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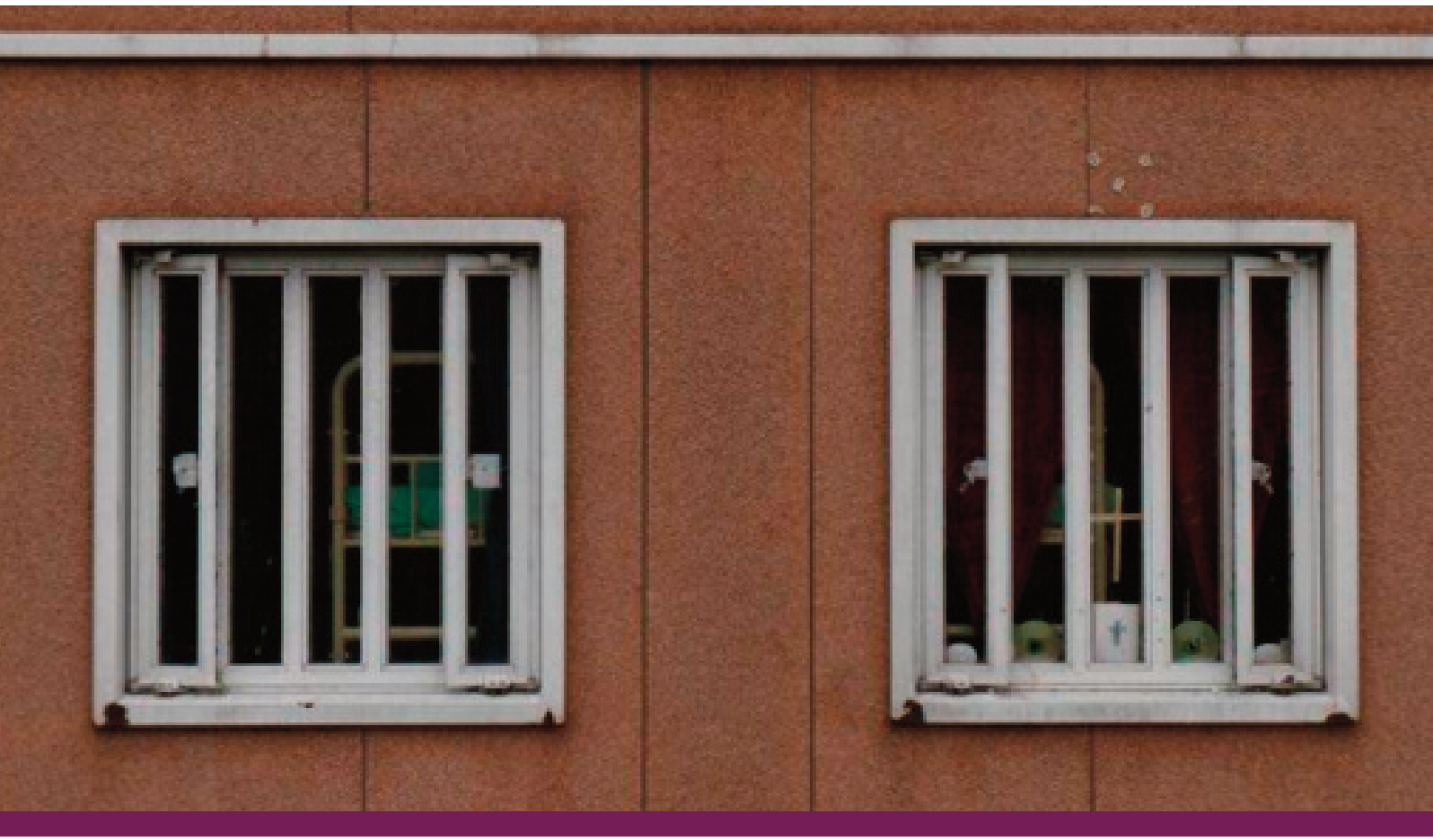

Fatally flawed:

Has the state learned lessons from the deaths of children and young people in prison?

The work of the Prison Reform Trust is aimed at creating a just, humane and effective penal system. We do this by enquiring into the workings of the system; informing prisoners, staff and the wider public; and by influencing Parliament, government, and officials towards reform.
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INQUEST is a charity that provides advice, information and specialist casework to bereaved families and their lawyers following contentious deaths, particularly in detention, and links the issues arising to its strategic policy and campaigning work with parliamentarians, policymakers, the media and the wider public.
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The Diana, Princess of Wales Memorial Fund continues the Princess' humanitarian work in the UK and overseas. By giving grants to organisations championing charitable causes, advocacy, campaigning and awareness raising, the Fund works to secure sustainable improvements in the lives of the most disadvantaged people in the UK and around the world.
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First published in 2012 by Prison Reform Trust

ISBN: 978-1-908504-03-6

Photo credit: Edmund Clark www.edmundclark.com

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Acknowledgements

This report, Fatally Flawed, was written by Anna Edmundson and Deborah Coles at INQUEST (with contributions from colleagues Helen Shaw, Scarlet Granville, Richard Fontenoy and Jo Easton), Rebecca Nadin at the Prison Reform Trust and Dr Jessica Jacobson, independent policy researcher/consultant.

INQUEST has been identifying trends and concerns emerging from the deaths of children and young people in prison custody since the death of 15 year old Philip Knight in 1990. Between 2003 and 2010 INQUEST provided specialist casework services to the families of each of the five children, and two thirds of the young people who died in custody. Specialist casework means the provision of a comprehensive service to a bereaved family from the point of contact until the conclusion of any legal procedures that is then linked to related policy and parliamentary work. INQUEST's research and policy work draws on this experience and includes the first detailed analysis of this subject published in 2005: In the Care of the State? Child deaths in Penal Custody in England and Wales by Barry Goldson and Deborah Coles (supported by The Diana, Princess of Wales Memorial Fund).

This report relies on INQUEST's unique dataset: a combination of the available official statistics and the material available from INQUEST's casework which entails detailed monitoring and involvement in actual investigations and inquests into individual deaths alongside bereaved families and their legal teams.

INQUEST is extremely grateful to the families and friends of the children and young people whose individual stories are profiled in this report for sharing their experiences and deepening our understanding of the complex issues involved. We are also indebted to the members of the INQUEST Lawyers' Group who advised and represented the families, often over many years, and who ensured the circumstances of the death were scrutinised as robustly as possible.

This report was commissioned by the Prison Reform Trust as part of its Out of Trouble programme to reduce children and youth imprisonment in the UK. Out of Trouble has been generously supported by The Diana, Princess of Wales Memorial Fund for five years.

Foreword

May I say from the start how much I welcome this report and hope that the Justice Secretary and Ministerial colleagues across government departments will read, mark and learn from its findings and recommendations. Too often 'tough' talk about crime and punishment does not result in the authoritative action needed to rectify the flaws in our criminal justice system. This system and services in the community, whose failures are described in the report, have demonstrably let young people down, for all the wrong reasons, for far too long.

In May 1999 HM Inspectorate of Prisons, of which I was then the Chief Inspector, published a thematic review entitled 'Suicide is Everyone's Concern', based on exactly the same concerns that prompted Fatally Flawed. Regretting their lack, we called for focussed policies for young people, including the need to train, support and supervise staff to enable them to better understand and manage disturbed and disturbing young people.

But my prime concern was the lack of a proper framework within which any improvements could be implemented. At the time I stated that '…suicide and self-harm can and will be reduced, and that accountability for that reduction begins at the top and goes right down to the bottom'.

That was thirteen years ago, but the principle is the same. Until and unless named individuals are made responsible and accountable for ensuring that things happen, nothing will happen. I think that it should be a matter of serious concern that the findings in Fatally Flawed echo what has been said, repeatedly, for years, and are a devastating indictment of bad practice.

Since that date, however, another sanction that sets out the responsibilities held by the Justice Secretary and the Chief Executive of the National Offender Management Service has entered the arena. The provisions of the Corporate Manslaughter and Corporate Homicide Act now apply to people in prison, meaning that management failure, identified in inquiries and inquests, can result in legal action. As poor and inconsistent management, manifested in the failure to implement lessons learned, is behind most of the findings, I hope that a system is developed that holds named managers to account for overseeing policy implementation and improving practice.

I hope that this will be the last report on avoidable failure, resulting in the human tragedies that are so starkly described. If those responsible listen to those whose motivation stems from their understanding of the needs of both victims and ill-supported staff, and positive action results, then the authors of this report will have performed a more valuable service than merely updating old concerns. In particular I hope that Ministers and officials will meet with, and listen to, some of the families of victims, remembering the deep impression that the dreadful experiences, and delays in the inquest process, recounted by those brought to us by INQUEST, during the preparation of our thematic report, made on me and my colleagues. But that depends on whether the state can at last learn lessons and if the Justice Secretary and Ministerial colleagues will act to put a flawed system right. I wholeheartedly endorse this report's final recommendation that an independent review be established, with the proper involvement of families, to examine the wider systemic and policy issues underlying the deaths of children and young people in prison.

Lord Ramsbotham

Summary

The inquests and investigations into the deaths of children and young people in prison between 2003 and 2010 reveal that they were often very vulnerable and that none received the level of support and protection they needed. In many of the cases, the fact that they were in prison in the first place can be seen as symptomatic of failures by agencies within and outside the criminal justice system to address their multiple, often complex, needs. The detailed stories of six of the children and young people who died in prison which feature in this report vividly illustrate the extent of their vulnerabilities and the shortcomings of their treatment both within the justice system and by agencies outside.

The information and evidence collated for this report revealed common themes in the experiences and treatment of children and young people who died in prison between 2003 and 2010. These overlapping findings included that they:

1 were some of the most disadvantaged in society and had experienced problems with mental health, self-harm, alcohol and/or drugs;
2 had significant interaction with community agencies before entering prison yet in many cases there were failures in communication and information exchange between prisons and those agencies;
3 despite their vulnerability, they had not been diverted out of the criminal justice system at an early stage and had ended up remanded or sentenced to prison;
4 were placed in prisons with unsafe environments and cells;
5 experienced poor medical care and limited access to therapeutic services in prison;
6 had been exposed to bullying and treatment such as segregation and restraint;
7 were failed by the systems set up to safeguard them from harm.

Our analysis also found there had been:

8 inadequate institutional responses to the deaths of children and young people in prison.

Our findings indicate there have been failures in how the state treats children and young people in conflict with the law and that the learning and recommendations from inquests and investigations into previous deaths have not been properly implemented. The question this report addresses is whether the State can learn lessons from the deaths of children and young people in prison and act now to put right the flaws identified in order to prevent further deaths in the future.

1. Introduction

The death of Joseph Scholes

The death of 16 year old Joseph Scholes in 2002 raised so many serious questions about his experiences and treatment that it sparked calls for a public inquiry. The then Government rejected those calls and an inquiry has never been held. This report is an analysis of trends and evidence derived from the deaths of children and young people between 2003 and 2011, after the call for a public inquiry was first made and rejected. It has a particular focus on the findings of the investigations and inquests into the deaths of 98 children and young people who died in prison between 2003 and 2010. It examines what, if any, lessons have been learned from Joseph's death, and those of the other children and young people whose stories are told in this report.

Joseph Scholes[1]

Joseph Scholes was 16 when he died in Stoke Heath young offender institution (YOI) in March 2002. He was nine days into a two-year sentence for robbery. The inquest into his death heard from a number of experts that Joseph should not have been placed in the YOI prison setting, and the jury noted in their verdict that 'risk was not properly recognised and appropriate precautions were not taken to prevent it'.

Joseph's early childhood was unsettled. From the age of six he had allegedly been severely and repeatedly sexually abused by a member of his father's family. As he got older, he became increasingly distressed and started to self-harm. In 2001 he attempted suicide by taking an overdose and trying to jump from a window, receiving a community sentence following an altercation with ambulance workers. His challenging behaviour became too difficult for his mother to manage, and he was taken into what she hoped would be the specialist care of the local authority, who placed him in a children's home.

A week after his arrival, Joseph went out drinking with other children from the home. In the course of the evening, they encountered another group of children and demanded their money and mobile phones. As a result, Joseph was charged with robbery. Such behaviour was out of character.

As Joseph's court appearance approached he became increasingly anxious and his self-harming escalated. When he was sentenced, it was acknowledged that, although he had been present during the robbery, he had played a peripheral role and had not threatened or committed any physical violence. The Crown Court judge who passed sentence had reports from social workers, the youth offending team and a consultant psychiatrist, all of which identified Joseph's vulnerability. The judge stated that he wanted the warnings about Joseph's self harming and alleged sexual abuse 'most expressly drawn to the attention of the authorities'. His mother also telephoned Stoke Heath to inform them of his risk.

Given Joseph's recognised vulnerability, the Youth Justice Board had the power to place him in a secure children's home or secure training centre; however, no such placement was available and he was sent to HM YOI Stoke Heath. On arrival, because staff had been made aware of his vulnerability, Joseph was placed in a cell under intense observation. He wore a canvas garment with Velcro fastenings, described at the inquest as a 'horse blanket', under which he was naked. He was not seen by a psychiatrist. Joseph repeatedly told staff that he would kill himself if he was moved to a normal location in the YOI. Nevertheless, staff proceeded with an incremental transition to the main YOI by moving him into a cell in the health care centre where he was less intensely observed.

Nine days after arriving at Stoke Heath, Joseph made a noose from a bed-sheet and hung himself from the bars of his cell. His body was discovered by a maintenance worker who had been called to the health care centre to unblock toilets. Joseph left a message for his mother and father telling them he couldn't cope and that 'I tried telling them and they just don't fucking listen.'

In November 2003, Joseph's mother (supported by INQUEST and Nacro) called for a public inquiry into his death:

> *When mothers hand over the care of their children to the state, they expect a role to be fulfilled. When a policeman knocks on your door and tells you your son has died whilst in the care of the state, hundreds of questions have to be answered. Only a public inquiry can answer these.*[2]

Her call received overwhelming support from children's charities, the Prison Reform Trust and other penal reform groups, human rights organisations, leading members of the legal establishment, and over 100 MPs and Peers.

The April 2004 inquest into Joseph's death, at which Joseph's family was represented by specialist lawyers, returned a detailed narrative verdict. Afterwards, the coroner took the exceptional step of writing to the Home Secretary recommending a full public inquiry into "all the circumstances…include[ing] sentencing policy which is an essential ingredient but outside the scope of this inquest".[3] The Parliamentary Joint Committee on Human Rights also supported the call for a public inquiry so as to ensure that "lessons can be fully learnt from the circumstances that led up to his tragic death".[4]

The call for a public inquiry was rejected by the Government in 2006 on the grounds that it "was unlikely to bring to light any additional factors not already uncovered in previous investigations". A letter to Mrs Scholes' lawyer stated that:

> *Having given proper consideration to the question, the Minister did not consider that a full public inquiry would be the best or most appropriate response.*[5]

In the ten years since Joseph's death, a further nine children and 188 young people have died in prison.[6]

Joseph's inquest raised a number of serious concerns about the treatment of vulnerable children and young people within the criminal justice system; concerns which have resurfaced in subsequent inquests held into the deaths of children and young people but which have not yet been adequately addressed. Many of the investigations and inquests into these individual deaths made recommendations for change and pointed to lessons that needed to be learned for the future. However, there has not been a concerted attempt to gather together and scrutinise the information emerging from all these reports and reviews and as a result, the issues underlying the deaths have never been properly examined or addressed.

