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From His Honour Richard Pollard
Assistant Deputy Coroner for the County of Northampton

To: The Rt. Hon. Jack Straw M.P.
Secretary of State for Justice and Lord Chancellor
Ministry of Justice
Selborne House
54 Victoria Street
London SW1E 6QW

18/07/07

Re: the Inquest into the death of Gareth Myatt

As you may be aware I conducted the Inquest into the death of Gareth Myatt. I write to you pursuant to my duties under Rule 43 of the Coroners Rules. I believe that there are actions which should be taken to prevent the recurrence of fatalities similar to that in respect of which the Inquest was held. For the record I set out the findings of the Jury:

Gareth Paul Myatt, who was born on 10th January 1989 at Stoke-on-Trent,

Died on 19th April 2004

At: Walsgrave Hospital, Coventry in the County of Warwick

Cause of Death: Asphyxia resulting from a combination of inhalation of gastric content and his body position during physical restraint

Time and place of injury causing death: The said physical restraint took place at Rainsbrook Secure Training Centre in the County of Northamptonshire between 20:58 hrs and 21:23 hrs on 19th April, 2004.

Verdict: We find that the death was probably caused during lawful restraint and was probably accidental and we therefore record a verdict of "Accidental Death".

Other Findings made by the Jury:

The Jury were asked to answer specific questions and then asked if they wished to add any other matters which they concluded had caused or contributed to Gareth's death.

- 1) There was no adequate assessment of the safety of Physical Control in Care, and the Seated Double Embrace in particular, before it was introduced and that inadequate assessment caused or contributed to Gareth's death. The other relevant matter on this aspect that we wish to record as causing or contributing to Gareth's death is that there was information available, and concern here and abroad, about Positional Asphyxia; but this was not considered when the 1st or 2nd Panels were assembled.
- 2) Failure to undertake a medical review of the safety of Physical Control in Care, and the Seated Double Embrace in particular, by the Home Office or the Youth Justice Board, before Gareth's death caused or contributed to Gareth's death. There is no other relevant matter on this aspect that we wish to record.
- 3) Any inadequacy in the system of training the staff at Secure Training Centres in the use of Physical Control in Care prior to Gareth's death did not cause or contribute to his death. We wish to record that not all members of staff had a copy of the PCC Manual for their own reference; training did not include adequate discussion and learning of the theory of "medical advice"; we record also, however, that the real dangers of Positional Asphyxia were not known to the Trainers, or even the National Instructors.
- 4) There was nobody at the Youth Justice Board with specific management responsibility for the safety of Physical Control in Care prior to Gareth's death and this fact caused or contributed to Gareth's death. There is no other relevant matter on this aspect that we wish to record.
- 5) Inadequacy in the response by the Youth Justice Board to the National Children's Bureau Report as to the urgent need for the medical review of Physical Control in Care caused or contributed to Gareth's death. There is no other relevant matter on this aspect that we wish to record.
- 6) Inadequacy in the response by the Youth Justice Board to the Tuck letters of 12 June 2002 and 2 July 2003 caused or contributed to Gareth's death. There is no other relevant matter on this aspect that we wish to record.

- 7) Inadequacy in the monitoring of the use of Physical Control in Care at Rainsbrook by the Youth Justice Board caused or contributed to Gareth's death. We also record that there was a problem with the lack of response by the YJB organisation to the Reports from Rainsbrook.

- 8) Inadequacy in the monitoring of the use of Physical Control in Care at Rainsbrook by Rebound management caused or contributed to Gareth's death. We also wish to record that there was a problem with the lack of response by Rebound to the information from Rainsbrook.
- 9) There are no other matters which we wish to record as having in some way caused or contributed to Gareth's death.

There are, of course, other areas of concern which arose from the more general scope of the Inquest, for example the question of references of injuries to local Social Services and how complaints by trainees were dealt with. In order to assist me as to the formulation of the actions that I believe should be taken to prevent the recurrence of similar fatalities I have, since the formal closure of the Inquest, received written submissions and some updated information from those involved.

I understand that there is now to be a "joint review" on restraint, involving Young Offender Institutions, STCs and Local Authority secure units, namely LASUs and LASCHs. I trust that no-one will lose sight of the particular and very immediate problems of PCC and the STCs. Earlier quests for a uniform solution as between STCs, YOIs and Local Authority units resulted in very serious issues being completely overlooked by the YJB, the need for a review of PCC being the prime example.

I trust that the actions and reviews I suggest below will be considered by the "joint review" only where appropriate. For the reason given I also trust that the actions I suggest will be looked at quite independently of that "joint review". The Jury concluded that one of the factors that caused or contributed to Gareth's death was the failure by the YJB and the Home Office (as it then was) to undertake a review of the medical safety of PCC. It would be a wholly unforgivable and a double tragedy, would it not, if the holding of this "joint review" was to obscure the clear and urgent issues raised by Gareth Myatt's death, or was to lead to any delay in learning from and acting on the lessons that result from his death?

