Neutral Citation Number: [2009] EWHC 76 (Admin)

Case No: CO/7082/2007

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 22/01/2009

Before :

THE HON. MR JUSTICE BLAKE

- -

Between :

R(ON THE APPLICATION OF CAROL POUNDER)	**Claimant**
- and -	
HM CORONER FOR THE NORTH AND SOUTH DISTRICTS OF DURHAM AND DARLINGTON	**Defendant**
-and-	
YOUTH JUSTICE BOARD	**1st Interested Party**
-and-	
SERCO HOME AFFAIRS LIMITED	**2nd Interested Party**
-and-	
LANCASHIRE COUNTY COUNCIL	**3rd Interested Party**

- -
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Richard Hermer (instructed by **Bhatt Murphy Solicitors**) for the **Claimant**
Richard Perks (instructed by **Hewitts Solicitors**) for the **Defendant**
Wendy Outhwaite (instructed by the **Treasury Solicitors**) for the **1st Interested Party**
Samantha Leek (instructed by **Lupton Fawcett Solicitors**) for the **2nd Interested Party**

Hearing dates: 18th, 19th December 2008

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Approved Judgment

The Honourable Mr Justice Blake:

Introduction

1. Adam Rickwood has the mournful distinction of being the youngest person to die in a British penal establishment, at least in modern times. On the 8th August 2004, shortly before midnight, he was found in his bedroom cell at Hassockfield Secure Training Centre (STC) having strangled himself with the assistance of a shoe-lace. Resuscitation failed and in due course he was pronounced dead. He was 14 years at the time, having been born on 14th November 1989. He was a troubled child with a history of offending, self-harm, substance abuse and absconding from care. In his cell were found two documents: a farewell letter to his family and a statement complaining of his treatment at Hassockfield STC some six hours earlier that day.

2. On the 29th June 2004 Adam had appeared before the Burnley Pendle and Rossendale Magistrates' Court who ordered his secure remand on a charge of wounding with a knife and an offence of burglary. No secure beds were available. Adam absconded on three occasions from less secure local authority children's accommodation, and on the 10th July 2004 he was placed at Hassockfield STC in response to the repeated decisions of the magistrates' court who had ordered secure remand. It was his first experience of custody. Hassockfield STC is a custodial centre run by a private company Serco Ltd (the second interested party in these proceedings), under powers given to the Secretary of State under s.7 of the Criminal Justice and Public Order Act 1994. At that time STCs were intended to house particularly challenging children aged between 12 and 15 who were sentenced by the criminal courts. Subsequently, the age range for admission to an STC was increased to 17 for those on remand or sentenced to a detention and training order. Other offenders over 15 and under-21 could be assigned to a Young Offenders institution run by the prison service directly.

3. There was a detailed contract made between the relevant government department (originally the Home Office and now the Ministry of Justice) setting out the powers and duties of the STC and its staff. The monitoring and enforcement of this contract as well as the duties of purchasing and allocation of placements in secure facilities for children who had been sentenced or remanded in custody was to be performed by the Youth Justice Board (YJB) who is the first interested party in these proceedings. The YJB is an executive non-departmental government body set up under the Crime and Disorder Act 1988.

4. As Adam had died in a penal institution, the Coroners Act 1988 s. 8(1) and (3) required the Coroner to conduct the inquest with a jury. By s.11 (5) of that Act the inquisition shall set out as far as the particulars have been proved who the deceased was and how, when and where the deceased came by his death. The proceeding before this court is an application for judicial review of that inquest made by the claimant, Adam's mother. The defendant in this matter is HM Coroner for the North and South Districts of Durham and Darlington. The first two interested parties have already been identified. The third interested party is Lancashire Country Council which was the local authority with statutory responsibilities for Adam. It participated in the inquest proceedings but has played no part in the proceedings before this court.

5. It should be stated at the outset of this judgment that it is clear from the three volumes of the transcript of the record of the inquest, the three volumes lodged in support of this application for judicial review, and the detailed grounds and skeleton arguments of the parties that the defendant Coroner conducted a very substantial inquiry into a

number of questions that may have caused or materially contributed to Adam's self-inflicted death. Over a five week period from 30th April 2007 the jury heard from at least 33 different witnesses into many and various aspects of the history whereby Adam came to be remanded to Hassockfield STC, his assessment of suicidal vulnerability on arrival there, and his subsequent inmate history there.

6. It is plain from the evidence gathered and the inquisition returned by the jury that Adam was unhappy at being remanded in custody at all and was unhappy at being detained at Hassockfield STC in County Durham some 100 miles and three hours away from his family in Burnley the other side of the Pennines. There are very real limits to the extent that an inquest is either required or is able to investigate questions of resources and juvenile penal policy that led to this remand. The decision-making process that led to this outcome was fully explored before the jury as was his request for a transfer.

7. Adam was assessed at high risk of self harm on arrival at Hassockfield STC and was placed on the register of those who were considered to be at high risk of self-harm (HRAT). Nevertheless, he seemed to make progress in addressing his situation and the reasons why he was there. He was regarded as a model trainee who had earned substantial privileges by reason of his good behaviour and at the end of July 2004 a decision was taken to remove him from the HRAT register. Again the reasons for doing this were explored at the inquest and no complaint is made of the way the jury examined these issues and the conclusion to which it came that this decision was an appropriate one.