There is no starker illustration of this than the self-inflicted deaths of two children in young offender institutions, within a week of each other, in January 2012. Jake Hardy, aged 17, was serving a six month sentence in Hindley YOI for affray and common assault. He was found hanging in his cell late at night on 20 January; he was taken to hospital and

subsequently pronounced dead on the morning of 24 January. In the evening of the 24 January, 15-year-old Alex Kelly was found hanging in his cell at Cookham Wood YOI where he was serving a 10 month sentence for theft from a dwelling and motor vehicle. He was pronounced dead the following day in hospital.[7]

This report seeks to address this gap in analysis and to illuminate both the immediate and broader circumstances of these deaths in prison by drawing together the learning from the official inquests and investigations that followed them. This enables a critical examination of what has and, more importantly, what has not changed following individual deaths. This recognition of where there are significant shortcomings in the protection and support available to vulnerable children and young people in trouble with the law – both within and outside the criminal justice system – is the first step towards addressing the issues that underlie many of the deaths discussed in this report. It is hoped that this report will contribute to the development of much needed change in the way we treat children and young people in conflict with the law.

Structure of the report

This report comprises seven chapters. Chapter 2 provides an overview of the inquest and investigation process and the application of Article 2 of the European Convention on Human Rights. Chapter 3 outlines the issues relating to deaths in prison among children and young people. Chapter 4 then looks in closer detail at the backgrounds and circumstances of the children who have died, through a discussion of the general population of children in prison, and the presentation of the circumstances leading up to a small number of individual deaths. Chapter 5, which follows a broadly similar structure, focuses on deaths among young people in prison; it also includes an analysis of the vulnerabilities of young people and children who have died in prison. Chapter 6 sets out the main findings and discusses the key issues and learning to emerge from the preceding accounts and chapter 7 presents a set of recommendations for improving provision for the most vulnerable children and young people, and thereby reducing the risk of deaths in prison.

Terminology and methodology

Throughout this report, the term 'children' is used to refer to individuals under the age of 18,[8] and the term 'young people' to refer to individuals aged 18 to 24.[9] The report's focus on the 18 to 24 age group (alongside children) reflects the fact that this is a group within the criminal justice system who have particular needs which are frequently unrecognised and unmet. The Prison Reform Trust is a member of the Transition to Adulthood (T2A) Alliance, a coalition of organisations and individuals making the case for a distinct and radically different approach for 18 to 24 year olds within the criminal justice system.[10]

The term 'prison' is used to refer to all forms of prison custody used for children and young people including secure training centres (STCs), young offender institutions (YOIs) and, in the case of young people, adult prisons. It does not include police custody. The information on the deaths of children and young people in prison presented over the course of this report derives from several sources.

The quantitative data is primarily derived from analysis of INQUEST's statistics and monitoring databases which include: official statistics; answers to parliamentary questions and freedom of information requests; INQUEST's casework and media monitoring as well as (from 1996) individual notifications of each death in prison; and detailed statistical tables provided to INQUEST by the Prison Service, National Offender Management Service and Ministry of Justice.

The qualitative data has been collated from INQUEST's casework database and analysis of case files. This includes: information from the families of children and young people who have died in prison; details gathered from official investigations into deaths (including Prisons and Probation Ombudsman reports which are not automatically published on the PPO website); and INQUEST's records, notes, verdicts and Rule 43 recommendations from the inquests.

2. The investigation and inquest process

Material and learning emerging from investigations, reviews and inquests are the source of key parts of the data on the deaths of children and young people presented in this report.

Prisons and Probation Ombudsman investigations
Following a death in a secure children's home, secure training centre (STC), young offender institution (YOI) or adult prison there will be an initial police investigation to determine if there was third party involvement. In most cases this will be quickly established, and if there is no further police investigation the process is then handed to the Prisons and Probation Ombudsman (PPO), an independent investigatory body which has non-statutory powers to conduct an investigation into each death or 'fatal incident'.[11]

PPO investigators aim to find out as much as possible about what was happening to the person before their death, through, for example, examining relevant prison documents and policies and interviews with staff and prisoners. The PPO is "committed to putting family and friends at the centre of all investigations into deaths in custody."[12] As well as interviewing families and aiming to ensure their concerns are addressed by the investigation, families are given an opportunity to comment on the draft investigation report before it is finalised. The local primary care trust will also carry out a clinical review of the health care provided to the person before their death. The investigation process is often complex and lengthy. On completion of the investigation, the PPO produces a report which is passed to the coroner who will then determine whether any additional enquiries are needed and set a date for an inquest hearing.

In some cases, once the inquest has taken place the PPO publishes an anonymised version of the final report on their website. However, not all PPO reports are published and available for public examination.

Serious Case Reviews
Since April 2008, Local Safeguarding Children Boards (LSCBs) are obliged to carry out reviews following any unexpected child death in their area – including those in prison. This process involves a serious case review and the setting up of a LSCB sub-committee including a consultant paediatrician from the local NHS primary care trust (PCT) and other relevant agencies such as the Crown Prosecution Service and the coroner, where appropriate. The serious case review process is intended to work in parallel with other investigative processes with the emphasis on learning lessons.[13] This process does not take place in public and, although an increasing number of overviews and executive summaries of serious case review reports are published, the full reports are not usually made available.

The inquest

An inquest is defined in statute as an inquisitorial fact-finding exercise, and is directed towards addressing four key questions: who the deceased was; where the deceased came by their death; when the deceased came by their death; and how the deceased came by their death.

Since two House of Lords' judgments in 2004[14] it has been clear that deaths in custody will engage the right to life protected by Article 2 of the European Convention on Human Rights. This means that investigations and inquests into these deaths are required to be thorough and far-reaching and the inquest must examine the broader question of `in what circumstances' the death occurred.

The European Convention on Human Rights

Article 2 of the European Convention on Human Rights means there are 'minimum standards which must be met, whatever form the investigation takes' following a death in custody.[15] Those minimum standards are:[16]

- the investigation must be independent
- the investigation must be effective
- the next of kin must be involved to an appropriate extent
- the investigation must be reasonably prompt
- there must be a sufficient element of public scrutiny
- the state must act of its own motion and cannot leave it to the next of kin to take conduct of any part of the investigation.

The purposes of the Article 2 procedural duty include:[17]

- ensuring that the full facts are brought to light
- that culpable and discreditable conduct is exposed and brought to public notice, and those responsible are identified and brought to account
- that suspicion of deliberate wrongdoing (if unjustified) is allayed
- identifying and rectifying dangerous practices and procedures
- ensuring that lessons are learned that may save the lives of others[18]
- safeguarding the lives of the public, and reducing the risk of future breaches of Article 2.

Narrative verdicts

Following the landmark Article 2 judgments in the House of Lords, inquest juries now increasingly return narrative verdicts. This is a detailed form of inquest verdict in which a jury can establish any disputed facts and give an explanation of what they think are the most important issues contributing to the death, including identifying individual or systemic failings.

The fuller account given in narrative verdicts has a range of potential benefits including making the inquest process more meaningful and fulfilling for bereaved families because they often reflect the full range of evidence heard at the inquest. Narrative verdicts also

allow coroners' courts to record comments on failings that have not directly contributed to the death but caused unnecessary distress to an individual as they died. Crucially, in the context of this report, they can also:

> *act as a valuable learning tool for state agencies responsible for implementing policy and practice and make a significant contribution to the prevention of similar future fatalities. Common subjects of narrative verdicts now include delays in discovering a self-suspension; identifying key systemic communication failures between different professionals and other system failures; lack of first aid training; delays in arranging transfer to hospital; and the non-availability of suitable emergency equipment.*[19]

Narrative verdicts are not collated, analysed or published by central government.

Coroners' Rule 43 reports

Under Rule 43 of the Coroners Rules 1984, a coroner has the power to announce that he or she intends to report the circumstances of death to those authorities who have the power to take action to prevent the recurrence of such fatalities. In 2008, an amendment was made to the Rules which means that coroners now have a wider remit to make reports to prevent future deaths. A person or organisation who receives a report must now send the coroner a written response within 56 days outlining what action has been taken in response to the report or giving an explanation if no action has been taken. A copy of the report and responses is sent to the Lord Chancellor at the Ministry of Justice.

Current difficulties with accessing Rule 43 reports cannot be underestimated. The Ministry of Justice publishes a *Summary of Reports and Responses under Rule 43 of the Coroners Rules* containing short summaries of Rule 43 reports. However, these are filtered, scant in detail and not a comprehensive overview of the reports. There is no publicly-accessible database or website which allows access to these key reports: for coroners, prisons, healthcare bodies, local authorities or central government.

Corporate Manslaughter and Corporate Homicide Act 2007

The Corporate Manslaughter and Corporate Homicide Act 2007 should be a new tool to address problems of repeated deaths in similar circumstances. The Act came into force in September 2011 and creates a new legal framework in which custodial agencies should receive and respond to the findings of investigations and inquests into the deaths of children and young people. Under the Act an organisation can be found guilty of corporate manslaughter if the way in which its activities were managed or organised resulted in a death and amounted to a gross breach of a relevant duty of care to the deceased. Section 2(1)(d) of the Act means the offence can be applicable to custody providers. It is not yet clear how the Act will be interpreted by prosecuting authorities and the courts or whether it will have a deterrent effect by forcing custody providers to address known problems to prevent future deaths and culpability under the new legislation.

Coroners and Justice Act 2009

The current inquest process is beset with practical problems including lengthy delays, which are distressing, affect the bereavement process for families, and frustrate the possibility of timely organisational learning to assist in the prevention of further deaths. The Independent Advisory Panel on Deaths in Custody has gathered data from coroners which showed that, between August 2010 and January 2011, approximately 25% of death in custody inquests were taking more than two years to complete.[20] The reasons given by coroners for the delays included outstanding investigations by other bodies such as the PPO and resources.

The Coroners and Justice Act 2009 will provide a new legal framework for the inquest system. In November 2011, following parliamentary pressure and a successful campaign led by INQUEST and The Royal British Legion, the government announced that it would implement the majority of provisions in the Act and appoint a Chief Coroner to offer national leadership and judicial oversight to the fragmented coroners' system. Key sections of the Coroners and Justice Act 2009 are expected to be implemented from 2013 though some fundamental provisions (including those relating to appeals) will not be brought into effect. Though the provisions in the Coroners and Justice Act are likely to have a positive impact on some of the problems in the current coroners' system they will not be a panacea and will not, for example, expand the scope of inquests to address some of the broader, underlying issues relating to deaths in prison such as sentencing policy or practice (as in Joseph Scholes' death).

Investigations and inquests following the deaths of children and young people in prison

With regard to child deaths in prison, *In the Care of the State?* by Goldson and Coles argues that:

> *The limited independence and effectiveness of investigation and inquest processes, their circumscribed scope, the ongoing impediments to disclosure and transparency and protracted bureaucratic proceedings all combine to seriously impede family participation…*
>
> *Investigations and inquests following child deaths in penal custody simply do not allow for a thorough, full and fearless inquiry, for discussion of the wider policy issues, or for accountability of those responsible at an individual or institutional level. Neither do they necessarily facilitate an honest and open approach that might help ensure that changes are made to prevent future child deaths in similar circumstances.*[21]

Despite the obstacles to their involvement, bereaved families and their legal representatives in inquests have played a crucial role in uncovering previously hidden information on practices and treatment of children and young people in prison and flaws in the current system. Shaw and Coles have explained the practical effect of this participation:

> *In pushing at the boundaries of the inquest system lawyers instructed by families have helped to expose systemic and practice problems that have contributed to deaths. Many of the changes to…officer training and guidance, changes to the law in relation to inquests, increases in information entering the public domain about deaths in custody, and increased public awareness of the issues have been a direct consequence of the deceased's family's participation in the inquest proceedings and lobbying work thereafter for change.*[22]

A large amount of the evidence analysed for this report relies on previously unpublished material. This may not have been available for public scrutiny had bereaved families and their lawyers not been actively involved in the investigation and inquest process.

3. Deaths in prison

This chapter provides a brief overview of deaths of children and young people in prison (including STCs, YOIs and adult prisons) over the past 21 years – that is, from 1990 to 2011. Drawing on the more detailed information that is available for the latter part of this period, the second and third sections of the chapter provide an analysis of, respectively, the deaths of children and young people between 2003 and 2011.

Unless otherwise stated, the data presented over the course of this chapter is derived from analysis of INQUEST's casework and monitoring. INQUEST's sources include casework, media monitoring, official statistics, and questions asked in Parliament, as well as (from 1996) individual notifications of each death in prison provided to INQUEST by the Prison Service/National Offender Monitoring Service/Ministry of Justice.

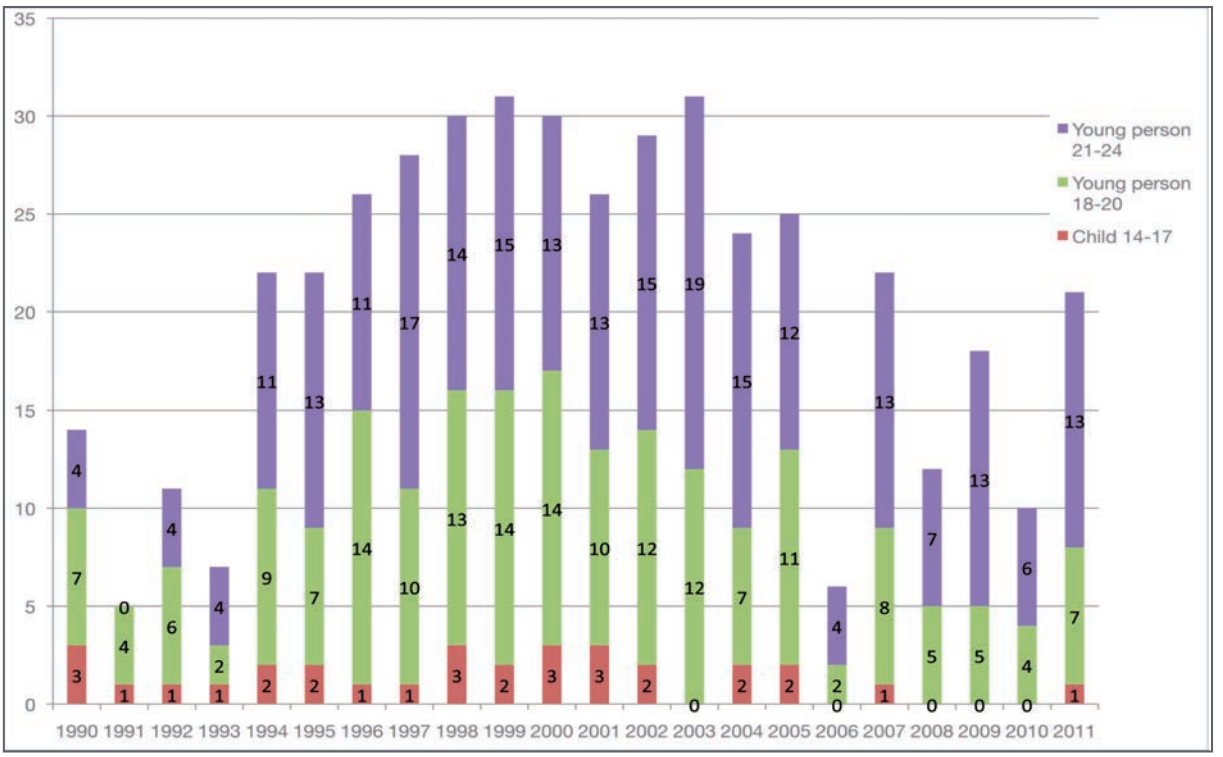
Deaths of children and young people in prison, 1990 to 2011

Joseph Scholes was one of thirty-one children aged 14 to 17 – all boys – who died in prison over the 21-year period 1990 to 2011. Twenty-nine of these deaths were self-inflicted; one was restraint-related and one a homicide.

Over the same 21 year period - 1990 to 2011 - 419 young people aged 18 to 24 died in prison, of whom 380 were young men, and 44% (183) in the 18 to 20 age group. Almost nine in ten of the deaths of young people (87%, or 363) are classified as self-inflicted.[23]

As shown in Figure 3.1, the number of deaths in prison fluctuated from year to year – with the largest cluster of deaths occurring from 1996 to 2003 (inclusive), during which there were between 26 and 31 deaths each year.

