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YOUTH JUST

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WRONG

Carlile Inquiry — 10 years on

Lord Alex Carlile of Berriew CBE, QC chaired the Howard League Inquiry into physical restraint, solitary confinement and forcible strip searching in the juvenile secure estate.

In 2005 I was asked by the Howard League for Penal Reform to lead an independent inquiry into the use of restraint, solitary confinement and strip-searching in penal institutions for children. The inquiry was launched in the wake of the deaths of 15-year-old Gareth Myatt, who died whilst being restrained by officers, and 14-year-old Adam Rickwood, who was found hanging in his cell after he had been restrained by staff.

The rationale for the inquiry was that the rule of law and the protection of human rights should apply to all children equally, regardless of whether they are detained or in the community. The treatment children receive in custody should not risk making them more dangerous, more likely to commit criminal or anti-social acts, or more violent on release than on reception. The standards we applied were designed to uphold human rights, but also, and just as importantly, to ensure that children learn how to respect others and to avoid resort to conflict and violence. The way they are treated in custody will determine whether they consider violence as an acceptable way to reduce conflict when they are released. All the children we met, and all the children in custody since and now, are going to be released back into the community, some in days and some after a longer time.

The findings of the inquiry were published in 2006.¹ They included recommendations that restraint should never be used as a punishment or to secure compliance; that the infliction of pain was unacceptable and may be unlawful; that strip-searching should be risk-led; and prison segregation units should not be used for children.

10 years on

Ten years have now passed since the inquiry concluded and there is much to celebrate in youth justice, not least the reduction in the number of children in custody in England and Wales. At the time of the inquiry, there were nearly 3,000 behind bars. This has reduced to 1,000. Although there is still further to go to ensure that only the few children who require a period in a secure environment are detained, this is a considerable achievement. The secure estate itself has rapidly shrunk over the last 10 years. My team visited 11 institutions in 2005, only six of which still hold children. As I recommended, there have been particular successes in reducing the number of 'split-site' institutions, where adults and children are detained separately but within the same prison: there were nine split-site prisons and now there are two. One of the privately-run secure training centres, where Adam Rickwood died, has been closed.

The reductions, however, have also given rise to challenges. Children are now held further away from home and many of the small, local, secure units, highlighted by the inquiry as providing the best care and support for children, have been closed in order simply to make financial savings. In 2005 there were 15 secure children's homes, which held up to 235 children. There are now 10 units with a total of 138 places and this number is set to reduce further in 2016.

There have been particular successes in the treatment of girls in the system. When the inquiry was undertaken, there were over 200 girls in custody, many of whom were incarcerated with adult females, or in small, claustrophobic units attached to women's prisons. The number has now reduced to fewer than 40 and prison service accommodation is no longer used for girls, all of whom are now held in small, secure units.

As recommended by the inquiry, unannounced inspections are now carried out in all establishments at least once a year. HM Inspectorate of Prisons now undertakes joint inspections of secure training centres. The excellent work of the inspectorate has improved scrutiny, transparency and accountability of child custody.

There have also been improvements within custody itself. Social workers are now centrally-funded to work in all penal institutions; a particular success given the overrepresentation of looked after children in the youth justice system. There have been advances in the provision of education, mental health assessments and treatment and staff training.

More fundamental questions still need to be asked, however, about the number of children that are sent to prison. Although there has been an overall welcome reduction, the number of white boys has reduced at double the rate compared to the number of Black, Asian and Minority Ethnic (BAME) boys. BAME children now account for 42 per cent of the total child prison population.² Despite a change in legislation³ designed to reduce the use of remand, which came into force in 2012, 1,930 children were remanded to custody in 2013-14, accounting for 21 per cent of the average custodial population. Of these, 62 per cent were not given a custodial sentence. Of these, 25 per cent were acquitted.⁴ This is, clearly, unacceptable.

^{1.} Lord Carlile of Berriew (2006) An Independent Inquiry into the use of physical restraint, solitary confinement and forcible strip-searching of children in prisons, secure training centres and secure children's homes. London: Howard League for Penal Reform.

Ministry of Justice and Youth Justice Board (2016) *Youth Custody Report: November 2015.* London: Ministry of Justice and Youth Justice Board.
Section 98 and 99 of the Legal Aid, Sentencing and Punishment of Offenders (LASPO) Act 2012.

^{4.} Ministry of Justice (2015) Youth Justice Statistics 2013/2014: England and Wales. London: Ministry of Justice.