8. Adam died late on a Sunday night. On the previous day he had lost privileges and had his television removed from his bedroom cell because he had been supplied with two contraband cigarettes by his mother during a visit. Adam was also under the mistaken impression that an application for bail was being made to a judge in chambers the following week and he believed he had good prospects of success in such an application. On the Sunday evening he twice spoke to his solicitor, and as a result of one of those conversations he learned that no such application was to be made. The jury concluded that his loss of privileges and the disappointing news as to the possibility of an imminent bail hearing contributed to his decision to take his life. No complaint is made of those conclusions.

9. Another factor that was a potential contributory cause of his self-inflicted death, was the treatment he received around 6.00pm on the Sunday 8th August. This was the subject of an oral complaint made to staff, his statement found in his cell and the topic of at least one of the conversations he had with his solicitor that evening. It is the consideration given by the inquest to this factor that forms the basis of this application for judicial review.

10. In broad terms the evidence adduced at the inquest reveals the following picture. In the early evening in question, Adam and another inmate were in their free association period outside their bedroom cells. A third inmate who had been deprived of association and sent to his cell for disciplinary reasons passed a note under his cell door to Adam in which abusive remarks were made about the female training officer (Ms Murray) who was supervising the trainees. As a result of disobeying an order to hand over the note, Adam was himself ordered to go to his cell by way of sanction. He refused to go to his cell protesting that he had done nothing wrong. He sat down

and resisted requests to move without offering any violence to himself, other inmates or staff or inciting other inmates to violence or disorder. Ms Murray called a more senior officer (Mr Gardiner), whose attempts to persuade Adam to go to his cell were also unsuccessful and who in turn called for emergency assistance from other members of staff by way of a call known as first response. The evidence before the inquest suggested that calling for first response tended to result in the use of physical restraint. Officers Hamilton, Lowerson, Clark and Hodgson attended the scene in response to the call. As Adam still refused to leave the association area voluntarily two male officers (Hamilton and Lowerson) physically took hold of each of his arms. He struggled in resistance to this and so a third officer (Hodgson) controlled his head with both hands. There was further resistance and a fourth training officer (Clark) came from behind Adam and took hold of both his legs. He was lifted off the ground and moved face downwards to his cell where he was placed face down on the floor before the officers left the cell. Officer Horseman attended to make a video recording of the restraint. During the manoeuvre, Mr Hodgson, the officer who held Adam's head feared that Adam was trying to bite the officer's fingers and so applied what is known as a nose distraction technique. This is a short sharp movement applying force by fingers under the nostril against the counter-force of the other hand holding the back of the head. It is a pain-compliant technique. It made Adam very upset and angry during the rest of the manoeuvre and immediately thereafter. It caused his nose to bleed. This was not an unusual outcome of the application of this technique in Hassockfield. When he was locked into his cell and left alone for some 30 minutes he was bleeding from his nose and shouting that he would use violence on the officer who had applied the force. He smeared blood over the walls to his cell, smeared toothpaste over the spy-hole to his cell door and flooded his cell with water. Later he appeared to have calmed down, was allowed out on association, cleaned up his cell and spoke to his solicitor. He made it plain that he wanted to complain about the force used on him. Around 8.00pm he was seen by a nurse who noted a small amount of swelling over the bridge of the nose, and dried blood around the nose and mouth. She did not consider any hospital treatment was needed that evening. He went to bed and was last checked inside his cell around 9.30pm when he seemed to be calm and focused on the day ahead. He was observed to be moving around his cell through the hatch over the next two hours. At one point he was required to remove a piece of card blocking the hatch. He was found in his bedroom cell fatally asphyxiated shortly before midnight. The injuries he received in the restraint were minor and not the direct cause of death.

The issue of legality of restraint at the inquest

11. There were controversial questions at the inquest about whether the staff order that gave rise to the incident was a lawful order, whether the use of any physical restraint to enforce a staff order was lawful in the circumstances of this case, and whether any member of staff was entitled to use a pain-complaint nose distraction technique on a child of Adam's age in the circumstances of his case. The staff members most closely connected with the incident made witness statements to the police who were called on to investigate the death. They were subsequently interviewed under caution where it was pointed out and accepted that the Secure Training Centre Rules 1998 (SI

1998/472) generally and Rules 36 to 38 in particular did not give the staff of the STC authority to do any of the three things identified above. The Rules provide as follows:

"Rule 36 - Removal from Association

(1) Where is appears to be necessary in the interests of preventing him from causing significant harm to himself or to any other person or significant damage to property that a trainee should not associate with other trainees either generally or for particular purposes (the director) may arrange for the trainees removal from association accordingly.

(2) The trainee shall not be removed under this rule unless all other appropriate methods of control have been applied without success.

Rule 37 – Use of Force

(1) An officer in dealing with a trainee should not use force unnecessarily and, when the application of force to a trainee is necessary, no more force than necessary shall be used.

(2) No officer shall act deliberately in a manner calculated to provoke a trainee.

Rule 38 – Physical Restraint

(1) No trainee shall be physically restrained save where necessary for the purpose of preventing him from –

a. Escaping from custody

b. Injuring himself or others

c. Damaging property or

d. *Inciting another trainee to do anything specified in paragraph b or c above.*

And then only when no alternative method of preventing the event specified in any of the paragraphs a-d above in available.

(2) No trainee shall be physically restrained under this rule except in methods approved by the Secretary of State and by an Officer who has undergone a course of training which is so approved.

(3) Particularly the very occasion on which a trainee is physically restrained under this rule shall be recorded within 12 hours of its occurrence."