Figure 3.1: Total number of deaths of children and young people in prison, 1990-2011



(Source: INQUEST casework and monitoring)

Deaths of children in prison, 2003-2011

Over the years 2003 to 2011, six children died in prison. All were boys and five were white, while one (Gareth Myatt) was from a mixed race background. The youngest of the boys was Adam Rickwood, who died in August 2004 at the age of 14; of the others, two were aged 15, one 16, and two 17.

As shown in Table 3.1, two of the boys who died were being held in secure training centres (STCs), which are privately run institutions; the other four were in Prison Service-run young offender institutions (YOIs). While Adam Rickwood and Ryan Clark were on remand at the time of their deaths, the others had been convicted.[24] Five of the boys deaths were self-inflicted by hanging, but one – 15 year old Gareth Myatt – died in 2004 from 'positional asphyxia' as a direct result of the use of restraint on him by STC staff.

Table 3.1: Circumstances of child deaths in prison, 2003-2011

Name	Date	Age	Institution type	Legal status	Cause of death
Gareth Myatt	2004	15	STC	Convicted	Positional asphyxia – restraint-related
Adam Rickwood	2004	14	STC	Remanded	Hanging – self-inflicted
Gareth Price	2005	16	YOI	Convicted	Hanging – self-inflicted
Sam Elphick	2005	17	YOI	Convicted	Hanging – self-inflicted
Liam McManus	2007	15	YOI	Convicted	Hanging – self-inflicted
Ryan Clark	2011	17	YOI	Remanded	Hanging – self-inflicted

Source: INQUEST casework and monitoring

Deaths of young people in prison, 2003-2011

Over the period 2003 to 2011, a total of 163 young people aged 18 to 24 died in prison. Of these 163 deaths, 85% (138) have been classified as self-inflicted. Of the young people who died:

- 17 (10%) were young women, 16 of whose deaths were self-inflicted; the other death (dating from 2011) is awaiting classification.
- 38 (23%) were from black, Asian or minority ethnic (BAME) backgrounds - 79% of the deaths of BAME prisoners were self-inflicted.
- 61 (37%) were in the 18 to 20 age range - 92% of the deaths of 18-20 year olds were self-inflicted.

All the young people who died were in adult prisons or YOIs. One-third (54) were on remand at the time of their deaths; of the others, all but three were serving custodial sentences following conviction. The other three are recorded as having been in prison as 'immigration detainees' or 'awaiting deportation' at the time of their deaths.

The primary offences for which the young people who died had been convicted, or for which they had been remanded in custody,[25] are shown in Appendix Two. One-third had been convicted of, or charged with, a range of non-violent offences including theft or handling stolen goods (11%), burglary (8%), and breach of an order or licence conditions (3%). The remaining two-thirds of the young people who died had been convicted or charged with violent or sexual offences – ranging from murder or attempted murder (10%) at the most serious end of the spectrum to common assault at the least serious end (2%).

4. Children in prison

Children in prison: the statistics

The average child custodial population has reduced considerably in recent years. In June 2008, for example, there were 3,029 children in custody. By June 2012, this had fallen to 1,690, a 44% reduction. Likewise, the number sentenced to custody has also fallen. In 2000/01, 7,498 children were sentenced to custody, falling to 4,177 in 2010/11.[26] Use of remand is also thought to have reduced although different systems of measuring make direct comparisons difficult.

The breakdown of the population by type of establishment and legal status is shown in Table 4.1; Table 4.2 provides a basic demographic breakdown. (The figures derive from the YJB's monthly data and analysis June 2012 custody report).[27]

Table 4.1: Breakdown of under-18 custodial population by establishment type and legal status, June 2012 (n = 1,690)

Type of establishment	
Secure children's home	8%
Secure training centre	15%
YOI	77%
Legal status	
Remand	20%
Sentenced - DTO	60%
Sentenced - other	20%

Table 4.2: Demographic breakdown of under-18 custodial population, June 2012 (n = 1,690)

Gender	
Male	95%
Female	5%
Age	
12	<1
13	<1
14	3%
15	13%
16	27%
17	57%
Ethnicity[28]	
White	61%
Black, Asian & minority ethnic (BAME)	27%

As Table 4.2 shows, black, Asian and minority ethnic children (BAME) are over-represented amongst the child custodial population, accounting for more than one in four children in custody yet only 15% of the general 10-17 population.[29] The disproportionate number of black children is especially stark – whilst only 3% of children aged 10-17 in the general population are black, the proportion for children in custody is 14%. In addition it is worth noting that the significant total reduction in use of custody for children seen in recent year's masks considerable variation across ethnic groups. Whilst the number of white children in custody has halved (from 2,061 in June 2008 to 1,027 in June 2012), the respective reduction amongst BAME children has been 42% (from 776 in June 2008 to 452 in June 2012). These disproportionalities have yet to be fully analysed.

Children in prison: the legal and policy framework

In England and Wales, the age of criminal responsibility is 10 - considerably younger than in most other jurisdictions. The youth justice system of England and Wales deals with children aged between 10 and 17 who have offended or are alleged to have offended. Most criminal cases involving children are heard in the youth court, a specialised form of magistrates' court. Under certain circumstances, such as where the alleged offence is very serious, or where there are adult co-defendants, children can appear in adult magistrates' courts or the Crown Court.

Youth secure estate

The youth secure estate, to which children can be sent on remand or under sentence, comprises three types of institution:

- **Secure children's homes (SCHs):** Run by local authority social services departments, SCHs generally accommodate girls aged 12-16, boys aged 12-14, and boys aged 15-16 assessed as 'vulnerable'. The focus of SCHs is on meeting the physical, emotional and behavioural needs of children. Children generally follow a school day timetable. They have a high ratio of staff to children and tend to be small facilities, ranging in size from six to 40 places.

- **Secure training centres (STCs):** STCs are provided by private contractors commissioned by the Ministry of Justice for vulnerable children up to 17 years of age. Children in a secure training centre should receive up to 30 hours of education and training every week. Their ratio of staff to children tends to be 3:8, and their size ranges from 50 to 80 places.

- **Young offender institutions (YOIs):** YOIs are run by the Prison Service and the private sector and accommodate 15-18 year olds (separate YOIs accommodate young people up to the age of 21). YOIs hold the overwhelming majority of children in prison (more than three-quarters as of June 2012). Juvenile YOIs house between 200 and 440 individuals, and they have a lower ratio of staff to children than either STCs or SCHs. Children and young adults in YOIs are supposed to receive up to 25 hours of education, skills and other activities every week.

The Crime and Disorder Act 1998 established the Youth Justice Board (YJB) for England and Wales, a non-departmental public body that oversees the youth justice system. As well as having oversight of youth offending teams, the YJB is responsible for commissioning and placements in the secure estate; its duties include the delivery of a 'safer custody' agenda to minimise the likelihood of death or harm in prison. Thus children with identified needs and risk factors should be placed in establishments that can effectively manage those needs.

Once in the youth secure estate, there is a complex interaction between different state agencies owing various duties of care to imprisoned children. As well as the YJB, other public bodies have formal responsibilities with respect to detained children, including:

- the institutions themselves (STCs, YOIs, prisons) including those run by private contractors such as G4S and Serco
- the Prison Service[30]
- youth offending teams
- local authority social services departments[31]
- local health authorities.

Where children or young people have been in care or are care leavers, statutory guidance and regulations state that "where a…former relevant child enters custody, pathway planning must continue. The young person must be visited on a regular basis and it is good practice for the first visit to take place within ten working days of their placement".[32] There are also broader duties on local authorities to continue to provide support to care leavers up to the age of 21 (and up to the age of 25 for those wishing to undertake a programme of education or training), including by visiting those who end up in prison.[33]

Remand

Children on remand typically account for between one-fifth and one-quarter of all children in prison; however, because their average stay in prison is shorter than for those under sentence, they account for a larger proportion of prison receptions.[34]

Children who are imprisoned on remand have been refused bail either prior to conviction or after conviction but prior to sentence. There are currently two routes by which a child may be remanded by the courts: first, a court-ordered secure remand to an SCH or STC; secondly, a remand in custody, whereby the child will be placed in a YOI. (Additionally, a child may be remanded by the court to local authority accommodation, and the local authority may then apply for the child to be held in secure accommodation). The route taken by the court depends on the age and gender of the child, and whether the child is considered to be at risk of harm to themselves or others. Specifically, boys aged 15-16 will only receive a court-ordered secure remand if they are deemed 'vulnerable' on the grounds of being physically or emotionally immature, or having a propensity to harm themselves; otherwise boys in this age bracket, along with boys and girls aged 17, are remanded in custody.[35]

From November 2012, a new framework[36] comes into force which will simplify the remand decision-making process, raise the threshold for secure remand, and make all children who are remanded 'looked after'. As of April 2013, the relevant budget will be devolved to local authorities. Vulnerability will no longer be a specific criterion of secure remands, as all children will be subject to the same order, and the criteria for placing children on remand will be the same as that for sentenced children. It is expected that the new framework will see fewer children imprisoned on remand.

Sentencing

Children under sentence make up the bulk of the population of children in prison. Several types of custodial sentence for children are available to the courts, of which the detention and training order (DTO) is by far the most commonly used. This is a sentence for 12 to 17 year olds varying in length from four to 24 months; the first half is spent in prison and the second half in the community under supervision. As with all other custodial sentences (whether applied to children or adults) a DTO can only be imposed if the court deems the offence "so serious that neither a community sentence nor a fine alone can be justified".[37] Children aged 10 to 17 who have committed the most serious offences can be sentenced - by the Crown Court only – to a mandatory life sentence; long-term detention for 'grave crimes' other than murder; or detention for public protection[38] or an extended sentence for public protection.

While, by law, custody can only be imposed on a child (as indeed on an adult) where the offence is 'so serious' that no other penalty can be justified, there is ample research evidence that many children are in fact imprisoned for offences that are not very serious. Research by Barnardo's into custody thresholds applied to 12-14 year olds concluded that "Parliament's clear intention of making custody for such young children genuinely a last resort is not reflected in sentencing practice".[39] Prison Reform Trust research found that around three-fifths of the 3,151 children sentenced to custody in the latter half of 2008 were convicted of offences that usually result in non-custodial sentences, and thus were at the less serious end of the spectrum of offending; while around half of the children were imprisoned for non-violent offences. Overall, just over one third were imprisoned for offences that were both less serious and non-violent.[40]

Multiple disadvantage

> *The lives of children and young people in prison are characterised by social inequality; educational failure; drug, alcohol and mental health problems; experience of abuse, bereavement and neglect that go hand in hand with high offending rates. Their custodial experience exacerbates and compounds this vulnerability.*[41]

It has been well-established through a range of research studies that children in prison are among the most disadvantaged in society; and that, moreover, these children tend to experience multiple and interlocking layers of disadvantage.[42] Studies cited in the Bromley Briefings Prison Factfile[43] have found that among children in prison:

- 27% of boys and 55% of girls reported having spent time in care
- One in eight had experienced the death of a parent or sibling
- Two out of five girls and one out of four boys reported suffering violence at home
- 40% had previously been homeless
- 86% of boys and 82% of girls reported having been excluded from school, and around half said they were last in education aged 14 or younger
- 23% had learning difficulties (IQ of below 70) and 36% borderline learning difficulties (IQ between 70 and 80)
- 39% of girls and 34% of boys had a problem with drugs on arrival at their establishment.

The high prevalence of emotional and mental health problems among children in prison is a particular concern. A 2002 study found that among 12-17 year old boys in secure care (that is, accommodated in secure children's homes on either criminal justice placements or welfare placements), 91% had a conduct disorder, 22% major depression and 17% generalised anxiety disorder.[44] Other research found high levels of mental health problems among 17 year old girls in YOIs: for example, 71% of 73 respondents had some level of psychiatric disturbance, a figure which rose to 86% when long-standing disorders were included.[45] A review of international research literature concluded that "prevalence of mental health problems for young people in contact with the criminal justice system range from 25-81%, being highest for those in custody."[46]

Identifying and assessing 'vulnerability'

While vulnerability is currently an explicit element of court decisions on remand (with respect to type of remand and subsequent placement only),[47] it is not an explicit factor in sentencing decisions. However, vulnerability may form part of the mitigation considered by a sentencer in deciding whether or not to pass a custodial sentence, given that the courts are obliged (under the Children and Young Persons Act 1933) to 'have regard to the welfare of the child' in passing sentence. The Sentencing Council's guideline on Sentencing Youths notes various points to which the courts 'should be alert' in having regard to the child's welfare, which include "the vulnerability of young people to self-harm, particularly within a custodial environment".[48] Additionally, following a decision to impose a custodial sentence, vulnerability should be taken into account in the YJB's placement of a child within the secure estate. As noted above, children who are more vulnerable should be placed within SCHs or STCs rather than YOIs; in particular, SCHs are the more appropriate type of establishment for the youngest and most vulnerable children given their high staff-to-child ratio and focus on "attending to the physical, emotional and behavioural needs of the young people they accommodate."[49]

Although vulnerability is meant to be a key consideration in decisions by the courts and the YJB about whether and where to place children in prison, it is subject to differing definitions by different agencies. The YJB itself has argued that the concept is problematic:

> *Vulnerability is an imprecise term. It can cover a broad range of characteristics and behaviours. Some may be inconsequential and some very serious indeed. Defining a young person simply as 'vulnerable' is not helpful as it does not make clear to anyone else what the specific risks may be. The YJB is moving away from the term and talks in more precise terms about the young person's characteristics and how these may affect an assessment outcome, such as a placement decision.*[50]

Nevertheless, 'vulnerability' remains an important term in the ASSET assessment tool used by youth offending teams to collate information on all children who come into contact with the youth justice system. Guidance for YOTs states that within ASSET, vulnerability refers to "specific and direct risks that a young person may face", and can be due to "the behaviour of others, their own behaviour, or specific events and circumstances".[51] The 'core' ASSET form includes a section on 'indicators of vulnerability', which refers to "the possibility of the young person being harmed – either physically or emotionally", and includes a question about known problems during previous experiences of prison. Prior research for the Prison Reform Trust involved a survey of 200 ASSET forms that had been completed for children who subsequently received a custodial sentence. In 72 (over a third) of these forms, the response to the question: 'Are there any current concerns about vulnerability if s/he were to go to custody?' was 'yes'. Excluding the 'don't knows' (eight cases) and missing data (34), this amounted to almost half of the 158 cases for which there was an answer.[52]

Another route by which the vulnerability of a child in the youth justice system may be identified is through the completion of two mental health screening tools - the screening questionnaire interview for adolescents (SQIFA) and the screening interview for adolescents (SIFA). These assessments should be undertaken if a child's score on the emotional and mental health section of the ASSET is over a certain threshold.[53]

Liam McManus[54]

Liam McManus was 15 when he died at Lancaster Farms YOI in November 2007. He was being held for five weeks for breaching his licence conditions following earlier release from custody. He was found hanging from a bed-sheet tied to the window of his single cell.

Liam was a boy who loved football, was a good gymnast, and took great pride in being a member of the Sea Cadets. However, he had suffered significant loss and trauma in his early years. His father died when he was three, and he then moved in with his grandmother because his mother's heroin addiction rendered her unable to look after him; his grandmother died shortly thereafter. After a period in foster care, his uncle and aunt became his legal guardians, and he settled into their family alongside his four cousins. When he was ten, one of the cousins – whom he looked up to as an older brother – died.

According to Liam's uncle, in 2006 Liam 'got in with the local yobs' and started to drink heavily. By May 2007 he had committed four acts of theft from a shop and one of assault, for which he initially received a community sentence. Liam had extensive contacts with the youth offending team, social services, and mental health services. He was known to self-harm as well as to have a problem with alcohol. At 14 he had been diagnosed with ADHD, and his education had been interrupted by frequent truanting. 'Child in need' procedures had been invoked in the year prior to his death. Meanwhile, his social worker had re-introduced him to his birth mother, which had an unsettling impact on him.

