

WHY ARE CHILDREN DYING IN CUSTODY?

CALL FOR A PUBLIC INQUIRY INTO THE DEATH OF JOSEPH SCHOLES

INQUEST and Nacro supported by

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plus over 100 MPs and Peers

On 24 March 2002 a deeply disturbed child, 16 year-old Joseph Scholes, hanged himself in Stoke Heath Young Offenders Institution just nine days into a two-year custodial sentence. Since Joseph's death, another five children have died in similar circumstances.

A mother's need to know why her son died and to prevent future deaths of children has inspired a nationwide campaign for justice. With the backing of INQUEST and Nacro, Yvonne Scholes has since won support from all the major penal reform, child welfare and human rights groups. In Parliament, an Early Day Motion tabled by Yvonne's constituency MP, Chris Ruane attracted 112 signatories, and the death has been debated extensively in the Lords.

The campaign is calling for a public inquiry to address the issues arising from the death so that lessons can be learned about the treatment of children throughout the criminal justice system.

The number of children sent to prison has doubled in the last ten years and an increasing number of younger children are receiving custodial sentences.

While the vulnerability of Joseph Scholes was recognised from the outset, his allocation to Prison Service accommodation and general treatment failed to meet the standard of care required and this became clear to all who heard evidence given at the inquest into his death. In an exceptional move, the coroner wrote to the Home Secretary expressing his concerns and noting that his inquest was not able to examine all of the issues raised by this tragic death. He recommended a review that should take the form of a public inquiry.

BACKGROUND

Joseph Scholes had an unsettled childhood and became a disturbed young boy. He had allegedly been sexually abused from an early age. 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.

On 30 November 2001 he went into voluntary care of social services and was placed in a children's home. Six days later, 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.

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When no other place could be found, troubled teenager **IAN POWELL** was remanded in custody at HM Prison Parc in Bridgend. His probation officer eventually found more suitable accommodation but was unable to inform the prison due to work commitments. Two days later, on 6 October 2002, Ian was found hanged from a light fitting.

The Powell family were given an apology for the two-year delay in beginning the inquest. The coroner also remarked on the 'mystery' of missing cell inspection files covering the three hours before Ian's death. The jury returned a verdict of Death by Misadventure.

On 19 April 2004, **GARETH MYATT**, aged 15, from Stoke-on-Trent died after being physically restrained by three adult members of staff at the Rainsbrook Secure Training Centre, Northamptonshire. His death begs questions about how potentially lethal methods of restraint were being used against children in secure training centres. INQUEST has raised parliamentary concerns about the disproportionate use of restraint techniques and the over representation of black people with regard to restraint related deaths in custody. Over two years after his death and six months after the CPS took a decision not to prosecute there has been no disclosure of the police investigation.

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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.

Prior to sentencing, the judge at Manchester Crown Court was alerted to Joseph's vulnerability. Tragically, the trial was held at a time of heightened public anxiety over street crime and guidelines were widely interpreted as requiring an automatic custodial sentence.

On 15 March 2002, Joseph was sentenced to a two-year detention and training order. 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*".

No exploration though was made at the sentencing hearing as to where Joseph would in fact be detained and whether the institution could cater for his needs.

After sentencing, the Youth Justice Board (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 accommodation available and placed Joseph in Stoke Heath Young Offender Institution (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 YOI, he was stripped of his clothing, including underwear, and placed in a garment like a horse blanket with stiff Velcro fastenings – treatment a child care expert described as "dehumanising".

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 window.

A two-week inquest into his death in April 2004 heard disturbing evidence of the way vulnerable children are ill-treated in prisons. Investigations carried out by the Prison Service, by a child care consultant acting on behalf of the area child protection committee, and by a consultant adolescent psychiatrist instructed by the coroner, all found that prison service accommodation was completely unsuitable.

The jury returned a verdict of "*accidental death in part contributed to because the risk was not properly recognised and appropriate precautions were not taken to prevent it*".

