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INQUEST further evidence to the JCHR Inquiry Use of Restraint in Secure Training Centres 2007

Introduction

1. That the issue of child deaths in custody is receiving public and parliamentary exposure is a tribute to the determination of bereaved families that what happened to their children does not happen to other children and other families. Despite the evidence that emerged from the investigations into the deaths of Adam Rickwood and Gareth Myatt the only government response thus far has been:
   (a) the introduction of the Statutory Instrument without public consultation or debate;
   (b) the announcement of a 'independent review' of the use of restraint the terms of reference of which are yet to be agreed.

   The current investigatory processes are incapable of dealing with the systemic issues highlighted in the cases of Adam Rickwood and Gareth Myatt.

The review of restraint

2. As of 1 October 2007 no detailed terms of reference of the review had been made public nor had a Chair been appointed. Our understanding is that the review will report six months from the appointment of the Chair which means that it is now unlikely to report until Spring of 2008.

3. Lord Hunt's announcement in the House of Lords on Wednesday 18 July 2007 that the review intends to focus on restraint and the narrow question of uniformity is in grave danger of repeating a pattern of missed opportunities and failings of the past. A review of the use of restraint across the entire juvenile estate was carried out by the National Children's Bureau in 2003. The focus of this report was the question of uniformity of restraint. Such was their concern about the lack of a medical assessment of Physical Control in Care (PCC) within STCs they recommended an <u>urgent</u> medical review. This never took place. We note conclusion two of the jury's narrative verdict following the death of Gareth Myatt:

   i. "(2) The 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."

4. On paper the mission statement of YJB remains to ensure that custody for children is safe, secure and addresses the causes of their offending behaviour. Despite all the evidence that has emerged during the inquests into Adam Rickwood and Gareth Myatt about the dangerous methods of restraint being used too soon, too often and for purposes outside the contract, the rules themselves, and the YJB's Code of Practice, it is quite shocking – and inexplicable – that there has been a continuing failure to carry out a medical assessment of PCC. The YJB panel that oversees restraint has not been reconvened since March 2005; no pathologist or other expert on restraint related deaths or restraint asphyxia has been consulted by the YJB, nor has one been appointed to the panel. Evidence emerged at the Adam Rickwood inquest in 2007 that Jon Collier, the lead instructor at the Prison Service National Training College on PCC was under the impression that injuries from the use of the nose distraction were rare, as if not he would have been informed by the YJB. He was visibly shocked when shown for the first time (by counsel for the family) the injuries actually suffered by children at Hassockfield

Inspection and monitoring of STCs

5. The monitoring system within STCs has been too focused on 'contract compliance' and contractual 'outputs' for the centres rather than on the real 'outcomes' for children in terms of their treatment, experiences and conditions.

6. The inquests exposed fundamental flaws in the inspection process of STCs which have recently passed from the CSCI to the Office for Standards in Education (Ofsted) As a matter of principle and common sense, secure establishments should be inspected by people with the requisite expertise and experience. HM Inspectorate of Prisons remains responsible for inspecting Young Offender Institutions and individuals within in 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 custody. Their most recently published inspections of Brinsford YOI (July 2007) and Werrington YOI (September 2007) drew attention to the shocking practice of forcibly strip searching children and the high use of force. We propose that Her

Majesty's Chief Inspector of Prisons should take over the inspection of STCs.

Staff training

7. There needs to be a proper review and analysis of recruitment and training against the background that:
    (a) staff frequently do not have relevant previous experience of working with children;
    (b) prison officers have a 13 week training course, compared to 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. Staff are required to fulfil a function for which they are neither professionally trained nor adequately equipped.

Public Inquiry call

8. INQUEST believes that the current debate around the use of restraint of children in secure training centres needs to be seen in the wider context of the treatment of children and young people within the youth justice system. In increasing the number of children and young people detained in manifestly unsafe environments the state is failing in its duty of care. There is the ever present risk of more death and injury to children.