Liam's first custodial sentence, of four months, was passed after he verbally abused a shopkeeper. He served much of this sentence at a secure children's home, to which he returned when subsequently sentenced for an offence of affray. Soon after his release from this second spell in custody, Liam breached his curfew and his licence was revoked. Around this time, social services closed his file following the departure of his allocated social worker.

Although it had been recognised at an earlier sentencing hearing that, because of his vulnerability, Liam should not be placed in the closed regime of Lancaster Farms YOI, this was where he was sent on 8 November 2009 for the licence breach. The YOT officer had recommended this, stating they felt that, after Liam's two previous stays at a secure children's home, he needed a fresh start somewhere different. The differences between the secure children's home where he had previously been held and the YOI's prison environment were stark. In particular, telephone contact with his family was much more limited at the YOI; and the family were unable to visit because, due to an administrative error, the only Visiting Order received from the institution was blank and had to be returned. Liam repeatedly asked staff when his YOT officer would visit him, but this visit also did not materialise during the 22 days he spent at the YOI.

Liam did not see the personal officer assigned to give him help and advice until 18 days into his time at the YOI; and an internal care planning meeting which should have taken place within ten days of his arrival in custody had not been held by the time of his death.

On 28 November, after completing his induction at the YOI, Liam was transferred to a new wing on a night when reduced staff levels meant that prisoners had not had association and were restless. Heightened shouting and bullying on the night of his death included calls for Liam to 'string up'. At 7.10am on 29 November, Liam was found hanging in his cell.

Liam's uncle has said: 'Despite all that he did, Liam was not a bad kid. He had his problems…But he never really had a chance.'

Mental health and self-harm

Prevalence of self-harm – extending in its most extreme form to attempted and actual suicide – has long been observed among children in prison, and particularly among girls. More than a third (36%) of girls in prison surveyed had harmed themselves in the past month.[55] Of a sample of 200 children sentenced to custody, 20% were reported to have harmed themselves and 11% to have attempted suicide (at any previous point in their lives).[56] Other research found that one in five of a sample of children in secure settings had (ever) attempted suicide, and two in five had harmed themselves.[57]

A Home Office study drawing on the views of children and young people themselves revealed that self-harm and suicidal thoughts were part of day-to-day life in a young offender institution. It cited a conversation between young men in a YOI:

> *"When you hang yourself all your problems are solved."*
> *"Well I can understand people hanging themselves, but when people cut their wrists that's just nasty. It was just coming out of his arm."*
> *"When I was in one YOI about three people tried hanging themselves."*[58]

Safety in Custody figures published by the Ministry of Justice reveal the number of self-harm incidents by 15 to 17 year olds in YOIs over the years 2004 to 2011 (these figures do not include under-18s held in secure children's homes and secure training centres).[59] As shown in Table 4.3 below, the annual number of self-harm incidents by 15 to 17 year olds reached a high of 1,473 in 2008, and dropped down to around half that number in 2011. The number of individuals harming themselves in this age category ranged between 318 in 2004 and 463 in 2009. The discrepancy between self-harm incidents and individuals who harm themselves reflects the tendency of individuals to injure themselves repeatedly. The gender breakdown included in Table 4.3 reveals that the small minority of girls in prison (5% as of June 2012) account for a disproportionate number who harm themselves, and that girls who harm themselves do so with greater frequency than boys and young men. The 2011 Safety in Custody report notes that "prisoners aged 15-20 years committed 5,783 incidents of self-harm in 2010. This represented 21% of all incidents during the year while this age group represented only 11% of the prison population."[60]

Table 4.3: Number of self-harm incidents and self-harming individuals among 15-17-year-olds in prison, 2004-2011

Year	All incidents	Male	Female	All individuals	Male	Female
2004	1,074	482	592	318	243	75
2005	1,260	610	650	437	346	91
2006	1,011	697	314	400	322	78
2007	1,101	504	597	366	285	81
2008	1,473	770	703	450	355	95
2009	1,085	751	334	463	398	65
2010	725	611	114	350	308	42
2011	722	536	186	326	298	28

Source: Ministry of Justice Safety in Custody Statistics Quarterly Bulletin January to March 2012, England and Wales, Statistical Tables: self-harm, Tables 2.3 and 2.4, www.justice.gov.uk/publications/statistics-and-data/prisons-and-probation/safety-in-custody.htm

Restraint

According to the Ministry of Justice, the use of restraint by staff on children should be "as a last resort, for example to prevent them causing harm to themselves or others".[61]

However, in 2010/11, there were 7,191 incidents of restraint involving children in prison, up 4% on the previous year. This amounted to an average 659 incidents involving 429 children every month.[62] These resulted in 259 injuries, 95% of which were minor,[63] although it is not uncommon for more serious injuries to result from staff interventions. Over a two year period, for example, children and young people in Castington YOI[64] sustained seven confirmed and three suspected fractures following the use of control and restraint techniques by staff. Likewise, between April 2007 and March 2009, 101 injuries were sustained by children during restraint at Medway STC. The use of handcuffs during restraint is not unheard of. Between 2006-2010, children in Hassockfield STC were restrained using handcuffs on 57 occasions.[65] A High Court ruling[66] has since found that, between the years 1998 and 2008, children (including Adam Rickwood) were restrained unlawfully, in pursuit of good order and discipline rather than as a measure of last resort.

Statistics also show that black, Asian and minority ethnic children (BAME) in prison are more likely to be restrained than white children. In 2010/11, for example, BAME children accounted for less than a third of the average child custodial population, yet 39% of monthly incidents of restraint.[67]

Specific concerns over the use of restraint, and the legality of techniques employed by staff in secure training centres emerged as a result of the investigation and inquests into the deaths of Gareth Myatt and Adam Rickwood. In the wake of their deaths, the government instigated a review of restraint in 2007.[68] The authors of the review observed:

> *The degree of violence and abuse to which many of these young people have been subjected in their short lives....is of huge concern to a civilised society....We learned very early on in the review that there is no such thing as 'entirely safe' restraint. Restraint is intrinsically unsafe. Even where it does not end in physical injury the experience and the memory can be profoundly damaging psychologically.*[69]

The report recommended better overview of the use of restraint and this led to the setting up of the Restraint Advisory Board (RAB) which was asked by the Ministry of Justice to consider the system of Physical Control in Care and Control and Restraint and make recommendations about improvements to safeguard children and young people in prison. RAB included specialists in paediatrics, pathology and behaviour management. In July 2012 the Ministry of Justice announced that RAB's recommendations would be adopted and a new system of Minimising and Managing Physical Restraint would be introduced for use in STCs and YOIs. The government recognised the new system was required to bring about a "significant cultural change in the way challenging behaviour is managed." [70]

The new system still allows for the deliberate use of pain-inducing restraint techniques on children in prison, despite the fact that some secure institutions do not use them: pain restraint techniques are prohibited in all SCHs and are no longer used in Hassockfield STC (where Adam Rickwood died).[71] The RAB called on the Restraint Management Board to "commission research into the feasibility of developing a restraint system which does not incorporate pain induction techniques",[72] a recommendation which was accepted by the Government.

The links between use of restraint and self-harm and suicide are, as yet, relatively un-explored. However, the evidence that emerged during the inquests into the deaths of Gareth Myatt and Adam Rickwood demonstrated that the use of force against vulnerable children, especially those who have experienced physical or sexual abuse, is severely distressing.

Adam Rickwood[73]

Adam was 14 years old when he died at Hassockfield secure training centre in August 2004, making him the youngest child to die in custody in England and Wales.

Adam had a history of self-harm. His behaviour deteriorated after the deaths of three close family members in the years before he was sentenced to custody. Over this period, he was struggling with the transition between primary and secondary school and was ultimately excluded from school. Adam's mother made concerted efforts to secure professional help for her son with limited success. As Adam's grandmother explained: 'My daughter battered her head off every wall she could find to get help for her son.'

Adam's initial contacts with the police were mostly limited to warnings received for riding old motorcycles over open ground near his home. However, on one occasion he clashed with a man in his 20s, which resulted in his facing a charge of wounding. He was bailed by the court on condition that he wore an electronic monitoring tag. After breaching this condition, he was sent to Hassockfield on remand. Despite the 300-mile round trip from home that this entailed, Adam's family made regular visits to see him. They became increasingly concerned about his emotional fragility and his mother asked that he be closely monitored.

The day before Adam was due to appear in court for a further bail application, he was ordered to go to his room by a member of staff and refused, at which point he was subjected to physical restraint. This was the first occasion on which he had failed to comply with a staff request.

Four members of staff (all male) were involved in restraining Adam. They utilised the 'nose distraction' technique, which entails applying pressure to the nose in order to inflict pain on the subject and to distract and confuse him. It caused Adam to bleed from the nose for approximately an hour and he suffered facial abrasions. The members of staff on duty that night were not told that he had been restrained earlier. At approximately midnight, he was found hanging in his room.

After his death a 'statement' was found in Adam's room in which he described his experience of being restrained, as follows:

> *My Statement [to the authorities] On the 8th August at approx 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.*

Evidence emerged at the first inquest held into Adam's death, in May 2007, that children were regularly restrained for non-compliance, but the coroner refused to rule on the legality of force used on Adam shortly before his death. Adam's mother judicially reviewed this ruling, and the High Court held that the coroner's decision had resulted in a flawed inquiry and verdict.

A second inquest was therefore held in January 2011. Here the jury found that the use of the nose distraction technique on Adam had been unlawful, and that this unlawful use of restraint had contributed to his death. The jury also found that Hassockfield was running an 'unlawful regime' with respect to the use of restraint, and that the YJB had failed to prevent this. Finally, the jury went on to find that staff were inadequately trained in suicide awareness, behavioural management and the use of restraint.

5. Young people in prison

Young people in prison: the statistics

As of the end of June 2011, there were 21,974 people in custody aged 18 to 24 years old, accounting for 25% of the total prison population of 85,374. More than a third (7,927) were aged 18 to 20, with the remaining (14,047) aged 21 to 24. Four per cent of prisoners aged 18 to 24 were women.

There has been little research that has focussed specifically on prisoners in their late teens to mid-20s. Unlike under-18s, they are not treated as a distinct group within the custodial population – other than to the extent that those aged 18 to 20 should be held in YOIs. As a result, it is difficult to determine any distinctive characteristics of this group compared to the rest of the adult prison population.

What is clear, however, is that young people in the 18 to 24 year old age range have a disproportionate level of involvement in the criminal justice system. As a report prepared for the Transition to Adulthood (T2A) Alliance emphasises:

> *Criminal justice statistics show that young adults aged 18-24, who constitute less than 10% of the population....mak[e] up almost one-third of offenders found guilty or cautioned for an indictable offence, more than one-third of those commencing a Community Order or Suspended Sentence Order, and almost one-third of those sentenced to prison each year. More than a quarter of the sentenced prison population is aged 18-24.*[74]

Young people in prison: the legal and policy framework

The prison estate

In contrast to the situation for children, there is no specific legal framework governing the treatment of young people by the courts and in prison - although 18 to 20 year olds who are sentenced to custody should be placed in a YOI rather than an adult prison and should usually remain in the YOI until they are at least 20. However, some 18 to 20 year olds are co-located with adults in local prisons, in cells, and subject to regimes, which are supposed to comply with YOI rules but in practice vary little from those for adults. In June 2011, 40% of all 7,885 18 to 20 year olds in prison were held in dual-designation establishments (that is, establishments designated as both a prison and a YOI) rather than dedicated YOIs.[75] In addition, adult prisoners are increasingly co-located with young people in young offender institutions in cells which have been re-classified for this purpose - ostensibly to make use of spare capacity in the YOI estate. The Chief Inspector of Prisons (2011) has highlighted his concern that young adults are being held in prisons with “no specific strategy to meet their needs”.[76]

Sentencing

For the most part, remand and custodial sentencing decisions are applied to 18 to 24 year olds in the same way that they are applied to other adults. An exception to this general rule, however, is the availability of the sentence of Detention in a Young Offender Institution, or DYOI, the primary sentence for 18-20 year olds who have committed imprisonable offences. A DYOI should be served in a YOI rather than adult prison (for as long as the young person is within the requisite age range), and the period in prison must be followed by a period of supervision in the community, whatever the sentence length. (For older adults, only custodial sentences of 12 months or more are followed by supervision). The DYOI sentence was to be abolished under the Criminal Justice and Court Services Act 2000, but the relevant part of the Act has not been implemented. However, the recent re-designation of a number of local prisons as 'HMP and YOI' indicates that the DYOI sentence, requiring as it does a specialist age-appropriate regime, is being allowed to be undermined by population pressure and limited resources.

The DYOI sentence is a specific provision relating to the sentencing of 18 to 20 year olds. A more general provision relating to young people is that an offender's relative youth or immaturity may be treated by a sentencer as mitigation which could thus lessen the severity of a custodial sentence or even allow a non-custodial penalty to be imposed in place of prison. The Sentencing Council's 2004 guideline on offence 'seriousness' cites as an example of a mitigating factor: "Youth or age, where it affects the responsibility of the individual defendant".[77] Subsequent Sentencing Council guidelines for specific offence types (which, like the guideline mentioned earlier, are concerned with the sentencing of all defendants aged 18 and over) have reiterated that "age and/or lack of maturity" may be treated as mitigation.[78] Empirical research on personal mitigation in sentencing found that the youth of defendants was quite frequently mentioned by Crown Court judges as a relevant factor in sentencing, and that:

> *Sentencers appear to have a relatively broad understanding of 'youth' – which extends to men and women in their early 20s. Sometimes it was the immaturity or the naivety of the defendant rather than his or her specific age that had the mitigating effect.*[79]

Multiple disadvantage

As noted earlier, many children in prison face multiple disadvantages relating, for example, to mental health problems and learning disabilities or difficulties. These disadvantages are likely to be mirrored amongst 18-24 year olds in prison. Though to date little attention has been paid to the specific needs of this age group, research has shown that young people (16-20) in prison are more likely than adults to have mental health problems and are more likely to take, or try to take, their own life than both younger and older prisoners.[80]

Recent studies on cognitive behaviour and development have established that the processes by which the brain develops and matures in young people typically continue until they are in their early to mid-twenties. What this means is that while young people aged over 18 are formally considered 'adults' and, for example, are treated as such within the criminal justice system, they may still be maturing and developing the capacity to

control their behaviour and plan for the future. As the Transition to Adulthood (T2A) notes:

> *Young adults in trouble with the law often have particularly high levels of complex need and are from backgrounds of great disadvantage, and young adults with the most troubled or traumatic childhoods often take a lot longer than average to mature. Vulnerable young adults frequently lack positive adult role models and also suffer from high levels of mental ill-health and alcohol and drug misuse problems.*[81]

Moreover, as many children in prison enter the early years of adulthood, their disadvantages may be compounded if their transition between children's and adult services (outside the criminal justice system) is not managed carefully. It has often been noted that at this transitional point it is possible for individuals to fall in the gaps between services and for needs to go unrecognised and unmet.[82]

Children in care are among those whose transition to adulthood potentially poses particular difficulties in terms of their access to support. However, young people in prison who were previously in care are entitled to a certain level of support from the local authority up to the age of 21 – as applies to all 'former relevant' children who have left care. The relevant statutory guidance on local authority duties towards care leavers[83] includes a section on care leavers in the criminal justice system. This refers to the need for local authorities to have specific policies in place to ensure care leavers in the justice system receive the support to which they are entitled. This support includes regular visits to young people in prison until they reach the age of 21 (visits which must not, it is specified, be undertaken by YOT officers – which also, presumably, means that the duty to visit should not be fulfilled by probation officers); and the provision of help with accommodation following their release from prison. There is an explicit acknowledgement in the guidance that care leavers serving community or custodial sentences "will be especially vulnerable and will require carefully planned and well-focused support from their responsible authority".