The coroner has a public duty to prevent the recurrence of deaths and in this case, Mr John Ellery took an exceptional step in writing to the Home Secretary recommending an urgent and comprehensive review of policies and provision that failed to prevent Joseph's death. Backing the call first made by Yvonne Scholes in 2003, he recommended that this review should take the form of a public inquiry

The government has to date declined to establish such an inquiry. The Prisons Minister asked the Sentencing Guidelines Council to look at Joseph's custodial sentence, and the YJB to look at custodial provision for vulnerable young offenders. A former head of the Social Services Inspectorate was also appointed to examine any operational issues. His review has still not been disclosed to the family nor made public, despite being concluded in December 2004. Such an approach has denied the family any meaningful opportunity to participate and the issues of sentencing and allocation of vulnerable children still remain unaddressed.

From INQUEST's casework we know that child deaths in custody are too often linked to failings in the community, the inappropriate use of penal custody for vulnerable children, inadequate treatment whilst in custody whereby the institutions

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are unable to care for the vulnerabilities of those that they detain.

The number of children in prison stood at 2,819 in April 2006 – a rise of 96 since the previous year. 2,346 were held in Young Offender Institutions; 244 in Secure Training Centres and 229 in Secure Children's Homes.

Since 1990, twenty-nine children have died in custody (see back page table).

From the time of Joseph's death, five more children have lost their lives (see panels). The current inquest system is incapable of dealing with the systemic issues highlighted by these cases.

In considering the issue of an inquiry into the death of Joseph Scholes in January 2006, High Court judge Mr Justice Bennett said: "... *it is absolutely plain that there is great concern. As to whether young persons under the age of 18 years should be locked up at all, whether they should be in secure units outside the prison service..(or) in YOIs, what form of incarceration is necessary for protection of the public from young offenders, and what financial resources should be devoted to young offenders. Deaths in custody of young offenders must be an unimaginable and terrible trauma for the deceased, and must leave their families completely distraught. This rightly should attract a high degree of public scrutiny... these are matters for public and political debate.*"

Child deaths in custody raise thematic issues that need to be addressed in a joined up manner through a properly resourced inquiry so that appropriate recommendations are made to ensure that lessons are learned and safeguards put in place to protect the lives of children in the future.

The public interest case for a judicial inquiry remains urgent and pressing.

- For a detailed examination of the issues around child deaths in state custody, see *In The Care Of The State?* by Professor Barry Goldson and Deborah Coles, published by INQUEST in July 2005.

ADAM RICKWOOD, aged 14, became the youngest child to die in custody in modern penal history. He was found hanging in his room at the privately-run Hassockfield Secure Training Centre on 8 August 2004. He had been restrained by staff earlier in the day. Hassockfield was more than 100 miles from his home and family. Three weeks before the tragedy, Adam's mother Carol Pounder warned staff at the County Durham centre that her son was deeply troubled. An investigation into his death was subject to serious delay.

16 year-old **GARETH PRICE** was found hanging from a bed sheet ligature attached to the window latch of his "care and separation" cell (formerly known as the segregation unit) at Lancaster Farms YOI on 19 January 2005. He died the following day.

SAM ELPHICK was found hanged in his cell at Hindley YOI on 15 September 2005. He was 17 years old and finding prison very difficult. Despite a number of previous suicide attempts and Sam's obvious vulnerability he received little treatment and was viewed as a discipline problem and attention seeker.

UNITED NATIONS CONVENTION ON THE RIGHTS OF THE CHILD

Extract Article 37(b) ...*The arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time*

Article 37(c) *Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age. In particular, every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so and shall have the right to maintain contact with his or her family through correspondence and visits, save in exceptional circumstances.*

YVONNE SCHOLES Joseph Scholes' mother

"We must not falter in our battle to challenge Home Office Ministers' attempts to wilfully suppress damning evidence of the continuing abuse and deaths of children in custody. The Home Secretary should accept his responsibility and demonstrate moral integrity by reversing the flawed decision to deny us our right to a full public inquiry".

DEBORAH COLES, co-director, INQUEST

"The public inquiry call is motivated by the urgent need to address what is a serious human rights issue – the deaths and suffering of children at the hands of the state. The fact that 29 children have died in penal custody should shame the government into decisive public action".

PAUL CAVADINO, Chief Executive, Nacro

"A vulnerable child like Joseph should not have been sentenced to custody or held in Prison Service accommodation. His tragic case demonstrates the profound flaws in this country's system for dealing with children in trouble. A public inquiry into Joseph's case could carry out a fundamental examination of how future tragedies can be avoided".