(Emphasis supplied)

12. This court was informed during the hearing that when the papers were referred to the CPS, it gave weight to an argument that seems to have been advanced by Serco on behalf of its staff that although there was no power to restrain a trainee under the statutory rules, there was a power in s.9 (3) and (4) Criminal Justice and Public Order

Act 1994 to use reasonable force to ensure good order and discipline. Section 9 reads as follows

"Powers and duties of custody officers employed at contracting out secure training centres

(1) a custody officer performing custodial duties at a contracted-out secure training centre shall have the following powers, namely –

a. to search in accordance with secure training and rules any [person] who is detained in the secure training centre and

b. to search any other person who is in or is seeking to enter the secure training centre, and any article in the possession of such a person.

.....

(3) a custody officer performing custodial duties at a contracted out secure training centre shall have the following duties as respects [persons] detained in secure training centres namely –

a. to prevent their escape from lawful custody

b. to prevent or detect and report upon the commission or attempted commission by them of other unlawful acts.

c. to ensure good order and discipline on their part and

d. to attend to their well being.

(4) the powers conferred by subsection (1) above and the powers arising by virtue of subsection (3) above shall include power to use reasonable force where necessary."

13. By the time the inquest started, a decision had already been taken that there should be no prosecution. When staff were questioned on behalf of the claimant as to their authority to segregate and restrain Adam at all, in one way or another and with different degrees of clarity and emphasis, the statutory power was relied on to trump the limits of the powers afforded both under the STC Rules and the rules for the particular STC drawn up by its Director Mr. Wilson-Smith (Policies and Operational Procedures Directors Rules issued on the 29th September 2002). Rule 1.2 of these Rules provides as follows:-

"Physical force will be use(d) only:

-to prevent a trainee from escaping

-to prevent a trainee from harming him/herself or others

-to prevent a trainee from damaging property

> -to prevent a trainee from inciting another trainee to harm him or herself or others or damage property
>
> Physical force will not be used for any other reason or simply to obtain compliance with staff instructions, it will be a measure of last resort."

14. The suggestion was ventilated that the statutory power to use reasonable force where necessary in support of the duty to ensure good order and discipline, took priority over the STC Rules and either broadened or displaced them, and if there was a conflict between the Rules and the statutory power the latter should prevail. The statute and the rule making power will be further considered below later in this judgment.

15. It was and remains unclear when the members of staff immediately concerned with initiating the first response call that led to the restraint of Adam came to believe that they had a statutory power to do what they did to him. The claimant submits that this was not something that had been mentioned by them in their police statements or interviews. It is not referred to in the Physical Control in Care Training Manual (2003 edition) developed by the HM Prison Service which was the recognised and approved manual for dealing with physical restraints of young people. In this manual the reader was referred to the STC Rules for the specific circumstances when force and physical restraint can be used and Rules 37 and 38 were set out in the introduction.

16. Some of the staff questioned at the inquest could not remember the details of their training in restraint techniques before they took up their duties. Mr Clark was a team leader in the first response unit. In answer to questions from the family, he said that he understood Criminal Justice and Public Order Act gave authority to use force to restrain in the interests of good order and discipline, and that he had been told that during his training provided by the YJB. (Transcript 1/2/37) but he was not clear who told him this (T1/2/38). Mr Hodgson who applied the nose distraction technique and had been at Hassockfield since 2003, was a PCC instructor. In cross-examination his understanding as to his powers was explored with him. Although in the summary of his police interviews he had accepted that what he did was outside the scope of the STC Rules (T1/2/112) he now disputed that this was the case (T1/2/115). He relied in part on a factual suggestion mentioned in his police statement that he had been told by Mr Gardiner that Adam had been inciting other trainees to disorder. Mr Gardiner did not support this evidence in his witness statement or evidence at the inquest. There was no evidence that Adam was inciting anyone. Mr Hodgson further referred to various Acts that entitled him to restrain Adam. He identified the CJPOA as an authority to use force to maintain control (T1/2/118). In answer to questions from counsel for the YJB Mr Hodgson explained that he had been trained by Mr Collier of the Prison Service in accordance with the terms of the PCC Manual (T1/2/131-132). In answer to questions from counsel for Serco he stated that the CJPOA was mentioned in training and he regarded a power to maintain good order and discipline and to use force to secure it as very important (T1/2/135-136).

17. Mr Collier was an experienced prison service trainer who had made a statement critical of a number of the aspects of the restraint of Adam as arising from the witness statements of relevant staff at the STC. He gave evidence at the inquest, confirming

that restraint could only be authorised if the conditions set out in Rule 38 of the STC Rules were met (T2/5/42) and that all staff were taught this. He said that restraint could not be used to enforce an order where these conditions were not met (T2/5/43) and that the CJPOA was referred to in training as the statutory basis for STCs but not the source of authority to use force outside or inconsistent with the STC Rules (T2/5/46-47). He was also concerned about some other aspects of the use of PCC at the STC and was concerned that nose-bleeding seemed to be a regular outcome of the restraint.

18. The jury themselves were soon made aware of this conflict as to the source of the authority to restrain. When Officer Clark had completed his evidence one of them asked a question in the following terms:

> "Q: I'm having problems reconciling this quote at s.9(3) of the 1994 Act, PCC 2003Manual, It seems like the first one gives you authority to do certain things , and yet the second one doesn't , so in a legal sense, does the Act take priority across the manual, because its just the Manual?
>
> A: Yeah…The Act is a piece of legislation ..its the legislation that empowers everything else".