Identifying and assessing vulnerability

There is no definition or shared understanding of 'vulnerability' for 18-24 year olds.

There is also no special assessment process which is tailored to this specific age group. Instead, the Prison Service relies on the initial screening carried out on all adults when they enter individual prison establishments, with the Prisons Inspectorate identifying vulnerable prisoners as those who "may self-harm or be bullied, or have mental health needs or learning disabilities/ difficulties".[84] In the case of care-leavers or those receiving support from other agencies because of mental health or other needs, the prison's assessment should be supplemented by information that is sent to them, by relevant outside agencies.

Daniel Nelson[85]

18 year old Daniel Nelson was sent to HMP & YOI Doncaster in August 2005. It was his first time in prison. Less than a month after arriving, Daniel was found dead in his cell having attached a ligature to the top of the cell door in a 'ligature-free' cell.

Growing up in Leeds, Daniel was a promising footballer. From the age of 11, however, he faced severe problems at home due to his mother's drink and drug problems and suicide attempts. In 1999 Daniel and his younger brother were taken into care.

When Daniel turned 16, the support of his children's home came to an end and he began to struggle. Lacking a stable local authority placement Daniel drifted around different hostels, lost contact with his social worker and became involved in drugs. On 25 August 2005 he was remanded in custody relating to a charge of possession of Class A drugs. At the time of his remand, he was still subject to a social services care programme for young people leaving care.

Daniel did not have a history of mental health problems, but shortly after arriving at Doncaster his behaviour became erratic. Daniel began displaying signs of paranoia and asked to move cells because he was worried his cellmate was about to attack him. On 11 September, a distressed Daniel assaulted a prison officer at his cell door, was restrained and then taken to the healthcare centre. On the way, he apologised to the officer he had assaulted and spoke of committing suicide. At the healthcare centre – where he was to remain until he died - an FS2052SH self-harm form (the form used prior to the current ACCT plan) was opened.

While in the healthcare centre, Daniel made four attempts at suicide, three involving ligatures and one a plastic knife. He was placed initially on a 30-minute watch, changed after the first suicide attempt to a 15-minute watch, but was never subject to constant observation. He was moved to a ligature free cell, but twice before his death was found to have wedged a ligature in the door of his cell.

Because of his earlier assault on an officer, Daniel was subject to a 'two-man unlock', which meant that staff on their own could only speak to him from outside his cell door, which was covered with a cloudy sheet of perspex. A visiting psychiatrist who came to see him on 15 September had to conduct his assessment through this opaque, darkened door.

Daniel hardly slept. An entry in his medical notes records 'six days and nights of unrelenting outbursts'. No attempt was made to contact his next of kin, his step-sister Lisa, despite the fact that Daniel was repeatedly heard to cry out for her.

Though his personal adviser had found out he was remanded on 31st August and made an appointment to see him on 25th September, it wasn't until he was seen by the mental health in-reach team on 19th September that prison enquiries about his background were made of social services.

The day after he was seen by the mental health team, Daniel made a ligature from bedding and forced it between the cell door and frame in his 'ligature-free cell' (exactly as he had done on previous occasions). This time he died.

Following the inquest, the family solicitor said that Daniel's family

> *remain heartbroken that they were never informed that Daniel was on a suicide watch, exhibiting paranoia and bizarre behaviour, constantly calling for them and scarcely sleeping. They believe that contact from them would have helped to reassure Daniel and certainly they would have been able to press for a transfer...for Daniel to be committed to hospital under the Mental Health Act.*

Mental health and self-harm

The 1997 Office for National Statistics survey of psychiatric morbidity among prisoners in England and Wales included an assessment of mental health problems among young people in prison – albeit in the 16 to 20 age range rather than the 18 to 24 years age bracket of concern to us here.[86] Findings for the samples of young prisoners included:

- prevalence of any personality disorder was 84% for male remand and 88% for male sentenced prisoners
- prevalence of neurotic disorder (that is, disorder involving distress but not delusions or hallucinations) was:
  - 52% of the male remand sample
  - 41% of the male sentenced sample
  - 67% of the female sentenced sample.
- 20% of male remand, and 32% of female sentenced prisoners, had ever attempted suicide (see Table 5.1).

Table 5.1: Prevalence of self-harm and suicide attempts among young prisoners

	Male remand	Male sentenced	Female sentenced
Suicide attempt - past year	17%	12%	16%
Suicide attempt - lifetime	20%	16%	32%
Self-harm in current prison term	7%	9%	11%

Source: Lader et al (2000)

Table 5.2 shows the number of self-harm incidents involving 18 to 24 year olds in prison, as reported in the Ministry of Justice Safety in Custody statistics. The table reveals an overall increase in incidents per annum from around 7,700 in 2004 to 10,700 in 2010, before dropping back slightly to 9,948 in 2011, with the annual number of individuals who harmed themselves increasing from approximately 2,100 to 2,700 over the same period. As the table shows, the overall increase in levels of self-harm occurred at a time when the number of 18 to 24 year olds in prison was growing steadily. Table 5.2 also shows that young women (who make up around 4% of all prisoners in that age bracket) are responsible for a disproportionate number of self-harm incidents, and those who harm themselves do so with greater frequency than young men – reflecting the gender difference also seen in the under-18 custodial population.

Table 5.2: Total population and number of self-harm incidents and self-harming individuals, 18-24 year olds in prison 2004-2011

Year	Total custodial population	All incidents of self-harm	Male	Female	All individuals self-harming	Male	Female
2004	20,968	7,741	3,241	4,500	2,109	1,532	577
2005	20,775	9,300	3,537	5,763	2,238	1,613	625
2006	20,627	9,031	4,089	4,942	2,300	1,709	591
2007	21,391	9,376	4,118	5,258	2,379	1,814	565
2008	22,218	10,485	4,206	6,279	2,500	1,871	629
2009	22,824	8,825	4,772	4,053	2,573	2,060	513
2010	22,852	10,726	5,424	5,302	2,714	2,225	489
2011	21,974	9,948	6,323	3,625	2,746	2,259	487

Sources: Ministry of Justice *Safety in Custody Statistics Quarterly Bulletin January to March 2012, England and Wales,* Statistical Tables: self-harm, Tables 2.3 and 2.4, http://www.justice.gov.uk/publications/statistics-and-data/prisons-and-probation/safety-in-custody.htm; Custodial population data for 18-24 year olds: Ministry of Justice *Offender Management Caseload Statistics* 2011: Table A1.4.

Petra Blanksby[87]

Petra Blanksby was 19 when she died on 24 November 2003, five days after she was found in her cell at HMP New Hall with a ligature round her neck. She was on remand for arson with intent to endanger life. Petra had set fire to her mattress in her flat in an act of self-harm, and the life endangered was her own. She had no previous criminal convictions.

At the age of nine, Petra and her twin sister Kirsty were placed in local authority care. They had been physically and mentally abused by their mother after her divorce from their father. Petra lived with several foster carers and in children's homes where she had what she described as some 'very bad experiences', including sexual abuse and rape.

Petra was diagnosed with borderline personality disorder and had a long history of serious self-harm including by cutting, swallowing razor blades, setting herself alight and inserting objects into her body through wounds. At the age of 15, she was sectioned under the Mental Health Act into the care of a secure adolescent unit. When she was 16, Petra became engaged and pregnant, but separated from her partner because he could not tolerate her self-harming. Petra's son was born in 2002; he was 18 months old when she died.

Petra remained in the care of her local authority until she was 18, when she and her son were moved into a flat of their own. Petra was a loving mother but worried about the impact of her self-harming on her ability to care for her son. During difficult periods she would ask social workers to place him in temporary foster care.

At the time of her offence Petra's son was in care and she was receiving support from social workers and a community psychiatric nurse. She telephoned them for help, saying she had cut her wrists and tried to gas herself; but, following a visit to her flat, she was left there on the grounds that she could not be sectioned as her borderline personality disorder was 'untreatable'. Three hours later she set fire to her mattress. Alarmed by her own actions, she called the fire brigade who found her with her hair alight: she had doused herself with petrol. She was charged with arson with intent to endanger life and remanded to HMP New Hall.

Petra spent her 130 days in the prison on suicide watch, and seriously self-harmed at least 90 times – sometimes leading to hospital admission. While in prison, she made the decision to place her son for adoption because, although she loved him, she felt unable to care for him. On completion of the adoption process Petra told his social worker that she 'could now move on'. It was noted in her medical records that she had once said that when her child was safe she would be 'free to go'.

Witnesses at the inquest into her death gave evidence that there was a 'blatantly obvious' increase in her self-harming related to her son's adoption. Shortly after the adoption was finalised she tried to asphyxiate herself and spent five days in hospital. Her family was not informed. She was returned to prison and three weeks later was found to have strangled herself. She was taken to hospital, where she died after five days.

Kirsty Blanksby, Petra's twin sister, was also a prolific self-harmer but found appropriate support in a therapeutic community. Kirsty said her sister

> *wasn't offered the same services as me. Petra was offered nothing. The only person she had hurt was herself and yet she was punished for punishing herself. It is simply wrong that Petra was in prison instead of receiving the necessary and proper help for her deep-seated problems.*

The vulnerability of children and young people who died in prison

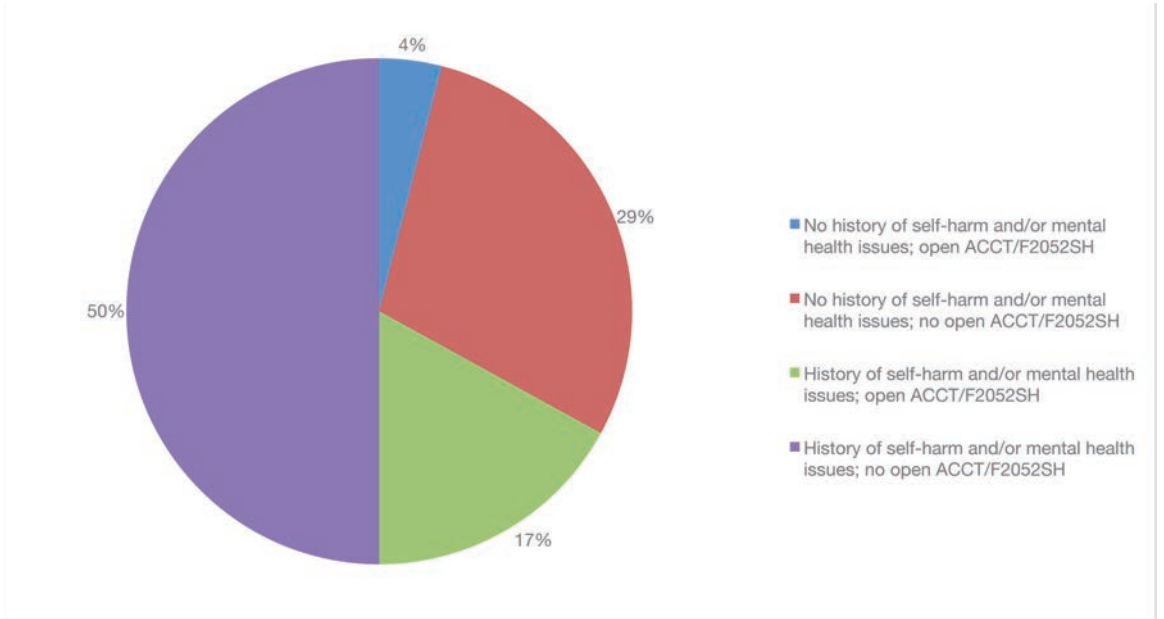
For the purposes of this report, INQUEST looked in detail at the circumstances of 98 children and young people who died in prison over the period 2003 to 2010, in order to gain an understanding of their vulnerability. The sample of 98 individuals comprises all five children who died in this period and 93 young people (out of the 143 who died) whose families have been supported by INQUEST's casework service.[88] The data used in the analysis were drawn from INQUEST's own case files and records.

Analysis of the data for all 98 children and young people revealed that:

- half (51%) had a history of self-harm;
- 48% had a history of mental health problems;
- more than a third (36%) had had problems with drug or alcohol use.

The data recorded that one in 12 (8%) of the 98 children and young people who died were known to have had experience of care. However, this is likely to be a significant underestimate. The records for young people aged 18-24 years examined for this analysis (such as PPO investigations) do not routinely capture information about historic experience of care. As the inquest only examines the circumstances immediately before the death of a young person, records from the coroner's court rarely reveal whether, for example, a 20 year old who died in prison is a care-leaver. Fuller information on the backgrounds of the 5 children who died was available for analysis (including serious case reviews) and this showed that 3 of the 5 had experience of care and all 5 had involvement with different statutory or community agencies before entering prison.

Figure 5.1: INQUEST cases - monitoring the risks of self-harm in the deaths of children and young people in prison, England & Wales 2003-2010



Source: INQUEST casework and monitoring

The analysis of vulnerability also examined how many of the children and young people were on open ACCT (Assessment, Care in Custody and Teamwork) plans at the time of their deaths. An ACCT plan is the form opened by staff in prison establishments (including YOIs, but not secure children's homes or secure training centres) when a prisoner is identified as at risk of suicide or self-harm. Its forerunner was a form called the F2052SH. ACCT is intended to be a 'care-planning system' to enable staff within the establishment to work together in order to:

- help defuse a potentially suicidal crisis and/or
- help individuals with long-term needs (such as those with a pattern of repetitive self-harm) to better manage and reduce their distress.[89]

However, in 50% of the deaths of the 98 children and young people in the INQUEST sample, there was a known history of self-harm and/or mental health issues yet no open ACCT or F2052SH at the time of death. Seventeen per cent of those who died had a known history of self-harm and/or mental health issues and were supposedly being monitored through an ACCT/F2052SH plan at the time they died. (See Figure 5.1 for more details.) These figures raise the question of whether the Prison Service's monitoring system has the capacity accurately to identify and address risks of self-harm and suicide.

Chay Pryor[90]

Eighteen year old Chay Pryor died in August 2008, while on remand in HMP High Down for an offence of possession of an offensive weapon – a broken bottle. He was the fifth young person to be found hanging in the prison in a 15 month period.

Chay had been diagnosed with ADHD in 2005. As a teenager, he committed acquisitive crimes to fund his heavy drinking and use of drugs. He also had a long history of self-harm.

In May 2008 Chay had been released from HMP High Down, where he had served nine weeks for theft, battery and failure to surrender to bail. A month later he was arrested on the offensive weapon charge. When he was taken into police custody following the arrest, doctors noted his vulnerability and high risk of self-harm. However, when he was screened on reception at High Down, staff did not consider him to be at risk.

The subsequent PPO investigation into Chay's death found:

> *no clear evidence that documents containing important information about events that had occurred immediately prior to Chay's admission to High Down on 9 June 2008 were available to reception staff or taken into account in the process of assessing his risk. The documents included a Prisoner Escort Record, a Detained Person's Medical Form (from the police station), Chay's previous prison record, and his previous clinical record, all of which contained clear evidence of risk of self-harm.*

Once in prison, Chay's behaviour began to deteriorate. Concerned staff sought to refer him to the mental health team, but the referral form was returned because it had been incorrectly completed. On 19 August 2008 Chay harmed himself and the following day was placed on an ACCT plan for those at risk of self-harm or suicide. He was assessed as being at low risk to himself.

At about midnight on 23 August Chay asked to speak to a Listener (a Samaritans-trained prisoner available to support fellow-prisoners who are in distress). He then changed his mind and asked to use the designated Samaritans mobile phone. Because of poor telephone reception near his cell, he was taken to the Listeners' suite to make the call. He was not searched before being taken out of his cell, and then left in the suite unsupervised. Fifty-three minutes later he was found hanging: he had taken a piece of torn bed sheet from his cell which he had used as a ligature.