More needs to be done to prevent children coming into contact with the youth justice system in the first place. As gatekeepers to the system, police play a key role in this and a move away from target-driven policing to community resolution and restorative justice has helped to reduce unnecessary child arrests. Figures collated by the Howard League show that the number of child arrests has reduced by almost two thirds since 2008.⁵

In 2014 the findings of a parliamentarians' inquiry I chaired into the operation and effectiveness of the youth court were published.⁶ In the report we suggested a range of reforms, which are designed to divert children from the formalities of the criminal justice process, in which often they flounder with little understanding. Where possible, children should not be taken before a court. Diversionary schemes, challenging options that oblige children and their parents and guardians to confront the problems in their lives, will often be better value than the sometimes clunking processes

of the courts. Where a more formal disposal is required, the courts must ensure that justice is done which serves the interests of victims, perpetrators, and society as a whole.

As part of the inquiry, numerous visits to courts were undertaken. In one case observed by our researcher and rapporteur, a teenage boy was being prosecuted for causing unnecessary fear, alarm and distress. The boy had been selfharming and in desperation a family

member called the police. The 'fear, alarm and distress' the boy was subsequently prosecuted for was the police officer's at seeing the self-harm. When questioned, the CPS solicitor refused to drop the prosecution as it 'was in the public interest'. The case is a parable of how things should not be done and the progress that needs to be made to ensure that, as a society, we are not criminalising vulnerability.

Safeguarding

Although progress has been made in the last 10 year, it is somewhat overshadowed by the decline in safety levels in children's prisons. In his latest annual report, HM Chief Inspectorate of Prisons stated: 'Establishments struggled to control violence and bullying. In all establishments, there were fights and assaults almost every day' and prisons 'have struggled to manage these children safely'.⁷ Given that the original inquiry was established following the deaths of Gareth Myatt and Adam Rickwood, it is particularly distressing that five more boys have died in prisons:

– Liam McManus, aged 15, died at Lancaster Farms prison in November 2007 after he was found hanging from a bed sheet in his cell. The jury at his inquest blamed 'systemic failings' which meant that there was a 'failure to protect' Liam.⁸

- Ryan Clarke, aged 17, died at Wetherby prison in April 2011. The jury at his inquest concluded that Ryan's actions were more of a 'cry for help' rather than intentional hanging, and ruled by majority that his death was accidental.⁹

– Jake Hardy, aged 17, died in hospital having been found hanging in his cell at Hindley prison in January 2012. The jury at his inquest concluded that a series of 12 individual failures more than minimally contributed to his death and that his decision to hang himself could have been prevented.¹⁰

– Alex Kelly, aged 15, died in

– Alex Kelly, aged 15, died in hospital having been found hanging in his cell at Cookham Wood prison in January 2012. The jury at his inquest concluded that numerous failures led to Alex's death and that he took his own life, but his intention at the time cannot be proven beyond reasonable doubt.¹¹

 A boy was found dead at Cookham Wood prison in July 2015.
At the time of writing, there was no

further information regarding his age or circumstances, although the Youth Justice Board (YJB) has stated that it 'have [sic] no indication that the young person took their own life or that the circumstances were suspicious'.¹²

In 2013 the Prison and Probation Ombudsman (PPO), published a 'lessons learnt' report into the deaths of Ryan, Jake and Alex.¹³ Key findings included:

- Children had been inappropriately placed in prisons against the recommendations of youth offending teams (YOTs) that they should be in smaller, more specialist units.

- Once in the prisons, two of the boys continued to show signs of extreme vulnerability, including withdrawing from social contact and self-harm.

- Two of the children were looked after children and the third had a statement of special educational needs. Two were in custody for the first time; the other had only spent a brief period in prison on remand. These are known static risk

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6. Lord Carlile of Berriew CBE, QC (2014) Independent Parliamentarians' Inquiry into the Operation and Effectiveness of the

7. Her Majesty's Chief Inspector of Prisons for England and Wales (2014) Annual Report 2013-2014. London: HMSO.

^{5.} Howard League for Penal Reform (2014) Child arrests in England and Wales 2013: Research Briefing. London: Howard League for Penal Reform.

^{8.} BBC News (2009) Care teams blamed for boy's death. 13 November.

^{9.} INQUEST (2014) Serious failures identified by jury at inquest into death of 17 year old Ryan Clark at HMYOI Wetherby. 28 January.

^{10.} INQUEST (2014) Inquest into the death of 17 year old Jake Hardy at HMYOI Hindley begins. 24 Feburary.

^{11.} INQUEST (2014) Inquest into the death of 15 year old Alex Kelly at HMYOI Cookham Wood begins. 10 November.

^{12.} Youth Justice Board (2014) Deaths in Custody: Action taken, lesson learnt. London: Youth Justice Board.