The Coroner's ruling

19. When, Mr Hermer, counsel for the claimant both in the inquest and before this court, became aware that Mr. Freeland QC, counsel for Serco at the inquest, was in effect relying on the statute to justify what was done to Adam and intended to seek that explanation from the staff called as witnesses, he submitted to the Coroner that a definitive ruling on the true legal position was necessary for him to make otherwise the investigation of the relevant facts and circumstances would proceed on a false basis and its outcome would be likely to be flawed. This submission was repeated with courtesy but persistency at a number of points during the inquest, notably after the jury's question apparently seeking clarification of the law from a witness in the case (see [18] above). It was consistently unsuccessful. Having initially deferred whether a ruling was necessary, after the jury's question, the Coroner decided he would give no ruling while the evidence was being heard:

> "What I propose to do therefore is to adopt a line similar to that suggested by Mr Freeland and to explain to the jury that there is an issue about what the staff to do in …2004. And that is clear from the questioning that they have heard, and this may then be the subject of further comment in due course. But I think that to say that it is legal or illegal or unlawful, is likely to hamper any inquiry rather than aid it. And if I am wrong on that then again, somebody will no doubt in time tell me if it's thought necessary."

20. Eventually at the end of the evidence, and before delivering his instructions to the jury, the defendant decided that it was unnecessary and undesirable for him to rule on the legality of the restraint used on Adam. All that mattered was the primary facts including the question whether any staff using restraint at the time they did honestly

thought they had the power to do so. Anything further would be a matter of recommendation for him.

21. The claimant at this point sought an adjournment to seek judicial review of this decision before the jury were put in charge of their deliberations. This course was vigorously opposed by counsel for Serco who pointed out that a ruling on legality at this stage in the proceedings might require further evidence to be admitted. The defendant decided against an adjournment to review the legality of his ruling. In the course of his ruling explaining the decision he said the following:

> "I think the strongest argument for not allowing Mr Hermer's application for an adjournment come in effect from Mr Hermer himself. One in particular that is how I look at it. If it is decided by another tribunal that the restraints were unlawful then that may well colour the opinions the jury have of the witnesses that gave evidence to them. I do not know what view the jury have taken of the credibility of the witnesses that they had before them. If they have formed a view and then are subsequently told what they were saying is right or wrong depending on which witness your thinking about then that could lead to all sorts of problems in the jury trying to decide on credibility of evidence. If it is decided that restraint is unlawful then, using Mr Hermer's phrase, the inquest may well be fatally flawed and whilst he might not wish to examine the further questions and re-examine witnesses then I have already indicated I might wish to do so, but it also may then be suggested in the interested of justice that the rulings and limitations I placed on counsel with regard to various lines of questioning were wrong and therefore it is possible with the benefit of hindsight those rulings might be wrong and in the interests of justice therefore it might well be beneficial for there to be a fresh hearing when all the witnesses could be re-examined and all the relevant points heard and examined. If it had been clear at the time what the relevant points were. On the other hand if matters went to the administrative court and the rulings were that restraints were lawful then all the risks in delay become unwarranted."

The Scope of the Inquest

22. At the outset of the inquest all parties were in agreement that the circumstances of Adam's death in custody engaged the investigative obligations inherent in Article 2 of the ECHR and made applicable to this inquest by s.6 Human Rights Act 1998. As Lord Bingham explained in *R (Middleton) v West Somerset Coroner* [2004] UKHL 10; 2 AC 182 at [35] this means that the word "how" in the Coroners Act and the Rules made under it should be interpreted in a broader sense as meaning not simply 'by what means' but 'by what means and in what circumstances'. It was therefore common ground that the Coroner was required to examine not merely how Adam met his death in the sense of the immediate cause of death, but also the circumstances in which he came by his death, in the sense of factors that may have contributed to his death.

23. In the case of *R (Amin) v Secretary of State for the Home Department* [2003] UKHL 51; [2004] 1 AC 653 the purpose of such inquiry is identified at [31]

> "In this country… effect has been given to that duty for centuries by requiring such deaths to be publicly investigated before an independent tribunal with an opportunity for relatives of the deceased to participate. The purposes of such an investigation are clear: to ensure insofar as possible that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrong doing (if unjustified) is allayed; that dangerous practices and procedures are rectified; and that those who have lost their relatives may at least have the satisfaction of knowing that lessons learnt from his death may save the lives of others."

24. In discharge of the procedural duties imposed in cases of this class, the parties were agreed and the Coroner decided that one of the circumstances that required investigation was the possible contribution to Adam's death of the decision to subject him to restraint and the type of force used in do doing. The claimant points out that the Second Interested Party had submitted as follows in its skeleton argument lodged at the outset of the inquest (1st June 2006) to assist the Coroner was asked to rule on the scope of his investigation:

> "28 Whilst it is not possible at this stage confidently to provide a comprehensive list of all the issues which might properly fall within in the scope of the inquest the prison service submits that on the evidence as currently constituted, the following matters are likely to be of central importance:
>
> ... (vii) the incident of the 8th August 2004 during the course of which Adam was restrained and taken back to his room by staff including the decision to resort to Physical Control and Care, the techniques and the impact of the incident on Adam"

On 6 November 2006 in further written submission on behalf of the YJB it said

> "9… whilst it is beyond doubt that the circumstances of Adam's restraint under PCC prior to his death fall within the scope of the inquest there is a need, we would submit, to focus on the issues arising from the restraint which properly fall within the type of investigation envisaged in Middleton. In the YJB submission those issues are as follows:
>
> (i) the effect that the restraint had on Adam's emotional state and the extent to which it is possible that it may have contributed to his decision to self-harm.