The inquest into Chay's death, in February 2011, heard evidence that prior to this death a prisoner had raised concerns about the ligature points in the Listeners' suite. These concerns had been recorded but not acted upon.

The PPO's report into Chay's death, dated May 2010, noted that it 'tells a sad story of a vulnerable young man'. Chay's parents said that they had

> *assumed Chay would be safe in HMP High Down and that the Prison Service would act on any information it received about his vulnerabilities. We are horrified that such a vulnerable young man was let down so badly by those responsible for his care.*

6. Findings and discussion

The information and evidence collated for this report revealed common themes in the experiences and treatment of the children and young people who died in prison between 2003 and 2010. These overlapping findings included that they:

1 were some of the most disadvantaged in society and had experienced problems with mental health, self-harm, alcohol and/or drugs
2 had significant interaction with community agencies before entering prison yet in many cases there were failures in communication and information exchange between prisons and those agencies
3 despite their vulnerability, they had not been diverted out of the criminal justice system at an early stage and had ended up remanded or sentenced to prison
4 were placed in prisons with unsafe environments and cells
5 experienced poor medical care and limited access to therapeutic services in prison
6 had been exposed to bullying and treatment such as segregation and restraint
7 were failed by the systems set up to safeguard them from harm.

Our analysis also found there had been:

8 inadequate institutional responses to the deaths of children and young people in custody.

Finding 1: the children and young people who died in prison were some of the most disadvantaged in society and had experienced problems with mental health, self-harm, alcohol and/or drugs

Multiple disadvantage is a common thread running throughout the population of children and young people in prison[91] and many have complex support needs, such as mental health, learning disability or speech, language and communication difficulties.[92] This is reflected in the backgrounds of those who have died. Goldson and Coles' research on the deaths of children in prison between 1990 and 2004 has documented that those who died were some of the most vulnerable members of society having been "routinely disfigured by multiple and intersecting forms of social disadvantage".[93]

The data examined for this report on the backgrounds of the 98 children and young people who died in prison has also underlined their complex needs and vulnerability. The six children and young people whose individual stories have featured in this report had experienced considerable disruption and difficulty in their short lives. Involvement with social services and the care system, mental health needs, incidence of substance misuse and domestic violence in the family and the deaths of significant family members were common experiences – all but one of the six had a history of self-harm, and suicide attempts in the community were regular occurrences. School exclusion, ADHD diagnosis and drug and alcohol dependency also featured prominently. A better understanding of

the interplay between welfare and health needs and offending, and addressing these needs, would ensure low-level and repeat offending is appropriately addressed.

The circumstances leading up to the death of 15 year old **Liam McManus**, whose offending was precipitated by a sequence of significant family events, should have triggered intensive, therapeutic interventions. Without that support and an understanding of the links between low-level and early offending and early-life experience of loss and bereavement, Liam's journey culminated in his imprisonment for breaching the terms of his licence in November 2007. In his case, the serious case review into his death acknowledged the failings of a range of agencies which should have intervened more effectively, earlier on in his life, finding that "Liam was propelled into detention and custody by a variety of circumstances and persistent low level offending over a short period of time, and by a failure to respond properly to his needs in the periods in between".[94] With a census of children in custody finding, for example, that one in eight imprisoned children had experienced the loss of a parent and/or sibling,[95] there is clearly a wider failure to connect our understanding of the profound psychological impact of bereavement in early life, abuse or neglect on children and young people and how this might lead to offending and act as a driver to prison.

The records analysed for this report suggested only a small minority of the 98 children and young people who died between 2003-2010 were known to have had experience of the care system. The individual stories highlighted in this report suggest this to be a significant under-representation rather than a true reflection of the 98 children and young people's early life experiences. As post-death investigations and inquests do not routinely enquire into or record the care experiences of the 18-24 year olds who have died in prison it is difficult to understand the potential scale of this issue or begin to address it. Indeed, the fuller records of background available for the 5 children who died revealed that most of them had experience of care and all of them had involvement with statutory or community agencies before entering prison.

A recent thematic report on looked after children in custody by HM Inspectorate of Prisons found that establishments "could not be confident of the care status of new arrivals",[96] with the attendant safeguarding implications that this brings. It is likely that the existence of young care leavers in the adult prison estate is similarly under-reported by probation staff and other statutory services though, to date, no such research on the systems in place for managing adult care leavers in prison has been undertaken. That such a significant experience in a child or young person's background, and an important indicator of potential vulnerability, is not being recorded hampers opportunities for safeguarding individuals.

Importantly, both looked after children and young care leavers in prison are entitled to extra support from community and statutory agencies. Social workers and others who have been involved with children or young people outside prison could play a key role in facilitating visits and family input into meetings planning the care and treatment of their children in prison. By not accurately recording information about care experience on arrival it is less likely that potentially critical support will be triggered quickly.

Finding 2: the children and young people who died in prison had significant interaction with community agencies before entering prison yet in many cases there were failures in communication and information exchange between prisons and those agencies

Inevitably, a number of the individual children and young people whose stories are highlighted had complex histories of involvement with different statutory and community services, including social services, and child and adolescent mental health services (CAMHS). However many did not receive the specialist help and support they evidently needed before they entered prison.

In **Petra Blanksby's** case, despite being entitled to statutory leaving care support, the involvement of a social worker allocated to her young son, and her history of complex, and often acute, mental health difficulties, she ended up in HMP New Hall charged with arson after dousing herself with petrol and setting her mattress alight. According to her sister, Petra had been "offered nothing. It is simply wrong that Petra was in prison instead of receiving the necessary and proper help for her deep-seated problems." Petra was failed by society and the community services which should have supported her before her involvement in the criminal justice system.

It is clear that some family members' attempts to secure help were frustrated. In the case of **Adam Rickwood**, though there were clear signs that he was finding it hard to cope in the years preceding his death, his grandmother noted that his mother had "battered her head off every wall she could find to get help for her son". Despite having been excluded from school, experiencing the loss of three close family members and having a history of self-harm, all of which are disproportionately prevalent amongst the youth offending population, it appears these signs of difficulty were not picked up by children's services (raising questions about thresholds at which access to statutory services are set), and adequate help and support were not forthcoming.

Once in custody, poor information flow and communication between community and statutory agencies and prisons (and vice versa) can be highly damaging. **Liam McManus'** YOT worker gave evidence to the inquest into his death that her pivotal decision to recommend he be sent to a YOI was made with two conditions in mind. Firstly, that "protective factors" in the form of visits from Liam's family, YOT worker and CAMHS worker would be in place and that these continuing relationships would safeguard his vulnerability; and secondly that the prison would have full knowledge of the contents of the ACCT document. Neither of these conditions was made clear on either the YJB vulnerability alert nor his ACCT document. Liam received no visits in his time at Lancaster Farms: his family did not receive any visiting orders and his CAMHS worker was on long term sick leave. One of the lawyers who represented his bereaved family at the inquest has noted:

> *although Liam had arrived at Lancaster Farms with an ACCT… officers gave evidence that they would not read the ACCT document and would pre-sign the induction forms and then fill in the form by reference to the young person's answers. Liam's mental health assessment was undertaken by a second year social work student on a placement at Lancaster Farms and it seemed that it was not common practice for workers in the prison to communicate with their community counterparts.*[97]

If the needs of looked after children who end up in prison are often not met, the position for care leavers, a long-neglected group in society, is often worse. The lack of a formal system for identifying care leavers upon entry to prison meant **Daniel Nelson**, who had been in care as a child and was subject to a pathway plan at the time of his death at age 18, failed to get the support he needed in a timely manner. In his case, a week passed before his personal adviser (the person tasked by the local authority with ensuring he received the support he had been identified as needing in his pathway plan), was informed that he had been imprisoned on remand. At this point, an appointment was fixed for his adviser to visit him and review his plan, though not for a further three weeks. Five days before the meeting was due to take place, Daniel was found dead in his cell. Had there been an automatic system of notification upon his reception to prison, triggering a message to his personal adviser and to others who might have been instrumental in supporting him, and in providing prison staff with information, (such as his medical history and next of kin contacts, which they subsequently spent a significant amount of time seeking),[98] Daniel could have received the support he needed from people and services who knew him.

The inspection framework has a role to play in ensuring that looked after children and care leavers in prison receive the support and services they are entitled to. It is encouraging that the prisons inspectorate has begun to scrutinise this issue including through their May 2011 thematic review into the care of looked after children in custody, where it was found that half of looked after children in prison received no visits from their social worker.[99]

Finding 3: the children and young people who died in prison, despite their vulnerability, had not been diverted out of the criminal justice system at an early stage and had ended up remanded or sentenced to prison

One of the stark questions that emerge from the individual stories and the analysis of the backgrounds of those who died is: why were these children and young people in prison? The answer lies in how vulnerability is identified by state agencies and how the criminal justice system responds to troubled children and young people in conflict with the law.

Coroners, inquest juries and child protection experts have repeatedly raised concerns over the different assessment frameworks in use (which vary from the ASSET

assessment tool used by youth offending teams to the ACCT plan used in prison), and variations in interpretation across different agencies. Coles and Shaw have highlighted:

> *What defines a vulnerable child has been differently understood by the YJB and YOTs. That the discourse on the meaning of vulnerability has most often taken place in adversarial settings – in the media, in court and in parliament has not been conducive to calm and thoughtful development of shared understanding and meaning. This adversarial struggle to both avoid and impart blame, has undermined objective and clear thinking and consequently the children have been the victims.*[100]

With the only legal definition of vulnerability, with its reference to "physical or emotional immaturity or a propensity…to harm [one]self",[101] no longer applying to remand with the introduction of a new remand framework for children,[102] the time is clearly right for discussion of the term, its usefulness and what it means in practice for children and young people in trouble with the law. That a distinction is drawn between the assessment of children and young people, for instance, when much research[103] points to the similarities between the needs of children and their older counterparts, shows the sense in developing an integrated assessment based on maturity across a currently disjointed system.

Following **Joseph Scholes**' death, the Home Office commissioned a review of the operational procedures for identifying, placing and safeguarding vulnerable children in custody. The subsequent Lambert Report, published in 2006, made 55 recommendations (most of which were accepted by the government) about the need for improvements in the completion of the ASSET assessment form, better information-sharing on vulnerability through the use of Secure eMail, and enhanced mental health provision in the secure estate. However, research published four years later, in 2010, which analysed the ASSET forms of 300 children imprisoned over a 6 month period, found that "in many cases, sections of ASSET appeared to be entirely missing, or were completed inconsistently…parts…were often very poorly completed, such that there were discrepancies between information provided in different parts of the form, or…[that] held on other…database[s]".[104]

A government update on progress made post-Lambert, published in September 2010, stated that the YJB would undertake "a review of how the term 'vulnerability' is used within all YJB guidance and documentation, including placement documentation…and ASSET, and ensure that the term is consistently embedded in youth justice processes and systems".[105] However, the YJB pages on the Ministry of Justice website state that "defining a young person simply as vulnerable is not helpful as it does not make clear to anyone else what the specific risks may be. The YJB is moving away from the term and talks in more precise terms about the young person's characteristics and how these may effect [sic] an assessment outcome such as a placement decision".[106] Given that ASSET remains the standard framework for assessing the needs and risks of all children

in contact with the justice system, it is unclear what this means in practice for those undertaking assessments who have responsibility for alerting services both in the community and in prison to vulnerable children. There are also dangers associated with a move away from the concept of vulnerability, which focuses on the individual child and their life circumstances, in favour of a discourse around the risk they pose to others, which has negative connotations, focusing more clearly as it does on their offending behaviour.[107]

Proper assessment is clearly a crucial element of ensuring vulnerable children and young people are identified and supported in the community and in prison. A new common assessment framework which is built on a shared understanding of vulnerability should be developed for use by welfare and criminal justice professionals, so as to avoid the arbitrary distinction made by many statutory services between children and young people.

The circumstances leading up to **Adam Rickwood's** death illustrate the devastating impact that incorrect or incomplete assessment can have. As became clear at the first inquest into his death,[108] Adam had been remanded to a secure training centre after he was assessed as being at no risk of harm. Despite having been known to social services from the age of three and having a history of self-harm and of hospitalisation following overdose, none of these factors were referenced in the report produced for the court by his youth offending team. It is not clear whether this was the result of a failure to recognise his vulnerability at the time he was assessed or of poor information-sharing between children's services and youth offending practitioners. However it happened, Adam was imprisoned on the basis of an incomplete report and an incorrect assessment of his vulnerability when he could have been managed more appropriately in the community.

However, assessment alone is not sufficient if a pre-agreed uniform pathway for managing a child who has been identified as vulnerable is not in place. This was evidenced in the circumstances leading up to the death of **Liam McManus**, who had been correctly identified as vulnerable by his YOT, but placed in a YOI on his third spell in custody on the recommendation of his YOT officer, who felt prior placements in a secure children's home had had little impact on his behaviour.[109] The jury at the inquest into his death concluded that "each of the organisations and agencies involved [in Liam's care] had individual interpretations of the definition of vulnerability and risk, and no common scale of recording or understanding" them.[110] Without a clear definition agreed, not just of what vulnerability means, but also of the procedures in place for ensuring identification triggers a robust response, individual children will continue to slip through the net.

In essence, the vulnerability and complex needs of the children and young people who died in prison were not properly recognised and too often they were treated as being in need of punishment, rather than care and support. Following **Adam Rickwood's** death, Lancashire Safeguarding Children Board (LSCB) conducted a serious case review into

his death. The subsequent report remarked that Adam had been 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".[111]

Both the individual stories and statistics compiled for this report suggest a fundamental review is needed of the way in which children and vulnerable young people in conflict with the law are treated.

The arguments in favour of a higher custodial threshold for children are well-versed.[112] It is sobering to note that **Adam Rickwood's** death in prison could have been avoided had breach of bail not been an imprisonable offence. With other evidence suggesting it is the youngest children who are most likely to end up in prison for failing to comply with statutory orders,[113] there is a strong case for taking this age group out of the criminal justice system completely. It is clear from a number of the individual stories that early (or inappropriate) entrance to the criminal justice system, and rapid escalation up the ladder of interventions for repeat minor offences, was a contributory factor in the imprisonment of some of the children and young people who died. Raising the age of criminal responsibility (bringing England and Wales in line with the European average and the recommendation of the UN Committee on the Rights of the Child), would prevent such children racking up substantial criminal records, and exhausting all current community-based criminal justice interventions, in a short period of time.

In the context of the initial decision to prosecute, it is welcome that the CPS suggests a revised Code for Crown Prosecutors should include an explicit consideration of whether it is in the public interest to prosecute children. The draft Code states, in relation to under-18s, "the interests and welfare of the child or young person must be considered" and "as a starting point, the younger the suspect, the less likely it is that a prosecution is required".[114] It is also suggested for all cases that "the level of culpability of the suspect" is another factor in deciding whether to prosecute and that Prosecutors should have regard to whether the person was suffering from any significant mental or physical ill health at the time of the offence as this may, in some circumstances, mean it is less likely that a prosecution is required. Had this Code been in operation earlier some of the children and young people whose stories are included in this report, such as **Petra Blanksby**, may not have been caught up in the criminal justice system in the first place.

If the courts are to "have regard to the welfare of the child" as set out in statute[115] and child imprisonment is to be used as a true measure of last resort, as required by the UN Convention on the Rights of the Child, sentencers must be better aware of the principles and sentencing guidelines which should underpin their decisions about the use of prison for children and young people. Concerns over the appropriateness of some custodial decision-making, particularly that which involves the youngest children, and over the interpretation of the principle of 'last resort', have been raised before.[116]

For the minority of children and young people whose offending is so serious that only a secure placement can be justified, a new, distinct secure estate with an emphasis on

therapeutic environments and interventions should be developed. In a number of the individual stories profiled in this report it is clear that the judiciary sentenced children and young people on the theoretical basis that they would be detained in institutions that could cater for their needs. In practice however this led to vulnerable children and young people being placed in prisons which did not have the resources, facilities or trained staff to do so. Full up-to-date information on locally available alternatives to custody for children and young people should be available to the courts.