^{13.} Prisons and Probation Ombudsman (2013) Child Deaths: Learning from PPO Investigations into three recent deaths of children in custody. London: Prisons and Probation Ombudsman.

factors for self-harm. Yet, there were inconsistencies in the assessment and evaluation of the risk these children posed to themselves.

 All three children entered custody with previously diagnosed mental health conditions, which were not adequately catered for.

- There were issues with poor assessments, missed medication and a lack of an escalation in mental health support provided, despite acts of self harm and concerns being raised by staff.

- There is evidence that two of the children were bullied, yet the investigations found that staff were aware of, or suspected, this bullying, but there was a lack of a robust response.

– There was a lack of a consistent and reliable staff presence.

The PPO concluded that:

'Many of the issues raised by the three recent deaths are not unique. The impact of bullying, weaknesses of reception assessments of vulnerability and mental health, weaknesses of personal office schemes and problems with ACCTs (Assessment, Care in Custody and Teamwork assessments) have been identified in our past investigations of child deaths between 2004 and 2007.'¹⁴

In 2014 Lord Harris of Haringey

was asked to lead a review of the 83 self-inflicted deaths of young people aged 18-24 years old in prisons between 2007 and 2013. The inquiry was expanded, however, to include the deaths of children in the same period. 'The Harris Review: Changing Prisons, Saving Lives'¹⁵ was published in July 2015 and made 83 wide-ranging recommendations. At the time of writing, the government had not published its response to the review, but it is hoped that radical changes can be made. As Lord Harris concludes: 'Not to implement our recommendations would mean that the opportunity to reduce the number of deaths of people, of all ages, has not been taken and will continue to die alone and miserable in prisons in one of the richest countries in the world'.¹⁶

Restraint

I have been disappointed too by the slow progress in developing and implementing one safe and certified

technique to be used on children across the secure estate. I recommended in 2006 that this was a matter of urgency. Numerous inquiries and boards have been set up and reported in the intervening period. In 2012 the government, finally, announced a new system of restraint for use in children's prisons: 'Minimising and Managing Physical Restraint' (MMPR), which has been slowly rolled out, although, at the time of writing the YJB is proposing to pause its implementation in order to realise £800,000 of in-year savings.¹⁷

There are, however, some key concerns with the new system. There are three techniques that cause the deliberate infliction of short bursts of pain on children, despite my recommendation that they are unacceptable and may be unlawful. In Wetherby prison, initial data on MMPR showed

that pain had been deliberately inflicted on children 23 times in six months.¹⁸ I recommended that restraint should never be used primarily to secure compliance. The use of force for 'good order and discipline' (or 'passive noncompliance' as it has since been renamed) continues be to widespread in young offender institutions (YOIs), in one prison accounting for over a third of all restraints.¹⁹ I also recommended that handcuffs should not be used on children, but they are still permitted

in the privately-run secure training centres and YOIs. In one prison they were used 86 times on children in six months.²⁰

In 2006 I recommended that there should be improvements to the recording and monitoring of the use of restraint on children. This has been implemented. In 2010, the Ministry of Justice published annual data showing for the first time a detailed breakdown of the use of recorded restraint and the number of injuries to children following its use. What these figures show, however, is that although the number of use of force incidents has reduced in children's prisons, the rate per 100 children in prison has more than doubled in the last five years. The latest statistics show that there were 5,714 incidents of restraint in the secure estate in 2013/14, down by 12 per cent on the previous year. However, the number of restraints per 100 children increased to 28.4 from 23.8 in the previous year.²¹ The statistics also show that there were 120 injuries suffered by children as a result of the use of force last year. 1,060 injuries were caused

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19. Ibid.

^{14.} Ibid, p.8.

^{15.} Lord Harris of Haringey (2015) Changing Prisons, Saving Lives: Report of the Independent Review into Self-Inflicted Deaths in Custody of 18-24 year olds. Cm 9087. London: HMSO.

^{16.} Ibid, p.6.

^{17.} Youth Justice Board (2015) Proposal to reduce the YJB's expenditure in 2015/16. London: Youth Justice Board.

^{18.} Youth Justice Board (2015) Statistical Notice: Minimising and Managing Physical Restraint (MMPR) Data Collection April 2014 – September 2014. London: Youth Justice Board.

^{20.} Ibid.

^{21.} Ministry of Justice (2015) Youth Justice Statistics 2013/2014: England and Wales. London: Ministry of Justice.

as a result of the use of force between 2009-14, 61 of which were classed as 'serious injury requiring hospital treatment'.²² This slow and piecemeal progress in implementing the recommendations of my inquiry means that children continue to be placed in danger. The continued and widespread use of pain compliant methods of restraint on children and the use of force to secure compliance should be viewed as a failure.