> (ii) whether the staff involved had acted appropriately in restraining Adam on the occasion in question and in particular whether the techniques they used were suitable and proportionate.
>
> (iii) insofar as it may be considered that the restraint was not appropriate (or appropriately conducted) some investigation for the reasons of that may be warranted. For example it may be that the adequacy of the training of the staff involved is found to be relevant."

In written submissions dated the 13 November 2006 Mr Freeland QC on behalf of Serco submitted

> "11… it is agreed that the circumstances of Adam's restraint under PCC prior to his death falls within the scope of the inquest as does whether the staff acted appropriately in restraining Adam on the occasion in question and whether the techniques that were used were proportionate."

The Coroner agreed with those submissions and questions about how and why Adam came to be physically restrained were permitted. However, as previously noted the Coroner declined to rule on whether there was authority to use force and restrain Adam, and whether the staff who took hold of him acted lawfully. It was said to be sufficient if the jury had the opportunity to comment on the facts and it was not necessary for them to be instructed on the legality of the restraint for them to do so.

25. A notable feature of the position of the respective parties at the inquest was the attitude of the YJB (the first interested party) to the answer to the question of legality if, contrary to its subsequent submissions, it was necessary for the Coroner to decide it. Ms Outhwaite counsel for the YJB both here and below, made plain in her written submissions that the Board now accepted that the restraint on Adam was unlawful. The court was informed that this was as a result of legal advice tendered for the purposes of the inquest.

26. As previously noted, the Coroner however decided that it was irrelevant what the position of the YJB as to the legality of the restraint now was. Although there was no documentary evidence to suggest that before Adam's death the YJB had taken a different view of the circumstances when restraint could be used, a different view did emerge when Mr Paul Bowers, a senior member of the executive of the YJB, at the time of the inquest Director of Secure Accommodation and now its interim Chief Executive, gave evidence to the inquest. He started at the Board in 2002. In answer to a question from the Coroner as to practice in 2004 he said (2/5/96-97):

> "Rule 38 was very clear and specific about the circumstances under which PCC could be used. However, the 1994 CJPOA did give this authority to use reasonable force to maintain order and discipline and the advice that the YJB were giving at the time was that reasonable force could be used under those circumstances and that our preference was for PCC to be used in the first instance

> because staff had been trained in that technique…That was our view at the time. Having said that I would say I think there's some confusion around our view but that's my recollection of how it was".

27. In answer to questions by the claimant he stated that the view of the YJB at the time was that STC Rules were not conclusive of the issue, and the statutory power gave officers a power to use restraint that the rules did not. He was taken carefully through all the available documentary evidence on the topic that was directly contrary to the proposition for which he contended (T2/5/3-34). He accepted that there was no documentation to support his evidence, and it was inconsistent with a great many public pronouncements of law and policy and the contract with the STC that the YJB were meant to be monitoring or enforcing. He considered that the view of s.9(3) that he was propounding was not a change of policy that Rule 38 provided the criteria but an unpublished extension of it (2/6/22-24). So incredible did it appear to the claimant's counsel that the YJB, who were vested with the public duty of close supervision of the use of restraints at privatised establishments like Hassockfield STC, could have apparently acquiesced in the undermining of the Rules that it was supposed to be enforcing, that it was put to Mr Bowers that he was not telling the truth about this (T2/6/25). However, in obedience to the Coroner's earlier ruling that the present understanding of the legal position was irrelevant, counsel could not pursue when and how the YJB came to adopt or change a position on the issue or when and why it had adopted a different view.

28. In a further exchange, Mr Bowers indicated what the conclusion would be if the view of the YJB in 2004 as to authority to restrain was wrong:

> "if children were assaulted and it was happening and we did nothing about it, that would be, I think a breach of our responsibilities, definitely" (2/6/34)

He accepted that such a state of affairs would be a failure on the part of the YJB, although did not agree with either of the accompanying adjectives suggested by Mr. Hermer namely either 'scandalous' or 'gross' (T2/6/35).

29. In the end the Coroner posed to the jury 11 questions for their consideration in reaching their conclusions in this case. The first five were concerned with Adam's treatment prior to August 2004 and do not need to be set out. Questions 6 to 8 were as follows:

> "Question 6: Were Hassockfield staff appropriately trained in matters of the HRAT, self-harm, and suicide prevention or awareness and PCC techniques.
>
> Question 7: Was first response an appropriate means of response by Hassockfield to the situation involving Adam on the 8th August and if not why".
>
> Question 8: Did Adam present as an increased risk of suicide and/or self harm at any stage after the termination of the HRAT on the 29th July bearing in mind in particular the events of 7th and 8th August".