I list below 34 Actions which I believe should be taken. I group them under various headings. Each and every Action suggested is, I believe, important in its own right. Many involve suggestions of consultations with outside bodies. The proper test for any individual or any institution as to the relevance of any Action must be this: if this Action is taken will it minimise the risk of a further death from the use of restraint? It would be useful for everyone in the whole system to ask themselves: if no Action is taken, what could be the result?

Given that this death occurred as a result of a PCC restraint at a Secure Training Centre I concentrate, of course, on PCC restraints and on STCs. I have not dealt in any way with techniques involving "pain" and "distraction" as these techniques were not immediately relevant to this Inquest. However, if you decide to pursue the Actions I have set out in this letter in relation to restraints then it might be useful to look at pain and distraction techniques at the same time, since many of the same considerations must apply?

ACTIONS THAT SHOULD BE TAKEN

A. THE TRAINEE:

Action 1: a system should be established to inform the staff coming on duty as fully as possible about the newly arrived trainees whom they will be dealing with. It is unsatisfactory that staff pick up the information piecemeal, for example by what they might be told by other staff handing over to them, or by using such information as might be available in their unit within files.

Action 2: every statutory Incident Report involving the use of PCC should contain full details of what happened, statements by those involved, any injury to a trainee or to staff, reasons for the use of PCC and reasons why other means of dealing with the situation were not used or had proved unsuccessful. Such Reports must also include a statement by the trainee, in their own hand where possible, and the form should provide the opportunity for a trainee to report any injury. Up to the time of Gareth's death there was no input from the child into this Reporting system. The new Reports should include a facility for both staff and trainees to conclude what lessons they had learned from the incident and how PCC might be avoided on a future occasion.

This need for the trainee's account, allied to the matters as to "complaints" under Action 3 below, came to be referred to during the Inquest as "listening to the voice of the child". That phrase is a telling one, and is one that ought to be borne in mind by everyone at all times.

Action 3: Where any complaint by a trainee is being investigated it is essential to talk to the trainee. It is not adequate simply to proceed only on the basis of what the trainee has put in writing and then interview only the staff. The practice should be adopted, whoever is investigating the complaint, that the trainee is spoken to, not only in the initial stages, but during the course of the investigation and after the investigation as well.

Action 4: there must be a clear policy developed by the relevant Ministries, the YJB, in fact all those involved, as to the circumstances in which matters such as complaints by a trainee and/or injuries to a trainee are referred to the Local Safeguarding Children Board, and/or to other local Children's Services and/or to the Police or any other outside body.

Action 5: in addition there must be a clear protocol as to what action should be taken and by whom when a complaint is made by a trainee, or after a decision has been taken to refer injuries or any other matter to an outside body. In particular there should be a clear protocol as to the circumstances, if any, in which it might be appropriate to ask the STC itself to investigate any matter. The reasons for a withdrawal of a complaint need careful investigation by outside bodies.

Action 6: The Children's Commissioner, the National Children's Bureau and child advocacy services should be asked to assist with the formulation of appropriate protocols and actions as to the matters raised in Actions 3, 4 and 5.

B. **RESTRAINT**

Background:

The Inquest revealed that there was a lack of clarity about where responsibility for PCC, and the proper scope of its use, actually lay. The Inquest also revealed very extensive use of PCC. By way of example figures, and reasons for those figures, were given in the Waplinton Report. Reference was also made at the Inquest to the very extensive use of PCC disclosed by Inquiry conducted by Lord Carlile. The YJB's own Monitor, referred at one stage to the possibility that Rainsbrook was becoming "dependent on PCC". He in fact subsequently became satisfied that Rainsbrook had not become "dependent on PCC", but it was apparent at the Inquest that there is an obvious danger that PCC can too readily be used as a "default" system for resolving difficult behavioural problems.

One of the issues raised at the Inquest was the use of PCC to gain compliance. The Waplinton Report covered this matter. I am aware that the matter of the use of PCC for compliance is the subject matter of Parliamentary debate following a recent proposed amendment to the STC Rules.

Whatever Parliament may decide, it is absolutely essential that there is the clearest possible definition of the circumstances in which a trainee can be subjected to physical restraint. Such clarity is required both in the interests of the staff and in the interests of the trainees. It was apparent during the Inquest that staff were not always clear about the reasons for which PCC could be used.

The YJB told the Inquest that their new Code of Conduct did not allow for the use of PCC to “enforce compliance” (see Paragraph 10.4 of “Managing the Behaviour of Children”). However it appears that the YJB are now supporting amendments to the STC Rules which would allow the use of PCC to ensure “good order and discipline”. Interestingly it is clear that “maintaining good order and discipline” has already been included in the new form of “Incident Report” as being a “reason for physical control”. It appears that these forms were in use before any amendment to the STC rules was proposed.