9. It is plain that if this country is to honour its International Treaty obligations as far as these deaths are concerned there must be effective remedial action taken. This obligation flows from the European Convention and was succinctly distilled by Lord Bingham when the Amin case came before the House of Lords. Vital among the article 2 objectives after a death in state custody are:

    i. "..that dangerous practices and procedures are rectified; and that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others." (*Amin*, [31], per Lord Bingham)

10. It is difficult to comprehend how 29 children could have died in custody since 1990 without a single public inquiry into any of the deaths taking place. INQUEST has been calling for a public inquiry into the treatment of children in the youth justice system since the death of Joseph Scholes at HMP Stoke Heath in March 2002. This call was supported by the Coroner who conducted the inquest, over 100 MPs and Peers, key penal reform, child welfare and human rights organisations, the General Synod

of the Church of England and the parliamentary Joint Committee On Human Rights.

11. In our written evidence to the JCHR Inquiry into deaths in custody in December 2003[1] we wrote:

> *"We would like to draw the committee's attention to the case of Joseph Scholes which is illustrative of the concerns these deaths raise about the way in which the criminal justice deals with children. It also reveals the inadequacy of the current inquest system to deal with the complexity of issues by these cases that engage Article 2 of the Human Rights Act.*
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> *Joseph was a deeply disturbed boy who had disclosed a history of alleged sexual abuse from an early age. On 24 March 2002 he hanged himself in his cell at Stoke Heath Young Offender Institution in Shropshire. His death occurred just nine days into his two-year sentence for street robbery.*
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> *Joseph's death and other tragedies like it, raise serious issues about the ability of the present system to cope with society's most vulnerable young people and to provide them with a safe as well as a secure environment. The question arises as to how best to identify any systemic failings that do exist and how future tragedies can be avoided.*
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> ***The case for a public inquiry rather than an inquest***
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> *INQUEST, Nacro and Yvonne Scholes, Joseph's mother recently launched a call for a public inquiry into his death.*
>
> *The narrative of Joseph's life is grim reading and reveals a catalogue of failures by state agencies to provide appropriate care and help to an exceedingly vulnerable child.*[2]
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> *Joseph's death raises a number of wider questions about the treatment and care of children in the criminal justice system and the accountability of those agencies responsible, in particular the Youth Justice Board, the Prison Service and Social Services Departments. It asks questions of society and how it should respond when children show clear signs of being disturbed and in need of professional intervention. It raises questions about how agencies and individuals could have intervened in Joseph's case and how we can ensure that we have better systems and better practice in the future."*

12. We also expressed concern in both the written and oral evidence about the number of restraint related deaths in custody and the lack of joined

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1 House of Lords House of Commons Joint Committee on Human Rights Deaths in Custody Third Report of Session 2004–05 Volume II : Oral and Written Evidence

2 A child's death in custody – Call for a public inquiry – INQUEST and NACRO Campaign Briefing – November 2003

up learning between state agencies following the use of dangerous restraint techniques.

13. In further written evidence to the JCHR Inquiry in September 2004 after the death of Gareth Myatt we wrote:

> *"We have warned of the ever-present risk of more deaths because of the slow progress in ensuring evidence based joined up thinking approach concerning restraint techniques, training and the dangers of positional asphyxia across **all** custodial settings….The death of Gareth Myatt begs questions about how it was that potentially lethal methods of restraint were being used against children and what medical input and advice was taken before such methods were introduced. Our understanding is that the restraint methods used are designed specifically for use on children and that training is provided by the Prison Service."*

14. The failure of successive governments to hold a public inquiry runs counter to the spirit of democratic accountability, transparency and the pressing need to learn form 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.

15. 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 is significantly wider in scope than any narrow review of restraint. In light of the wide-ranging issues requiring consideration and action the most effective way of responding to these needless and avoidable deaths and ensure the necessary learning and action takes place is through the establishment of a wider independent inquiry and examination of the treatment of vulnerable children in the youth justice estate with the proper involvement of families, children and those working in the area of child care and child protection. Proper, transparent and critical analysis of the defects of the custodial treatment of children is now essential.

Deborah Coles
Co-director INQUEST
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