30. The last three questions can best be described from quoting from the summing up when they were posed to the jury:

> "Number 9 is asking you to describe the incident that took place on the 8th August 2004 that led to Adam being restrained, the methods of the restraint used to tell the story in other words. What are your findings of fact relating to that incident? We have looked at systems fairly extensively.
>
> Number 10 is a question about systems. It says 'do you identify any system failures in the Hassockfield regime which contributed to Adam's death' so the failure has to be linked to the contribution'. Remember what it says on the front page of the form, contributes, not in a major or sole cause, nevertheless a cause which is more than minimal or trivial.
>
> You have got to decide that and the last question (11) gives you nearly free rein, 'are there any other matters in the evidence you have heard which contributed to Adam's death' always bearing in mind the type of words you can and cannot use. Is there anything else, in other words. Is there anything else that those questions don't cover that you feel contributed in that (sic) way to Adam's death. And finally, not surprisingly if there are any, tell me what they are.
>
> So those are the 11 questions that I am asking you to deal with. Okay. There is one thing I want to make clear to you now and we have heard a lot of evidence about the legality of restraint, how Section 9 of the Criminal Justice and Public Order Act interact with some of the STC rules. I am giving you no direction as to whether that is lawful or not. You do not have to decide. You must not decide whether that is lawful or not. That question is not with you. I am not giving you that. I have no intention of giving you that as a matter to decide, it is a matter of law and that is for me. You are to deal with matters of fact. What happened happened, be it in hitting his hand on the wall, playing football, going to his room, what happened happened. You are to decide what happened. You are not to put a label on that issue, particularly on that one of restraint, as to whether it is lawful, authorised by rules, whatever expression you think is the appropriate one, you are not to decide that. You steer away entirely from that. So I need to make that very very clear to you… just because something comes up as part of the questioning does not mean it comes to you to adjudicate upon. You have to look at matters that contribute to Adam's death, no doubt about that, but what I am directing you very clearly is that you are not to decide or give any consideration to whether those actions, in particular involving the restraint on the ear (sic) were lawful or not. Nothing to do with you."

31. Following those directions the jury concluded amongst other things that Hassockfield staff were appropriately trained in PCC techniques (Q6(iii)); first response was an appropriate means of response by Hassockfield to the situation involving Adam (Q7); Adam did not present as an increased risk of suicide bearing in mind the events of the

8th August (Q 9); there were no systems failures at Hassockfield which contributed to the death (Q 10); and Adam's treatment on the 8th August was not mentioned amongst the other matters noted which contributed to Adam's death (Q 11).

32. At the end of the inquest the Coroner wrote to the Secretary of State pursuant to Rule 43 Coroners Rules 1984 and noted the following:

> "5. The evidence clearly indicated that there was confusion between PCC instructors, PCC trainers, and Care Officers with regard to PCC its application, and the reasons therefore and when if ever guidance given in the appropriate manuals could be disregarded.
>
> …..
>
> 10. An urgent review should be undertaken to clarify the inter-relationship between the Criminal Justice and Public Order Act 1994 (section 9), the Secure Training Centre Rules issued there-under and the Directors rules to avoid any confusion whatsoever. It must be seen as essential that there must be no ambiguity in anyone's mind, young person, staff, management or those in the YJB or indeed Government as to when the use of restraint or force to maintain good order and discipline or for compliance reasons is authorised".

33. Although he declined to rule on the legality of the restraint, the court infers from the terms of the rulings and the report to the Secretary if State that if he had done the Coroner would have been more likely to accept Mr. Freeland's submissions and Mr Bowers' evidence as to the view of the YJB in 2004 that the statute had primacy over the STC Rules. The issue of concern was thus not the legality of what had been happening at STC Hassockfield and whether Hassockfield was being properly monitored by the Board, but the apparent confusion in that the Rules failed to correspond to the statute. In the absence of any ruling to the contrary, the jury were left to their own devices about the status of the Rules and the propriety of the restraint and most probably reached a similar conclusion. It is notable that in answer to question 6 training it concluded that there was no defect in training of staff at Hassockfield in PCC.

34. Dr Susan Bailey also gave evidence at the inquest. She was a psychiatrist with special experience of children in custody, had advised the YJB and been party to policy decisions relating to the use of force on children in custody. She indicated that use of pain compliance techniques other than in extreme situations would be contrary to the principles of the Children Act 1989 and counter-productive to a therapeutic relationship with children who may have hurt others or previously been hurt (1/3/88). She would not have expected restraint techniques to be used routinely or to enforce compliance with orders outside the circumstances of Rule 38 (T1/3/93). As a psychiatrist she expressed her concerns about such use of PCC as follows:

> "(A): It would be counterproductive all round in that it wouldn't in the long term end in the result that people wanted which would be for children to behave better and not cause harm to others and there would now be evidence that in a small group of these children it would make them more likely to behave in a aggressive fashion over time.

> (Q): What would your concerns be as a child and adolescent psychiatrist about the use of a technique that causes pain, the nose distraction technique that is expressly designed to cause pain, one generally about that technique and secondly in the context where it shows to regularly cause injury to regularly cause bleeding to a child's nose?"

35. There was objection by the YJB to this last question, and the Coroner disallowed it and indicated that it went beyond the purpose for which this witness had been called, which had been to assist in the formulation of policy by the YJB. There was no other evidence called as to what the likely effect on children generally or Adam in particular might have been.

Subsequent Events

36. Before turning to and resolving the submissions made in this application for judicial review, it is first necessary to summarise the events following the inquest. These have been set out in some details in witness statements made by Mr Bowers for the purpose of these proceedings. It is not necessary to set out here all the developments mentioned. There are at least three distinct strands of developments.

37. First, the YJB responded to Adam's death by making an unannounced visit to Hassockfield. It had already commissioned a review of Physical Control in Custody (PCC) that resulted in recommendations in October 2004 (the Waplington Report). In November 2004 the YJB conducted its own review of PCC and held an expert panel meeting to review PCC and Dr Bailey was a member of that panel. There were further reports from the Lancashire Area Child Protection Committee and the Prison Ombudsman in 2006. The Howard League for Penal Reform had also commissioned Lord Carlisle QC to advise and report on issues concerned with the coercive treatment of children in detention. The YJB took cognisance of these developments.

