffered by children at Hassockfield. It became clear that nose bleeds were a common occurrence following infliction of the distraction technique, this was known to the YJB and the STCs and yet the Prison Service training college with responsibly for training the PCC instructors had no knowledge of this.

A failure to listen to the child

- 4.42 Time and again, the voices of children who had been restrained were ignored by statutory agencies. Evidenced emerged at Gareth Myatt's inquest that there were many warning signs prior to his death none of which were adequately or effectively acted upon. Children often complained about the techniques that were used on them and Rainsbrook STCs monthly PCC panel noted numerous

shocking incidences of injuries suffered by children. Some examples are given below:

4.43 At a Rainsbrook PCC meeting on 23 May 2002 (nearly two years before the death) it was indicated that a trainee *"had highlighted what previous trainees have said in respect of the head hold and being bent forward as being the most uncomfortable hold"*. At the meeting on 26 June 2002 it was reported that trainees *"had complained that being bent forward caused discomfort and a sick feeling, which had resulted in the trainee vomiting on one or two occasions"* and *that a trainee had felt "unable to breathe"*.

4.44 A letter detailing these issues was sent to Daventry Social Services in June 2002 and was sent by the YJB Monitor at Rainsbrook and copied to the YJB headquarters in Carteret Street. In the letter a child's complaint detailed that:

"the approved technique of bending her forward and placing her head between her knees makes it difficult for her to breathe. She added that in her opinion this cannot be a safe way to proceed and cited two incidences of other females on her unit vomiting when placed in such a position. John Parker [Director of Rainsbrook] and I agree that she may have a valid point".

4.45 In an April 2003 monthly monitoring report sent by the YJB monitor to the YJB headquarters he noted:

"Trainee AE was taken to Ruby Hospital and referred straight away to Coventry & Warwick Hospital for specialist examination of his eyes, which had suddenly become very bloodshot. He had been involved in a PCC that morning... but these symptoms did not present until about an hour later... the capillary vessels in his eyes had broken as a result of the exertion of the restraint... His solicitor demanded a transfer on the grounds of the injury to the eyes... called into question his safety at

Rainsbrook... the injury was still strikingly obvious to anyone who met Aaron 2 weeks after the incident. The fact also that he was a small child who only turned 15 on the 26 April, would certainly raise doubts to anyone unfamiliar with PCC restraint techniques as to whether he had been restrained appropriately. The Monitor was content however that nothing untoward had taken place having spoken at length and individually with the Director, Head of Care and a member of Healthcare staff. Aaron could also have complained... but he did not"

- 4.46 In a further letter of 2nd July 2003 by the YJB monitor in response to the proposed revised PCC manual in July 2003 David Tuck wrote to the Prison Service Training College who delivered PCC training observing *"there have been a number of cases at Rainsbrook where a young person has complained that their head has been pushed too far forward and down into their groin. In some cases they have complained of restricted breathing and some have vomited. The Health Care staff here have also expressed concern about the possibility of lasting damage in young people, whose bodies are supple enough to be pressed into such extreme positions without offering much resistance"*.
- 4.47 Again this letter was forwarded to the YJB headquarters and again no action was taken. In the PCC meeting of 26 November 2003 there is reference to a trainee reporting that a *"pressure was placed to move her head further down and this was even more uncomfortable"* and that Rainsbrook would not use the 'new' headhold as this had led to *"two incidents when a trainee's eyes had become very blood shot following the PCC incident when using the new hold"*. David Tuck had also mentioned in his monthly reports an incident involving a boy who ended up in Rugby hospital with burst blood vessels in his eye in April 2003 and a girl who ended up in a neck brace in November 2003.

Inspection failures

- 4.48 The Social Services Inspectorate ("SSI") and the Commission for Social Care Inspectorate ("CSCI") also failed on inspection to recognise that children were being restrained using dangerous restraint methods and were routinely being restrained outside the rules.
- 4.49 As a matter of principle secure establishments should be inspected by people with the requisite expertise and experience. Since Gareth's death, responsibility for inspections of STCs has since passed from CSCI to the Office for Standards in Education (Ofsted). By contrast HM Inspectorate of Prisons remains responsible for inspecting Young Offender Institutions. HM Inspectorate of Prisons is widely respected at a national and international level and individuals within it have particular expertise in the treatment and conditions in which juveniles and young offenders should be detained (including addressing restraint related issues). Arguably, had STCs not been privatised at their inception, the responsibility for monitoring and inspecting their practices would have been within the remit of HM Inspectorate of Prisons.