PARLIAMENTARY JOINT COMMITTEE ON HUMAN RIGHTS

"*There has never been a public inquiry into the death of a child in custody. We recommend that the Home Secretary order a public inquiry into the death of Joseph Scholes in order that lessons can be fully learnt from the circumstances that led up to his tragic death. We also recommend that local authority secure accommodation should be used wherever possible for children, with use of prison service custody reduced to an absolute minimum*".

YOU CAN HELP

INQUEST, Nacro and many other organisations are backing this call for a public inquiry. To add your support please e-mail campaigns@inquest.org.uk

IN THE
CARE OF
THE STATE?

Child Deaths in
Penal Custody in
England and Wales

Barry Goldson and Deborah Coles

JUVENILE DEATHS IN CUSTODY (ENGLAND & WALES) FROM 1990

	Sex	Age	Date	Classification	Establishment	Inquest Verdict
Sam Elphick	M	17	15/09/2005	Self-Inflicted	HM YOI Hindley	Awaited
Gareth Price	M	16	20/01/2005	Self-Inflicted	HM YOI Lancaster Farms	Awaited
Adam Rickwood	M	14	09/08/2004	Self-Inflicted	Hassockfield STC	Awaited
Gareth Myatt	M	15	19/04/2004	Restraint	Rainsbrook STC	Awaited
Ian Powell	M	17	06/10/2002	Self-Inflicted	HMP Parc	Misadventure
Joseph Scholes	M	16	24/03/2002	Self-Inflicted	HM YOI Stoke Heath	Narrative verdict
Kevin Jacobs	M	16	29/09/2001	Self-Inflicted	HM YOI Feltham	Suicide + neglect
Mark Dade	M	16	27/07/2001	Self-Inflicted	HM YOI Wetherby	Misadventure
Anthony Redding	M	16	15/02/2001	Self-Inflicted	HM YOI Brinsford	Accidental Death
Kevin Henson	M	17	06/09/2000	Self-Inflicted	HM YOI Feltham	Suicide
Philip Griffin	M	17	01/08/2000	Self-Inflicted	HM YOI Wetherby	Misadventure
David Dennis	M	17	30/05/2000	Self-Inflicted	HM YOI Brinsford	Suicide
Anthony Howarth	M	17	29/08/1999	Self-Inflicted	HM YOI Hindley	Suicide
Kirk Edwards	M	17	30/05/1999	Self-Inflicted	HM YOI Wetherby	Suicide
John Keyworth	M	17	10/11/1998	Self-Inflicted	HM YOI Hindley	Accidental Death
Nicholas Whelan	M	16	09/07/1998	Self-Inflicted	HM YOI Glen Parva	Suicide
Colin Scarborough	M	17	17/04/1998	Self-Inflicted	HM YOI Doncaster	Suicide
Lee Wagstaff	M	17	17/01/1997	Self-Inflicted	HM YOI Hindley	Suicide
Ryan Winter	M	17	13/08/1996	Self-Inflicted	HMP YOI Lewes	Open
Mark Weldrand	M	16	03/12/1995	Self-Inflicted	HMP YOI Doncaster	Accidental Death
Chris Greenaway	M	16	02/10/1995	Homicide	HM YOI Stoke Heath	Unlawful Killing
Andrew Batey	M	17	08/08/1994	Self-Inflicted	HM YOI Low Newton	Suicide
Joseph Stanley	M	17	10/05/1994	Self-Inflicted	HMP Cardiff	Suicide
David Stewart	M	17	13/09/1993	Self-Inflicted	HMP YOI Exeter	Open
Patrick Murphy	M	16	02/05/1992	Self-Inflicted	HM YOI Deerbolt	Suicide
Jeffrey Horler	M	15	22/09/1991	Self-Inflicted	HM YOI Feltham	Accidental Death
Craig Walsh	M	15	26/10/1990	Self-Inflicted	HM YOI Glen Parva	Open
Simon Willerton	M	17	12/08/1990	Self-Inflicted	HMP Armley, Leeds	Open
Philip Knight	M	15	12/07/1990	Self-Inflicted	HMP Swansea	Open

Source: INQUEST Casework and monitoring