Again, in **Petra Blanksby's** case, had those involved in the decision to remand her to prison had a better understanding of her mental health needs, and had a community therapeutic placement which would better have met them been made available to her, she might not have ended up in prison. Given that research indicates significant proportions of the children and young people in prison have mental health problems,[117] it is vital that all those working in the criminal justice system, especially sentencers, are able to identify and divert those, like Petra, who clearly should not be there. Comprehensive training should be provided for sentencers (in both youth and adult courts) and their legal advisers to enable better identification of complex needs, vulnerability and the court's options under mental health legislation.

Finding 4: the children and young people who died in prison were placed in prisons with unsafe environments and cells

The individual stories of those who died after being sent to prison demonstrate it is a damaging and inappropriate environment to deal with the complex needs of children and young people.

One of the key conclusions from previous research into child deaths in prison was that:

> *'Caring' for children in penal custody, especially young offender institutions, is an almost impossible task. Many child prisoners live with a spectre of fear and an enduring feeling of being 'unsafe'. This, in turn, is thought to heighten the risk of damage and/or death.*[118]

Prison environments are rarely therapeutic, with accommodation holding children and young people having the highest rates of violence and bullying. Conditions and treatment experienced by children in prison documented in government statistics,[119] prison inspectorate reports,[120] investigation reports and inquest evidence include physical and mental health care neglect, endemic bullying, ill treatment (staff on child and child on child), racism and other forms of discrimination, long periods of cell-based confinement, deprivation of fresh air and exercise, inadequate education and rehabilitative provision, poor diet, ill fitting and shabby clothing, insufficient opportunities to maintain contact with family, and poor complaints processes.[121]

Against that backdrop, it is not surprising that one of the central concerns of the jury at **Joseph Scholes'** inquest was his placement in Stoke Heath YOI[122] rather than a more welfare-oriented placement in a secure children's home because a place was not available. Whilst reports from his YOT, social worker and a consultant psychiatrist all identified his vulnerability, and the presiding judge called for his history to be "most expressly drawn to the attention of the authorities", no inquiry was made as to where he might be placed before a custodial sentence was passed. At the conclusion of the inquest, the coroner issued a Rule 43 recommendation letter calling for "an urgent and comprehensive review" because

> *the [placement] allocation of vulnerable young children (typically 15 and 16 year old boys) should be determined on a needs basis and not a resources basis. This is all the more important if Courts are sentencing such vulnerable and disturbed young offenders in the belief, mistaken or not, that recommendations, such as that contained in the pre-sentence report and endorsed by the sentencing judge can be implemented.*[123]

Like Joseph, **Liam McManus** had been identified as vulnerable by his YOT prior to his imprisonment, but was also placed in a young offender institution. That four of the six children who died during the period 2003-2011 were in large young offender institutions run by the Prison Service, rather than smaller secure children's homes, which are perhaps best equipped to accommodate vulnerable children with their "therapeutic environment, 30 hours of education and key worker to meet individual offending behaviour & emotional needs",[124] raises questions about the initial assessments undertaken, and, fundamentally, why prison accommodation continues to be used to house vulnerable children.

This issue remains to be tackled by the state. At the beginning of 2002, prior to **Joseph Scholes'** death, there were 29 secure children's homes providing placements for children held under criminal justice legislation in England and Wales. By early 2010 this had fallen to 10 following a round of decommissioning.[125] More recently, the YJB took the decision to continue to commission places from these 10 units, but to reduce the total number of beds available by 17 in recognition of reductions in the number of younger children (aged 10-14) who are imprisoned (though this supposes that age is the dominant factor in vulnerability which is clearly not the case).[126] This translates into children and young people continuing to be sent to prison environments which are not able to address their complex needs.

What can be an intimidating environment in prison is often exacerbated by isolation from family and friends. In the cases of those who have died, placements in prison were often not only unsuitable in nature but were also inappropriate by location meaning manifestly vulnerable children and young people were often detained at great distances from their home area, rendering regular family visits near impossible. In 2010, an Ofsted evaluation of secure establishments noted:

The Youth Justice Board's target that at least 90% of young people in secure settings should be within 50 miles of home was discontinued in 2009. Inspectors met many young people who were more than 200 miles away from their families. Distant placements restricted the number of visits by families and increased the young people's unhappiness and sense of vulnerability. Distance also limited the extent to which families could be directly involved in planning and reviews. The main reasons for this situation were the lack of local placements and the concentration of specialist resources in a small number of centres."

That many children are imprisoned in establishments far from their families, and that the cost of travelling can make regular visits prohibitively expensive, is borne out by the fact many children in prison receive few or no visits.[127]

As is evident from the individual stories in this report, in spite of the obvious difficulties associated with enforced separation, parents and siblings remained a source of strength and comfort for many during their time in prison. Though there has been limited research on the impact of separation on children and young people who are imprisoned, interviews with children who were, or had been imprisoned, paint a vivid portrait of the struggle to deal with their separation from parents,[128] and it is clear from the research for this report that several of those who died sought to contact their loved ones at times of distress.

Just as important as regular contact between family members and prisoners, however, is communication between prisons and family members and next of kin. Many prisons use out-dated, overly-bureaucratic systems of communication, of which the issuing of paper visiting orders for making appointments is one example. The research for this report has shown that, too often, communication between prison staff and family members was confused and disjointed. Others were not given urgent information until it was too late, with the fact that **Petra Blanskby's** family were not told of her admission to hospital, nor **Daniel Nelson's** sister that he had been calling for her, until the inquest into his death, symptomatic of a lack of understanding of the role families can play in supporting individuals in crisis.

As well as the culture and atmosphere in prison being unsafe, the physical environment is often unsuitable because of poor design and inadequate consideration of safeguarding concerns, such as cell safety. Prison Service guidance, for example, highlights that "window bars and beds are most frequently used to attach ligatures",[129] with use of ligatures accounting for 52 of the 57 self-inflicted deaths in prison in 2011.[130] Both **Joseph Scholes** and **Liam McManus** were placed in cells in which ligature points were freely accessible. The serious case review undertaken following Liam's death called on the chair of the local safeguarding children board to write to ministers highlighting "the unsuitability of most cells at Lancaster Farms for children at risk of self-harm without higher levels of direct supervision and requesting that all cells in the secure estate used for children are brought up to safer cell standards".[131] Four years later, there are currently no plans to upgrade all accommodation in the under-18 secure estate to safe standards.

The term ‘ligature-free’ cells meanwhile, so-called because they are designed to hold individuals identified as being at risk of harm safely, was shown to be a misnomer after the death of **Daniel Nelson**, who died following his third attempt to use the cell door frame in the healthcare centre as a ligature point. In the case of **Chay Pryor**, the Prisons and Probation Ombudsman’s (PPO) report into his death expressed concerns as to whether it was appropriate to leave a distressed young man in a room with numerous ligature points, including light fittings and exposed pipe work, so he could call the Samaritans.[132] At the inquest into his death evidence was heard that prior to Chay’s death a prisoner had raised concerns about the ligature points in the Listener’s Suite. These concerns were recorded by the prison but not acted on.

Despite numerous inquest findings and rule 43 reports, the problem of inappropriate cell design continues to feature in the inquests following the deaths of children and young people in prison. In future, the repeated failures by the Prison Service and others to address known flaws in cell safety may well be open to more scrutiny in light of the Corporate Manslaughter and Corporate Homicide Act 2007 which from September 2011 now applies to all places of custody, including young offender institutions and prisons. It is also to be welcomed that the health and safety issues presented by these deaths are increasingly being examined by external agencies, including the Health and Safety Executive (HSE). For example, in February 2012 the HSE formally censured the Prison Service for allowing so called ‘safer cells’ at HMP Bullingdon to be modified to include shower rails with ligature points.[133]

Finding 5: the children and young people who died experienced poor medical care and limited access to therapeutic services in prison

Underlying the concerns about the poor medical care and limited access to therapeutic services experienced by the individual children and young people who died in prison are broader questions about whether they should have been in prison at all. For example, in her 2003 inspection report on HMP New Hall, the then Chief Inspector of Prisons noted that the prison where **Petra Blanksby** later died was “holding women and girls who should not be there”, concluding that there was “an urgent need to provide alternative therapeutic environments where appropriate treatment and support can be offered.”[134]

At the conclusion of the inquest into **Petra Blanksby’s** death the coroner noted he had been struck by the evidence given by a leading consultant psychiatrist that “in a civilised society someone as severely mentally disordered as Petra should not be in prison”. Her experiences in the community also highlight the need for a different approach to responding to, and treating, certain mental health needs, so that individuals diagnosed with, for example, personality disorders are not classified as untreatable and left to their own devices with no meaningful therapeutic input. At the inquest into her death, the jury highlighted the inappropriate imprisonment of vulnerable women, declaring “prison was not an appropriate place” for her given her diagnosis. They found that her traumatic life experiences, including mental and physical abuse in early childhood, coupled with an unstable upbringing and a lack of emotional support,

contributed to her death. The jury's narrative verdict also highlighted the lack of infrastructure in forensic mental health services for people with **Petra Blanksby's** difficulties. After the inquest, the coroner used his power under Rule 43 of the Coroners Rules to write to the Prison Service and the Department of Health urging the two bodies to work together to ensure suitable, therapeutic environments outside prison could be made available for vulnerable individuals, like Petra, who have no place in prison.

However, nearly a decade after **Petra Blanksby's** death, doubts have again been raised about whether progress has been achieved in the state's approach to imprisoning women. Commenting on conditions in the most recent inspection of HMP Styal, the new HM Chief Inspector of Prisons expressed "disappointment" at finding "too many cases of women, some of whom were clearly mentally ill, serving very short prison sentences which served little purpose except to further disrupt sometimes already chaotic lives", reserving his deepest criticism for the specialist mental health unit in the prison which was described as "more shocking and distressing than anything I have yet seen on an inspection".[135] Transfer under mental health legislation was also an area of significant concern, with the longest wait for assessment and transfer cited as five months, which was "too long".

That problems identified by HM Chief Inspector of Prisons in 2003 are still apparent is evidence of the continued criminalisation of mental illness and use of prison to plug gaps in specialist mental health provision in the community. Proposals for a nationwide network of liaison and diversion schemes which should be up and running by 2014 have the potential to begin to redress this imbalance by identifying those with mental health problems at the point of entry to the criminal justice system. However, this potential is in danger of being undermined as, without additional investment in community and specialist mental health provision to ensure those with acute needs are diverted into appropriate care and treatment, it is unlikely that such schemes alone will have the capacity to prevent unnecessary imprisonment.

It is clear that prisons continue to hold vulnerable, unwell individuals for want of alternative accommodation. A number of recent inspection and monitoring reports have raised concerns about delays in Mental Health Act assessments and the transfer of mentally ill people into specialist facilities. For example, the 2010-11 annual report from the Independent Monitoring Board at Glen Parva YOI, a prison holding young adult male prisoners, noted its concerns over "prolonged" delays in assessment under the Mental Health Act and "further wait[s] for transfer to a bed in a specialist facility despite the fact that the external health provider has a responsibility to find a bed within two weeks from the time of assessment".[136] Anecdotal evidence suggests this is as much a result of under-investment in specialist community provision as the inadequacy of protocols between individual prisons and health authorities. Such delays are not only harmful for the individuals involved, they also place additional pressure on prison and healthcare staff tasked with holding them safely in facilities which are ill-equipped to meet their needs.

The gulf between care in prison and a therapeutic facility equipped to deal humanely with distressed children and young people became clear during the inquest into the death of **Joseph Scholes'**, a boy with a well-documented history of self-harm, where it emerged he was placed alone in a strip cell in a canvas suit reminiscent of a horse blanket, described by a child-care expert at the inquest as 'dehumanising'. In the case of **Daniel Nelson**, one of the prison officers looking after him was asked what efforts had been made to talk to Daniel to get a sense of his state of mind. The prison officer told the jury: "We contact medical staff for that because we are not qualified".[137] The PPO report into Daniel's death questioned the decision not to position a prison officer outside his room on constant suicide watch and criticised the way the prison chronicled his deteriorating condition, which resembled "a diary, rather than any systematic review and reappraisal". It also noted that placing him in a cell with an opaque door not only inhibited accurate monitoring, but "must also have had a debilitating effect on him".[138] Indeed rather than conduct a face-to-face meeting, a visiting psychiatrist conducted an assessment of Daniel through the cell door.

Either way, legislation is clear that agencies tasked with delivering services into the secure estate have a statutory duty to provide vulnerable children and young people in prison with services which are equivalent to those in the community. The research and individual stories in this report call this into question and substantial improvements are needed in the availability and quality of mental healthcare provided to children and young people in prison. The imminent changes to healthcare provision in prisons should be taken as an opportunity to drive up standards.

Finding 6: the children and young people who died in prison had been exposed to bullying and treatment such as segregation and restraint

Children and young people in prison are detained in unsuitable and damaging environments and their experiences are often characterised by bullying, and degrading treatment such as strip-searching, segregation and restraint. In 2011 a Prisons and Probation Ombudsman report on violence reduction, bullying and safety in prison[139] recorded that 20% of the PPO's fatal incident investigations into self-inflicted deaths in custody had found evidence that the person who died was subject to bullying or intimidation by other prisoners in the three months prior to their death.

Some of the children and young people who died in prison between 2003-2010 had been bullied and this report documents how **Liam McManus** was encouraged to "string up" by other prisoners shouting between cells on the night of his death.

The use of restraint by staff on children and young people is also a common feature of prison life. In a joint review of the experiences of children in custody HM Inspectorate of Prisons and the Youth Justice Board[140] found that a third of boys and a quarter of girls in prison had been physically restrained. The report also found that black boys were disproportionately likely to be restrained by staff compared to white boys.

The dangerous and ultimately lethal use of restraint on children in prison first came to public attention as a result of the deaths of 15 year old **Gareth Myatt**[141] and 14 year old **Adam Rickwood** in secure training centres.

Adam Rickwood had been subjected to a Physical Control in Care (PCC) technique known as nose distraction shortly before he hung himself in Hassockfield STC and, at the second inquest into his death in January 2011, the jury found that its use contributed to his death. The jury also agreed that there was not only an unlawful regime in the use of PCC operating at the secure training centre run by private contractor Serco at the time of Adam's death but also that there was a failure by the Youth Justice Board (YJB) to prevent this regime.[142] That thousands of vulnerable children were systematically subjected to unlawful restraint in privatised child prisons, and that the regulatory or inspection bodies of the state with responsibility for monitoring the prisons did not tackle this, is deeply concerning.

It is also worrying that it took public hearings in the form of the inquests 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 in prison, death and suffering could have been prevented. The newly introduced system of restraint, Minimising and Managing Physical Restraint, must have robust monitoring mechanisms in place so that a similar situation is not allowed to develop.

Ongoing concerns about the use of restraint have been expressed by HMIP in individual inspection reports, most recently in Ashfield YOI where there had been a "significant increase in the use of force".[143] Although changes are to be made to the use of restraint, pain-inducing techniques have not been banned under the new system.

Finding 7: the children and young people who died in prison were failed by the systems set up to safeguard them from harm

Despite their known risks to themselves (including mental health problems and self-harming behaviour) all the children and young people whose individual stories are contained in this report were able to take their own life in prison. Taken together with analysis of the records of 98 children and young people who died between 2003-2010, the evidence in this report raises serious questions over: information-sharing between outside agencies and individual prisons; the ability of officers and practitioners accurately to identify those at risk of harm; and the system for managing and keeping safe individuals identified as at risk.