Training Issues

- 4.50 The inquests exposed serious training deficits amongst staff working in STCs – an issue that has come up frequently at inquests into the deaths in custody of other children. The priority of staff training is on the maintenance of discipline, order and institutional security. It is disturbing that those charged with the care of society's most vulnerable children had only between seven and nine weeks training on all issues of working in a secure environment. It goes without saying that expertly developed and highly refined skills together with ongoing professional training is required to meet the complex needs of child prisoners. However this is not available for staff working in children held in any form of penal custody. Staff are required to fulfil a role for which they are neither professionally trained nor adequately equipped.

- 4.51 Taken together, these themes of the overuse, dangerous and unlawful use of restraint; the failures in inspection and monitoring; failures in training; isolation of STCs from other custodial institutions; and the failure to listen to the voice of the child show the extent of disarray the youth justice system is facing.

5 RECOMMENDATIONS

- 5.1 It would be a fitting legacy to the deaths of Adam Rickwood and Gareth Myatt for there to be significant action taken to protect children in similar circumstances in the future. To this end, we make the following recommendations for action which we hope this review will endorse.

Recommendation 1: Public inquiry

- 5.2 What the inquests into the deaths of Adam Rickwood and Gareth Myatt uncovered is that the youth justice system urgently needs profound public scrutiny, investigation and review that are significantly wider in scope than any narrow review of restraint. If this country is to honour its international treaty obligations as far as deaths of children are concerned there must be effective remedial action taken. The failure of successive governments to hold a public inquiry runs counter to the spirit of accountability, transparency and the pressing need to learn from failures in the system that have cost these children's lives. The system not only fails the legacy of the children who have lost their lives. It fails their families and the wider public interest in denying opportunities to ensure that lessons are learned and further deaths and injuries avoided.
- 5.3 The only effective and meaningful way of responding to these deaths and the broader concerns about the increasing imprisonment of children is through the establishment of an independent inquiry, with the proper involvement of families, to examine the wider systemic and policy issues concerning the treatment of children in the youth justice system. Such an inquiry could look at the commonalities within, across and between cases as well as focusing on child welfare and youth justice policy and the law and policies that govern the question of child imprisonment.

Recommendation 2: A change in ethos so children are treated as being in need of care rather than custody

- 5.4 As identified by the Lancashire Safeguarding Children's Board Adam Rickwood was viewed by the 'whole youth justice system' as solely a "child in need of custody rather than a vulnerable child also in need of care and safeguarding". This mirrors our experience in other cases. There needs to be a complete rethink of the way in which children are treated in the criminal justice system in order that the "best interests" of the child are given proper emphasis and children are in practice given custody as a matter of last resort. The fiscal costs of keeping children in penal custody are extremely high and the failure of custody as a measure of crime prevention well documented, as is illustrated by the high reconviction rates in respect of children following release. It is also damaging and dangerous as illustrated by the high number of deaths and levels of self harm and distress.
- 5.5 Penal custody is an inappropriate environment to deal with the complex needs of child prisoners. Where custody is necessary in order that "best interests" are respected children should be placed in children's homes. We therefore recommend the abolition of *all* Prison Service and private sector custody for child 'offenders' and only the minimum use of Local Authority Secure Children's Home provision for children whose behaviour places themselves and or others at *proven serious risk*. In cases where children are deprived of their liberty '*as a measure of last resort and for the shortest period of time*' (United Nations General Assembly, 1989, Article 37b), the full weight of all relevant international human/children's rights standards, treaties, rules and conventions should, of necessity, apply as minimum and non-negotiable standards and these principles should underpin the manner in which children and young people are treated by those charged with their care.²²

²² In The Care Of The State op cit page 101

Recommendation 3: Reform of the YJB

5.6 On paper the mission statement of the YJB remains to ensure that custody for children is safe and secure and addresses the causes of offending behaviour. In practice there needs to be a wholesale change in attitude by the YJB to the lessons to be learned from the investigation into the death of this child. We are not convinced by the lip-service protestations of commitment to change made by the YJB and its new CEO²³. Further examples of alarming lack of fit between the YJB's words and actions include:

- The failure to take action to reduce the number of restraint being used against children in STCs despite overwhelming evidence that restraint is being used too frequently and for the wrong reasons;
- the gaping lack of pathologist or anybody with expertise of restraint-related deaths on the Panel until December 2007 – over three years since Gareth's death - and the failure to reconvene the panel from March 2005 until December 2007 despite the evidence emerging from the investigation and inquest;
- the failure to consult with the Children's Commissioner and others about the imposition of the amendment to the STC rules, and this in the context of PCC being used too soon, too often and for purposes outside the contract and the rules themselves, and the YJB's Code of Practice;
- the presentation to the public and parliament that restraint was limited to the circumstances set out in the STC rules whereas the contrary was the case;
- the presentation to the public that the amendments to the STC rules were simply for clarification rather than amounting to a change in the law.

There should be a proper assessment as to whether the YJB is "fit for purpose".