Segregation

In 2006 the inquiry reported on the largely hidden world of prison segregation. We found that most segregation units, which were known by a range of euphemisms, were little more than bare, dark and dank cells that in effect were inducements to suicide. In the intervening years, little has changed. There is no central data on the number of children placed in segregation units, the length of confinement or reasons for confinement. However, the latest survey of children in prison found that 28 per cent had been held in segregation at some point.²³ Children spent 7,970 days in prison segregation units in 2013/14.24 HM Chief Inspector of Prisons has stated that: 'Conditions for children in segregation units were poor and they were locked up for far too long.'25 At Feltham prison, 394 children were put on the segregation unit in the last year. One child was held there for 39 days.²⁶ At Cookham Wood prison, 'at one time during the period when staff were able to deliver little more than the basic care' five children were held in segregation between 98-168 days.²⁷ At Wetherby prison, inspectors found that one child had been segregated for 66 days and another two boys for 46 days.²⁸ The regimes on segregation units are limited, such as at Wetherby prison, where inspectors found: 'The regime on the unit was inadequate. All the boys we spoke to told us they spent most of their time locked in their cells. There was little evidence of any constructive activities, although staff sometimes allowed boys out of their cells to carry out cleaning work on the unit."29 In recent years, due to a combination of staff shortages and an increase in violence, children's prisons have increasing imposed restricted regimes, either across entire institutions or to 'manage' individual children, which includes locking them in their cells for 23 hours a day. The inspection of Feltham prison found that 26 per cent of the children being on restricted regimes, which meant that they 'were in effect experiencing solitary confinement on their residential units.'³⁰ This must be addressed with urgency.

Strip-searching

My inquiry reported on the abhorrent practice of the routine strip-searching of children. We concluded that:

Within the custodial context a strip-search is more than just the removal of clothes for a visual inspection. It is a manifestation of power relations. A strip-search involves adult staff forcing a child to undress in front of them. Forcing a person to strip takes all control away and can be demeaning and dehumanising.

The progress over the last 10 years has been slow but ultimately, successful. Routine strip-searching in secure children's homes and secure training centres, including on reception, was banned and replaced by an entirely risk-based approach. Following a review by the YJB conducted against the background in 2007 of the Gender Equality Duty and the Corston Report, routine strip-searching of 17-year-old girls in prison service units was replaced by a risk-based approach. In 2012 the prison rules were amended to introduce a risk-based approach replaced routine stripsearching in all aspects in boys YOIs, with the exception of on initial reception. Following successful and continued lobbying by the Howard League,³¹ the Ministry of Justice agreed to introduce pilots using a risk-based approach on reception. They were successful and in 2014 the prison rules were changed so that children do not have to strip on arrival. 10 years on from my inquiry, this is a welcome success in bringing to an end such an unnecessary, degrading and barbaric practice. That is a cause for celebration.

^{22.} Ibid.

^{23.} Prime, R. (2015) Children in Custody 2013-2014: An analysis of 12-18 year olds' perceptions of their experience in secure training centres and young offender institutions. London: HM Inspectorate of Prisons and Youth Justice Board.

^{24.} Hansard. HC Deb. 7 November 2014.

^{25.} Her Majesty's Chief Inspector of Prisons for England and Wales (2014) Annual Report 2013-2014. London: HMSO.

^{26.} See: http://data.parliament.uk/DepositedPapers/Files/DEP2015-0074/216277-216278-216279-216280-216281- IWW.PDF

^{27.} Independent Monitoring Board (2014) *HM YOI Cookham Wood: Annual Report of the Independent Monitoring Board 1 August 2013 – 31st July 2014.* London: Independent Monitoring Board.

^{28.} Her Majesty's Inspectorate of Prisons (2014) *Report of an unannounced inspection of HMP & YOI Wetherby 7-8 October 2013*. London: Her Majesty's Inspectorate of Prisons.

^{29.} Her Majesty's Inspectorate of Prisons (2015) *Report of an unannounced inspection of HMP & YOI Wetherby 12-23 January 2015*. London: Her Majesty's Inspectorate of Prisons, 30.

^{30.} Her Majesty's Inspectorate of Prisons (2015) *Report of an announced inspection of HMYOI Feltham 11-24 August 2014*. London: Her Majesty's Inspectorate of Prisons, 6.

^{31.} See: http://www.howardleague.org/fileadmin/howard_league/user/pdf/Letters/Letter_to_Jeremy_Wright.pdf