Action 7: The Ministry of Justice and the YJB must publicly clarify where responsibility for the system of PCC and its permitted use lies. Does the Ministry of Justice have responsibility for PCC, and for the way in which it is used? If so, who at the Ministry is actually responsible for the safety of PCC? The YJB obviously has responsibility for PCC and the way in which it is used. Who is it who actually has that responsibility at the YJB? Do the Ministry of Justice and the YJB have equal and shared responsibility? If there is another death during a PCC restraint then would that death be the responsibility of the Ministry of Justice or of the YJB, or of both? Does the new Ministry for Children, Schools and Families have any rights or duties in respect of PCC and its use? Would the new Ministry have any responsibility for any future restraint death?

Action 8: all those responsible for PCC must clearly state publicly the range of circumstances in which PCC can be used, whether there are immediate amendments to the STC Rules or not. Those responsible must also constantly consider whether or not PCC is being used too frequently, or is being used inappropriately, for example as a “default” system in the way I have already outlined.

Action 9: Whatever decision is made by Parliament as to the circumstances in which PCC can be used, there must full and careful teaching given to staff as to the meaning and full implications of the STC Rules. Staff and trainees need very clear guidelines as to the day-to-day interpretation of the STC rules and the circumstances in which physical restraint is and is not allowed.

Action 10: quite separate from any “joint review” on restraints there should be an immediate, urgent and complete Review by both the Ministry of Justice and the YJB of all the techniques of physical restraint and control within PCC, such review to include a review of the medical safety of each and every one those techniques. It became apparent during the Inquest that some holds authorised within PCC, for example the double basket hold, continue in use notwithstanding the conclusions of Dr. Bleetman and Mr. Boatman that they are dangerous. I understand that the use of such holds has been reviewed and that their use is subject to extra advice given by Dr. Bleetman. The continued use of such holds needs immediate review. The review should also consider other possible means of restraint. Before any such review is acted on, or any authorisation is sought from Parliament for amendments to the STC Rules, the views of the Children’s Commissioner, the National Children’s Bureau and Local Children Safeguarding Boards should be sought. The most up to date information available from the Forum for Preventing Deaths in Custody on restraint deaths should also be obtained.

Action 11: the Panel conducting that review suggested at Action 10 should include experts not only in the fields represented on earlier Panels but also in the relevant medical disciplines, for example a Pathologist or other Consultant with specific expertise in respiratory matters. In addition there needs to be an expert on restraint asphyxia.

Action 12: further consideration should be given by the Ministry of Justice and the YJB to implementing the teaching of PCC at national level by national instructors. This would be the best possible system.

Action 13: The resources at the Prison Service Training Centre at Kidlington (and elsewhere if relevant) should be reviewed, along with the system of training the National Instructors themselves, so as to ensure that all those at the highest level are familiar with developments in techniques and in medical knowledge. The Jury noted that not all national trainers had knowledge of Positional Asphyxia at the relevant time.

Action 14: In the event that teaching continues to be “cascaded down”, so that teaching continues to be carried out by STC staff at STC level, then as a bare minimum there needs to be nationally based supervision and inspection of such teaching, by the Ministry of Justice.

Action 15: Particular attention should be paid, during training, to the theory and practice as to “medical aspects” arising from the use of PCC, with full discussion of those aspects. There should be distinct “lesson plans” within the teaching to minimise any tendency for the teaching to be diluted by the “cascading down” process.

Action 16: the present PCC Manual should be reviewed immediately, and regularly thereafter, so as to ensure that it contains the most up to date medical information.

Action 17: the PCC Manual (or a simplified but adequate version of it, particularly with regard to medical safety) should be provided to all those staff in STCs who are empowered to use PCC. Such a document should also be provided to all those with monitoring responsibilities.

C. MONITORING

Action 18: there should be an immediate and thorough review by the Ministry of Justice of its own system of monitoring the YJB. The Ministry

must satisfy itself that the YJB adequately fulfils its duty to provide a safe environment at STCs. The Ministry of Justice will need to devise systems whereby it can say that its own monitoring of the YJB is satisfactory. Only by such means can the Ministry properly say whether or not the YJB is, in fact, providing the safest possible environment for trainees and therefore whether or not the YJB is, with regard to the safety of trainees, "fit for purpose".

Action 19: there should also be an immediate and thorough review by the Ministry of Justice and the YJB of the YJB's monitoring systems. Such a review should also establish systems to ensure that there is "qualitative analysis" of information gathered by monitoring. It is essential to assess not only the accuracy of information gathered but also the implications arising from that information. The issues arising from monitoring go way beyond the simple issue of testing whether or not the "contract" between the YJB and Rebound is being complied with. The review of monitoring systems should be geared to answer these questions: Is the information obtained through the monitoring system full and accurate? Is that information telling us what is really going on? Is the monitoring system actually helping us to provide the safest possible environment for trainees and thereby making us, with regard to the safety of trainees, "fit for purpose"?