As discussed earlier, the research for this report has revealed significant concerns about information exchange between community agencies and prisons. This poor information flow may help to explain why half of the 98 children and young people who died had a history of self-harm and/or mental health needs but had not been identified as being at risk of harm and were not on an open ACCT at the time of their death. The Prisons and Probation Ombudsman has stressed that :

> *a concerning feature of our investigations in the last year [2011-2012] is that many prison staff are not aware of known high risk factors and too much reliance is placed on how a prisoner presents on the day…it is recognised in other measurements of risk that the best indicator of future behaviour is past behaviour. All information needs to be assessed and known risk factors need to be balanced against presentation.*[144]

If prison officers and social workers in the secure estate are to fulfil their duty to hold children and young people who are locked up safely, it is essential that they are alerted to any factors which may increase vulnerability at the earliest possible stage. Relying on ASSET and the other forms which should precede arrival in prison may not be sufficient, given known delays in transferring files from YOTs and probation to the secure estate and concerns over the accuracy of some information on assessment forms. Social workers in the secure estate, for example, need proactively to seek information from children's services departments where they suspect a child or young person has involvement with statutory services or where information is still outstanding. Relying on children and young people themselves to self-report is not always feasible as they may not know, for example, their correct care status, or may withhold information that they think would single them out as 'different' to others.

Perhaps more worryingly, 79% of those who died were not on an ACCT at the time of their death, suggesting there are serious concerns around identifying prisoners at risk of self-harm.

Finally, that more than one in five (21%) of those who died was on an open ACCT at the time of their death is a stark indicator that the system for monitoring and caring for children and young people at risk of serious self-harm in prison is not working.

Finding 8: there have been inadequate institutional responses to the deaths of children and young people in prison

The most troubling aspect of the research conducted for this report has been the persistent numbers of deaths of children and young people in prison and the apparent failure of state bodies and agencies to learn lessons from numerous PPO investigations, inquest findings, rule 43 reports and serious case reviews. Taken as a whole the state's response to the deaths has been inadequate. If prisons are to hold safely and humanely those whose offending is deemed so serious that only a term of imprisonment is justified, it is essential that learning from deaths in prison is applied to policy and practice at the earliest opportunity. This would ensure that day-to-day practice becomes more responsive to the needs of those who are imprisoned, whilst at a strategic level, that the configuration and delivery of services supports the effective treatment of vulnerable children and young people, whether in prison or the community.

While a death in prison of a child or young person can be traumatic and upsetting for all involved (including other prisoners and staff members) it is a tragedy for family and friends. Families bereaved by a death in custody are dealing with a traumatic event and also the

fact that the death occurred in prison, behind closed doors, which adds further distressing practical and emotional dimensions to their experience. The circumstances of these deaths mean families are also involuntarily engaged in the investigation and inquest system which is beset with problems including lengthy delays.

The Independent Advisory Panel on Deaths in Custody has gathered data from coroners which shows that between August 2010 and January 2011, approximately a quarter of death in custody inquests were taking more than two years to complete.[145] Analysis of 500 of INQUEST's death in custody cases where the death and inquest occurred between June 2000-June 2011 shows that 48% of cases took two years or more to conclude, 24% took three years or more and in 9% of cases it took four years or more before the inquest was heard. There have also been delays of more than five years in hearing some inquests into deaths in prison.[146]

Coles and Shaw have explained that families "hope their questions will be answered and their concerns addressed. Instead they can be left feeling that they have been further damaged by the investigation and inquest which in turn exacerbates their anger and grief."[147] For example, the inquest into the death of **Chay Pryor** took place in February 2011, 30 months after he died in HMP High Down, and his parents have spoken of their feeling of "being robbed" of the right to mourn their son because of the inadequacies of investigations and their unanswered questions.[148] Similarly, **Adam Rickwood**, died in 2004 yet it was not until 2011, when the second inquest into his death had concluded, that his family received the answers they sought to their questions about how he had died. Speaking after the inquest jury had returned a narrative verdict, his mother, Carol Pounder, said she had "waited over six years for truth and justice. All I ever wanted is to find out the truth about what happened to my son".[149]

Crucially, whilst delays place an intolerable strain on families wanting answers, they also raise questions as to whether, had it been unearthed earlier, learning uncovered by the inquest might have been instrumental in preventing further deaths.

The recent appointment of a new Chief Coroner to inject judicial oversight and national leadership to coroners' courts should impact on some of the systemic problems such as delay that are a feature of the inquest system. However, without additional resources, it is likely coroners will continue to struggle to improve the system.

Bereaved families have a vital role to play in ensuring inquests do not merely sanction the official version of events. Indeed, they and their legal representatives have been instrumental in exposing "systemic and practice problems that have contributed to deaths. Many of the changes to…training and guidance, changes to the law…increases in information entering the public domain…and public awareness of the issues have been a direct consequence of the deceased's family's participation in the inquest proceedings and lobbying…for change."[150] Skilled advocacy for the family aids the inquisitorial process and can contribute to the making of coroner reports for the prevention of future deaths.

It is essential, therefore, that families are supported to participate at every stage in the investigation and inquest process as fully and as openly as possible. Families should

automatically be eligible for non-means tested public funding to cover the costs of legal advice and representation and subsistence costs for the inquest hearings. Lawyers instructed on behalf of a prison, the Prison Service and other public bodies whose conduct may be subject to scrutiny during the inquest are paid for from public funds and, for example, in the year 2009-10 the Ministry of Justice incurred legal representation costs of £2.7 million in relation to inquests into deaths in prison. In contrast, the entire amount spent on the exceptional legal aid budget (ie for all cases covered by that scheme and not just family representation at death in prison custody inquests) in the same period was £1.6 million.[151] This translates into a significant inequality of arms between bereaved families and the public institutions who may have failed the children and young people in their care. If we are serious about learning from tragedy, families whose children have died whilst in the care of the state must not be precluded from involvement in subsequent investigations because of financial concerns.

The inquests and investigations into deaths of children and young people should be a forum through which lessons can be learned. However, this report has illustrated that similar issues persistently arise in Prisons and Probation Ombudsman (PPO) recommendations, inquest juries' narrative verdicts and coroners' Rule 43 recommendations.

As Coles and Shaw have argued, one reason for this is that:

> *While the coronial service can and does make a vital contribution to the prevention of deaths and the conditions of safe custody, that input is at risk of being critically undermined by the failure (1) to recognise the value of properly-collected data; and (2) to monitor compliance with and/or actions based on the findings and reports that emerge from inquests. The lessons to be learned from the contents of these verdicts and reports are far too frequently lost: they are analysed poorly or ignored; misunderstood or misconstrued; dissipated or dismissed.*[152]

Much of the material examined for this report, for example, is not easily accessible or even publicly available. There urgently needs to be public scrutiny and analysis of the follow-up to coronial reports, jury findings, and recommendations arising from investigation and inspectorate reports. Without full publication and scrutiny, the current system of poor, fragmented learning will persist and the vital contribution that the coroners' service can make to the prevention of similar fatalities will continue to be hindered. Ultimately, potentially life saving recommendations will continue to disappear into the ether and the penal system's capacity to safeguard children and young people will be diluted. INQUEST has previously called for the establishment of a national, publicly-accessible database of narrative verdicts and rule 43 reports to be compiled and maintained.[153] This would allow coroners and relevant institutions to use the information and give third sector bodies, academic institutions and others access to this rich source of material for further research and analysis.

In the first instance a specialist deaths in custody database should be established with details of all rule 43 reports and narrative verdicts categorised by custodial setting and

issues raised. It could also contain or link to relevant findings and recommendations from Prison and Probation Ombudsman investigations. In relation to children all the recommendations arising from the numerous serious case reviews, PPO investigations, narrative verdicts, rule 43 reports and other reviews should be collated and published to enable proper scrutiny of progress.

However, publication is only the first step and there needs to be an effective, multi-disciplinary approach to developing an effective and permanent follow-up mechanism. In the short-term, the Ministerial Council on Deaths in Custody provides a forum for ensuring that steps can be taken to prevent further deaths from occurring as a result of poor practice, negligence or inadequate safeguards, whether in the community or in custody. A mechanism for doing so could be through the Independent Advisory Panel on deaths in custody initiating a working group to ensure that new learning from the deaths of children and young people in prison could be mainstreamed as a priority. Such a step would also ensure consideration at a Ministerial level by all relevant government departments.

In the long-term, it is time to consider a radical overhaul of the use of imprisonment for vulnerable children and young people. Investigations and inquests have uncovered that the youth justice system needs profound public scrutiny and review significantly wider in scope than the inquest process, which focusses solely on the question of 'how' and 'in what circumstances' the child or young person died in prison. This normally confines these processes to an examination of an individual person's experiences in a prison at a given moment in time and is held in isolation from a consideration of the other deaths. It is abstracted from an analysis of youth justice policy and consideration of the wider social, structural and institutional arrangements that featured in a child or young person's life before their death. Significantly, it does not allow for collective lessons to be drawn from an aggregated understanding of multiple cases.

An independent review into the use of prison for children and young people is needed, with a focus on the deaths that have occurred. This public process would have a remit which includes, but is not be limited to, questions of sentencing, commissioning and placement. As part of this process there should be a critical review of the way in which lessons from deaths in prison are learned and applied to policy and practice. Such a process could build on previous models of inquiry or independent review[154] to look at the commonalities within, across and between the deaths as well as focusing on child welfare and youth justice policy and the law and policies in this area. Most importantly, it could make recommendations for action to improve the approaches to, services for and interventions provided to children and young people in conflict with the law so as to prevent further unnecessary deaths.

Each and every one of the children and young people whose deaths have informed this report died in the 'care' of the state while the state was responsible for their health and safety. It is difficult to comprehend how, despite the high death toll, lessons have not been learned and there has never been a public inquiry or review held. The deaths of more than 197 children and young people in the ten years following **Joseph Scholes'** death now demand such a response.

7. Recommendations

This report documents the vulnerabilities and needs of children and young people in conflict with the law and illustrates how they continue to be placed in unsafe institutions that are ill-equipped to deal with their complex needs. The organisational learning drawn from the statistics and individual stories in this report must be used, both in the community and in the secure estate, to ensure the needs of these children and vulnerable young people are identified and better supported at the earliest possible stage.

The following are recommendations for change with the aim of preventing further deaths of vulnerable children and young people in prison:

1. The custody threshold should be raised to ensure imprisonment becomes a true last resort, and is reserved for the minority of children and young people who commit serious violent offences and who pose a significant risk to others. Prison should not be the default response to low-level persistent offending.

2. Minor offences and anti-social behaviour committed by children and young people should be viewed as a public health, rather than criminal justice, issue and diverted to the health, welfare and other agencies which are best-placed to address them.

3. A new, distinct secure estate with an emphasis on therapeutic environments and interventions should be developed for the minority of children and young people whose offending is so serious that only a secure placement can be justified.

4. A common assessment framework which is built on a shared understanding of vulnerability should be developed for use by welfare and criminal justice professionals, so as to avoid the arbitrary distinction made by many statutory services between children and young people.

5. Sentencers must be better aware of the principles and sentencing guidelines which should underpin their decisions about the use of prison for children and young people.
    a) Comprehensive training should be provided for sentencers (in both youth and adult courts) and their legal advisers to enable better identification of complex needs, vulnerability and the court's options under mental health legislation.
    b) Full up-to-date information on locally available alternatives to custody for children and young people should be available to the courts.

6. Research on the distinct support needs of 18-24 year olds in prison, how they differ from those of adult prisoners, and how they are best identified and addressed should be urgently undertaken.

7. A clear system for identifying and managing looked after children and care leavers in prison, and ensuring the input of all statutory partners including social workers, youth offending practitioners and staff in the secure estate, should be introduced.

8. A review of the operation of the ACCT scheme as it applies to children and young people in particular should be conducted with a view to improving the accuracy of assessments and providing better support to those identified as at risk of harm.

9. Substantial improvements are needed in the availability and quality of mental healthcare provided to children and young people in prison.
    a) Imminent changes to healthcare provision in prisons should be taken as an opportunity to drive up standards.
    b) Procedures for transferring prisoners out of the secure estate under mental health legislation should be re-examined, and, where necessary, updated with new guidelines.

10. Delays in the inquest process must be addressed as a matter of urgency to ensure bereaved families do not have to wait years to hear the circumstances of a relative's death in prison, and that organisational learning from deaths is timely.

11. Families bereaved by a death in custody should automatically qualify for non-means tested public funding to enable their legal representation at inquests.

12. All coroners' Rule 43 recommendations and juries' narrative verdicts should be publicly accessible through a national database and analysed, audited and brought to the attention of Parliament to ensure responses from relevant Ministers.

13. An Independent Review should be established, with the proper involvement of families, to examine the wider systemic and policy issues underlying the deaths of children and young people in prison. As a starting point the Ministerial Council on Deaths in Custody should commission a new working group of the Independent Advisory Panel to draw together the specific learning from recent deaths of children and young people and identify issues for an Independent Review to consider.

Appendix 1

Table 3.1: Circumstances of child deaths in prison, 2003-2011

Name	Date	Age	Institution type	Legal status	Offence	Cause of death
Gareth Myatt	2004	15	STC	Convicted	Assault; theft	Positional asphyxia – restraint-related
Adam Rickwood	2004	14	STC	Remanded	Wounding; breach of bail [alleged]	Hanging – self-inflicted
Gareth Price	2005	16	YOI	Convicted	Rape	Hanging – self-inflicted
Sam Elphick	2005	17	YOI	Convicted	Robbery	Hanging – self-inflicted
Liam McManus	2007	15	YOI	Convicted	Theft	Hanging – self-inflicted
Ryan Clark	2011	17	YOI	Remanded	Robbery	Hanging – self-inflicted

Source: INQUEST casework and monitoring

Appendix 2

Table 3.2: Offence profile (convictions and remands) for 18-24 year olds who died in custody, 2003-2011

Offence	No (%) remanded/convicted
Robbery	23 (14%)
Theft/handling	18 (11%)
Murder/attempted murder/manslaughter	16 (10%)
Burglary/attempted burglary	13 (8%)
Rape/attempted rape	12 (8%)
Section 18/20 Offences Against the Person Act (GBH/wounding)	11 (7%)
Possession of a firearm/offensive weapon	11 (7%)
Other violent offences	9 (6%)
Drugs offence	8 (5%)
Various sexual offences (exc rape)	8 (5%)
Section 47 Offences Against the Person Act (ABH)	7 (4%)
Threats to kill	6 (4%)
Criminal damage	4 (3%)
Breach of order or licence conditions	4 (3%)
Other non-violent offences	4 (3%)
Reckless driving/driving while disqualified/drink driving	3 (2%)
Common assault	3 (2%)
TOTAL	**160 (100%)**

Source: INQUEST casework and monitoring

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7 INQUEST Press release 'Call for action following second child death in custody in a week', 26 January 2012
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9 The phrase 'young adult' is not used in this report, in order to avoid confusion with the Ministry of Justice usage of this term to refer specifically to 18 to 20 year olds
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This report by INQUEST and the Prison Reform Trust considers the 169 children and young people who died in prison between 2003-2011, and asks whether the state can learn lessons from their deaths. It includes an in-depth analysis of the circumstances of 98 of those who died, finding that many were known to have been vulnerable prior to their imprisonment, their lives characterised by mental health need or self-harm, problems with drug or alcohol use, disruption and loss. Yet often these children and young people were not assessed as being at risk of harm once in prison.

It seeks to illuminate the immediate and broader circumstances of these tragic deaths by drawing together the learning from official inquests and investigations, something which is not routinely done by the state, and putting forward clear recommendations for change. It is hoped that by setting out what needs to be done, this report will mark a turning point in the way the state responds to some of the most troubled and troubling children and young people in our society.

FUNDED BY
Diana
Princess of Wales Memorial Fund
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ISBN 978-1-908504-03-6
9 781908 504036 >