38. Second, following the above initiatives and the Coroner's letter of June 2007, in July 2007 the Secretary of State for Justice responded by promoting an amendment to the STC Rules that would for the future allow restraint to be used in a broader class of case than hitherto had been provided and in particular would allow removal from association and restraint to be used in support of good order and discipline even where there was no risk of violence, injury to the person or damage to property.

39. These amendments were criticised in a report on the Use of Restraint in Secure Training Centres by the Joint Committee on Human Rights of both Houses of Parliament in March 2008 who called for their repeal as incompatible with human rights norms (the Report was subsequently published on the 17th July 2008 HL Paper 154; HC 979). By this time a challenge was pending in the courts to these rules in judicial review proceedings in which the Children's Commissioner participated. In February 2008 a Divisional Court refused the application for relief although was critical of the consultations undertaken before the rule changes were promoted.

40. The matter was appealed to the Court of Appeal who delivered a highly significant judgment in the case of *R (C) v Secretary of State for Justice* [2008] EWCA Civ 882 on the 20th July 2008. It concluded, first that the Divisional Court was wrong to fail to quash the amended rules on the grounds of procedural breaches. Second, it considered

that the amended rules would have infringed the human rights of the children to whom such restraint was to be applied and were contrary to the requirements of Articles 3 and 8 of the ECHR. It reached this second conclusion in a number of strands of reasoning which can be summarised as:

i) It reminded itself of the general position under Article 3 of the ECHR that physical force in respect of a person deprived of his liberty that is not strictly necessary diminishes human dignity and is in principle a violation of Art 3 [58]-[59].

ii) It noted that the House of Lords in its judicial capacity has declared that Article 3 when applied to children in custody had to be interpreted consistently with the provisions of the UN Convention on the Rights of the Child 1989 in particular Articles 37 and the views of the Committee on the Rights of the Child as the expert monitoring body charged with the implementation of the state's obligations under the Convention [60]. [1] It further noted that in General Comment 8 of the UN Committee on the Rights of the Child indicate that deliberate infliction of pain is not permitted as a form of control of juveniles [61].

iii) It concluded that both pain compliance control techniques, and restraint generally when applied for the purposes contemplated in the amended rules would violate the principles of Article 3, when applied to children [62] to [64].

iv) It rejected a submission on behalf of the Secretary of State that any over-broadness of the amended Rules could be cured when read down in the light of detailed policy instructions that the Secretary of State for Justice would give to staff operating the rule [68] to [69].

v) It concluded that in any event the advice given in the Code of Practice about restricting the use of restraint was uncertain and unsatisfactory and had not been changed to apply to the new regime of the amended rules broadening the power to use restraint in support of good order and discipline [72] to [78].

vi) It rejected the only evidence in the case in which it was suggested that use of restraint was strictly necessary to enforce good order and discipline [20] to [29]. This evidence was a statement of Mr. Wilson-Smith director of Hassockfield STC. The Court was critical of this evidence and its consistency with the law at the time of Adam's death [24]. It noted in particular that the view of the law taken by Mr. Wilson Smith and leading counsel for Serco at the Rickwood inquest was wrong [15].

vii) It concluded that the amendments could not be justified as strictly necessary to maintain discipline [79]. The amended rules therefore violated both Article 3 and Article 8 ECHR.

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[1] Art 37 UN CRC provides in part as follows:
"States Parties shall ensure that:
(a) no child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment…
(c) every child derived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in particular in a manner which tales into account the needs of person or his or her age"

This court was informed that an application by the Secretary of State to appeal to the House of Lords against this decision has been refused. The decision of the Court of Appeal is therefore final and will be examined further in the following section of this judgment when consideration is given to the law.

41. The third development is that the question of the use of pain-compliant techniques on children was reviewed as a result of the concerns arising from the deaths of both Adam and Gareth Myatt another child who died in custody in different circumstances. The Ministers for Youth Justice and Children Young People and Families, commissioned an independent review of policies for restraint of children across the detention estate, that is to say in secure local authority children's homes, secure training centres and young offenders institutions. The review was co-chaired by Peter Smallridge and Andrew Williamson, two senior public officials with a background in local government and social work. The report of the review was delivered to the Ministers in June 2008 and 58 recommendations were made.

42. The timing of this report of this review as well as the Government's response to the Report of the Joint Committee on Human Rights was shortly before the Court of Appeal decision declaratory of the law, confirming the relevance and importance of the UN Convention on the Rights of the Child and that the fact that amended rules were quashed as unlawful. Neither report, therefore, had the advantage of the judgment of the Court of Appeal and a number of assumptions about the rules and the relevance of the standards of the UN CRC to the question when and what force can be used on children turn out therefore to be false. On the 15th December 2008, shortly before the hearing of this application, the Government issued a response to this Report broadly accepting the conclusions and recommendations of the Report without any reference to the decision of the Court of Appeal.

43. The interested parties, in particular, submit that this flurry of policy activity in response to Adam's death demonstrates that the public interest in the circumstances relating to his death and the purposes of an inquiry required by Article 2 of the ECHR have been fully met. Even if, contrary to the primary submission of the defendant and the interested parties, there was an error of law in failing to direct the jury about the legality of the restraint used on Adam no purpose would now be served by convening a fresh inquest. It is submitted that all the facts have been brought to light; the policy issues have been addressed by the Coroner's recommendations and the various reviews referred to above have been undertaken and the position has moved on.