Action 20: I repeat the matters set out at Actions 3, 4 and 5 above as to complaints by trainees and the referral of matters to outside bodies as being relevant items on which there is a need for review once monitoring systems have been set up.

Action 21: in conjunction with the reviews already suggested, the YJB's system of monitoring based mainly on a single resident monitor should be looked at immediately. At the very least there should be more central oversight of monitoring and more on-site visits by the YJB Regional Manager and, indeed, by those higher up the YJB. The use of more than one monitor may be appropriate and further consideration should be given to the use of "teams of specialist monitors".

Similar considerations apply to Rebound.

Action 22: there should be an immediate review by the Ministry of Justice, the YJB and Rebound of Rebound's monitoring systems. Again this review should be geared to ensuring that the monitoring system answers these questions: Is the information obtained full and accurate? Is that information telling us what is really going on? Is the monitoring system actually helping us to provide the safest possible environment for trainees, and thereby making us, with regard to the safety of trainees, "fit for purpose"?

Action 23: the new "monitoring" system must include proper study and analysis of the Incident Reports, so that the actual techniques used during PCC can be monitored and so that the reasons why PCC was used can be monitored. That will also give rise to finding out why alternative strategies had not been used or had not worked.

Action 24: Reports of any injuries caused during PCC, or reports of any breathing difficulties or vomiting, need the most careful scrutiny and analysis by the Ministry of Justice, the YJB and by Rebound. Any such Reports need consideration at the highest level and must be regularly included in Reports to Ministers and to Parliament.

D. GOOD PRACTICE

Action 25: The YJB and the forum of STC Directors should develop a clear system of “best practices” as to behaviour management. These “best practices” should relate particularly to the need for, and the avoidance of the need for the use of, PCC. “Best practices”, and their teaching and adoption, will avoid PCC becoming the easy “default” system for resolving difficult behaviour. Consideration should be given to extending information sharing as to such “good practice” across the juvenile “secure estate”.

Action 26: continuing urgent consideration needs to be given to strategies that avoid the need for “segregation” (also referred to as “single separation”), that avoid the need for the removal of “risk-assessed items” from trainees’ rooms and that avoid, so far as is possible, the use of any physical intervention against a trainee.

Action 27: “best practice” guidance and teaching should be given by the YJB and Rebound to staff at STCs on a regular basis.

Action 28: consideration should be given to “separating” trainees into a room other than their own room, e.g. to a “cooling down room”. This would avoid the need for removing “risk-assessed” items from a trainee’s own room. CCTV could be used in such rooms. This would protect both staff and trainees. It also avoids problems of having CCTV in trainees’ own rooms.

Action 29: the Children’s Commissioner and the Local Safeguarding Children Boards should be involved in the process of developing “good practice”, so as to ensure that “outside” views of what is “good practice” is taken into account.

Action 30: the Forum for Preventing Deaths in Custody should be used by the YJB as a means of providing information to others about the circumstances of Gareth’s death and the lessons to be learned from that death, as well as a source of information about deaths in custody.

Action 31: the Forum for Preventing Deaths in Custody should become the collecting point for, and the source of distribution of, information from Inquests arising out of deaths in custody (for example, verdicts returned and any Rule 43 matters). Such information should be made readily available to all Forum members and, so far as is possible, to the public through its website.

Action 32: All those involved in the STC system need to consider very carefully and very regularly how they can learn lessons from what happened to Gareth Myatt, how they can build on good practice, and how they can prevent another trainee dying as a result of physical restraint.

E. **ACCESS FOR EMERGENCY VEHICLES**

Action 33: procedures to ensure speedy access for emergency vehicles to STCs should be reviewed.

F. **INSPECTION**

Action 34: All the matters raised by the death of Gareth Myatt should be brought immediately to the attention of Ofsted. Ofsted will, of course, need to examine and review the actual use of PCC by STCs. They will also need to examine the effectiveness of the system for complaints as well as the adequacy of the system for referrals to outside agencies.

I am copying this letter direct to the YJB and to Rebound. I am also sending copies to the Jury at their request. I have also asked the Press Office of the Northamptonshire Police to make it available, on behalf of the Coroner, to the Press and to the public. I am sure that I can trust your Ministry to contact all those who are potentially affected by the matters I have raised. I have in mind all Ministries involved in any way with the Youth Justice System (including at least the Ministry for Children, Schools and Families), The Children's Commissioner, the National Children's Bureau, representatives of the child advocacy services used by STCs, ACPO, the Association of Directors of Social Services, all Directors of STCs, Ofsted and the Forum for Preventing Deaths in Custody.