23 See the Channel 4 News interview with Ellie Roy by Jon Snow 29th June 2007

Recommendation 5: A review of PCC

- 5.7 It was obvious in the course of the inquests into Adam and Gareth's deaths that there was no agreement among staff of the circumstances in which PCC can be used. There should be clear, objective and unambiguous criteria as to when restraint could be used.
- 5.8 It should be part of the culture within STCs that what is central is what is in the best interests of the child rather than the convenience of the centre. We would commend consideration of the approach to restraint of children in Scotland set out in "Holding Safely" on this matter.²⁴
- 5.9 The PCC panel should be convened regularly. It is a wholly inadequate posture that the Panel lurks in the background as a safety net. It needs to be used proactively. It should not be a reactive response to identified problems 'flagged up' by monitoring²⁵.
- 5.10 The form of restraint used in STCs should also be open to public scrutiny. The previous failure of public scrutiny led to techniques being used which were or should have been known to be dangerous.

Recommendation 46: Monitoring

- 5.11 The focus of monitoring should not be on contract compliance but on the qualitative treatment of children. The aim of an STC must be to support and rehabilitate troubled children - not to silence them to ensure that contract requirements are met. The current focus must be shifted from contractual 'outputs' for the centres to real 'outcomes' for children in terms of their

²⁴ Holding Safely A Guide for Residential Child Care Practitioners and Managers about Physically Restraining Children and Young People (2005) Scottish Institute For Residential Childcare

²⁵ Channel 4 news interview op cit

conditions, treatment, experiences. Monitoring must be timely, effective, noted and acted upon.

Recommendation 5: Inspection

5.12 The inquest exposed fundamental flaws in the inspection process. We suggest that Her Majesty's Chief Inspector of Prisons should take over the inspection of STCs. As a matter of principle and common sense, secure establishments should be inspected by people with the requisite expertise and experience. Since Gareth's death responsibility for inspections of STCs has since passed from CSCI to the Office for Standards in Education ("Ofsted"). By contrast HM Inspectorate of Prisons remains responsible for inspecting Young Offender Institutions. HM Inspectorate of Prisons is widely respected at a national and international level and individuals within it have particular expertise in the treatment and conditions in which juveniles and young offenders should be detained (including addressing restraint related issues). Arguably, had STCs not been privatised at their inception, the responsibility for monitoring and inspecting their practices would have remained within the remit of HM Inspectorate of Prisons (who in fact remain responsible for inspecting privately run prisons housing young offenders). The Inspectorate has in the past combined expertise with Ofsted in joint inspections of the educational needs of children in penal custody²⁶.

Recommendation 6: Complaints

5.13 We do not seek to set out at length the complete overhaul that is required of the complaints procedure. In essence however the complaints system should: (1) hear the children's voices; (2) be independent, (3) be effective. One issue that emerged during Gareth's inquest was that the complaints system did not involve

²⁶ HM Chief Inspector of Prisons and The Office for Standards in Education (2001) *A Second Chance; A review of education and supporting arrangements within units for juveniles managed by HM Prison Service*, London, Home Office.

speaking to the trainee about the complaint. The position taken was that the trainee had said what they wanted to say in their complaint form. There were also many instances of incidents and complaints being referred to Social Services only to be handed back for investigation by the director of Rainsbrook who had a financial motivation not to uphold the complaints.

Recommendation 7: Staff Training

- 5.14 There needs to be a proper review and analysis of recruitment and training of staff in juvenile custodial settings. Staff frequently do not have relevant previous experience of working with children and whereas prison officers have a 13 week training course and far greater training is given to child care workers in Scotland there is 7-9 weeks for Training Assistants at STCs. The level of training and level of previous experience currently deemed appropriate for Training Assistants and Supervisors at STCs is wholly inadequate given that the children detained at STCs are among the most vulnerable children in Britain.

Recommendation 8: The inquest system

- 5.15 The inquest system needs to be reformed and the Coroners Reform Bill introduced. The inquest and investigations should be a forum whereby lessons can be learned from contentious deaths. Inquests are subject to serious delay, held in isolation, and cannot address issues regarding sentencing and allocation. The delays in the inquests into the deaths of Adam Rickwood and Gareth Myatt have frustrated the learning process as well as placing an intolerable strain on the families. At present there is a lack of central collation, monitoring, auditing, or publication of Coroners' Rule 43 reports. To date there has been no formal public response to the detailed recommendations of HJJ Pollard. There needs to be public scrutiny and analysis of the follow-up to coronial reports, jury findings, and recommendations arising from investigation and inspectorate reports. The vital contribution that the coroners service can make to the prevention of similar fatalities is currently hindered by the lack of a mechanism

INQUEST's submission to the Ministry of Justice & Department for Children, Schools and Families on the 'Review of Restraint'.

to ensure that potentially life saving recommendations do not disappear into the ether.