44. It is further submitted that the legality of the restraint was only one issue at the inquest, was not the most important issue, was not determinative of the immediate cause of death and the inquest jury found no link between the restraint on Adam and his decision to hang himself some hours later. In those circumstances it would be particularly disproportionate to incur the expense and the uncertainty of reconvening the inquest.

The law relating to restraint and the use of force

45. In the light of the Court of Appeal's decision in the case of *C* (above [40]) it is unsurprising that at the hearing of this application for judicial review nobody sought to defend what had happened to Adam as being in accordance with the law. This Court did not, therefore, hear detailed submissions on the question, as opposed to the

impact the question may have had on the inquest. In the light of how the matter was left to the jury, it is necessary for the position that appears to have caused so much confusion and uncertainty below to be clearly set out.

46. In my judgment, the legal position at the time of Adam's death was not difficult to ascertain. It was not the subject of confusing or conflicting interpretations of the law by government departments or the courts. Rules 36 to 38 of the STC Rules were crystal clear and repeated in the training manual, the Directors rules, the contracts for the running of the STC, the training provided by the prison service to STC officers and every public statement to which the court and the Coroner were referred from the relevant Secretary of State and the YJB.

47. In my judgment, applying conventional principles of statutory interpretation, the starting point is s.47 (1) Prisons Act 1952 as amended that empowers the Secretary of State to make rules for the management of prisons, remand centres, young offender institutions or secure remand centres and for the treatment, discipline and control of persons required to be detained therein.

48. The next step is to turn to s.7 (2) Criminal Justice and Public Order Act 1994 that requires a contract for the running of a secure training centre to be in accordance with the Prison Act 1952 *and in accordance with the secure training centre rules* subject to such adaptations and modifications as may be necessary (emphasis supplied).

49. From this it is reasonably clear that the disciplinary regime applicable to children in a contracted out STC was to be subject to the detailed rules made under the power provided by s.47 Prison Act, rather than the detailed rules being subject to some inherent statutory power in the staff of the STC to do what they considered necessary to enforce or maintain good order and discipline.

50. Such an approach is confirmed in s.9 (1)(a) of the Criminal Justice and Public Order Act 1994 (see [12] above) where the power of search granted is to be in accordance with secure training centre rules. Although there is no express reference to the STC rules in s.9(3) of the CJPO 1994, it would be remarkable if the power to use force in support of good order and discipline were to be read as a power to use force *despite* the definition of what is permissible by way of discipline and control of children and the strict restrictions on the use of force on children imposed by the STC rules.

51. Moreover, it should have been clear to all properly self-directing public authorities that the limits on the use of force on children in custody was driven by the core principles set out in the UN Convention on the Rights of the Child, to which effect was designed to be given in UK law by the Children Act 1989, and which informs any detailed elaboration of human rights relating to children set out in the Human Rights Act 1998. Deliberate infliction of pain and force on children as young as 14 could only be justified by very compelling reasons such as those contemplated by the STC Rules, rather than generally to support staff orders. The authors of the Smallridge and Williamson report to the Ministers were very much mistaken if they believed that the requirements of the UN CRC were irrelevant to the limits of restraint that could be used in the UK.

52. The term "good order and discipline" has no inherent statutory meaning. It will always be a question for judgment by the responsible Minister within the ambit of the

law what orders children should be subject to in an STC depriving them of association, and what sanctions if any should be applied for failure to comply with them. The Prison Act 1952 s.47 contemplates that the detailed code will be set out in the Rules.

53. The ambit of the power to use force granted by s.9 (3) has to be interpreted in the light of the foregoing principles and the principles identified by the Court of Appeal in *R (C) v SS Justice* at [40] above. Since the statute was providing a statutory power to use force against children where such force would violate human rights principles if not applied in circumstances where it was strictly necessary, it was necessary to interpret the power in a way that was compatible with human rights. The same restrictive interpretation would in any event have been applied at common law, where an interference with a child's right not to be subjected to violence when detained would only be inferred where very plain words were used by Parliament.

54. In all these circumstances, the statutory power to use force to maintain good order and discipline is to be read as a statutory right to use force in circumstances where the detailed disciplinary regime laid down by the rules permit it. It is not a free standing right to use force whenever a staff member thinks it necessary or appropriate.

55. In the present case the STC Rules were clear and specific as to what could and could not be done to order loss of association rights and as a sanction for disobedience to a staff order where there was no violence and risk of personal injury or damage to property. There was no question of a hiatus in the law, or circumstances arising not contemplated by the Rules. Either the Rules defined what could be done by way of force to maintain good order and discipline or they were somehow void and thus of no effect because of conflict with the provisions of the statute. Contrary to the evidence of Mr Bowers, there could be no use of the statute to extend the rules, if the proposed extension was to flatly contradict them as an exclusive test.

56. The *ultra vires* hypothesis that appears to have confused the issue before and during the inquest needs only to be mentioned to be dismissed. First, it is to be observed that Section 9(3) is not the rule making power and is not therefore the place where any limits of that power are to be found. It would be unlawful for the Rules to make novel provision of the use of force against children without specific statutory authority to do so; to that extent s.9 (3) may be necessary. However the existence of a power to use force in support of good order and discipline, is not an alternative to the STC Rules or a wider definition of what is permitted in support of good order and discipline. Far from the Rules subverting the statutory power, they gave substance to it. They provide a precise code capable of giving meaning to an otherwise incoherent term.

57. In my judgment, the principles of good government and human rights march hand in hand on the question of transparency and legal certainty. They may be summarised as "say what you mean and mean what you say". It is particularly important that the limits of authority are clearly spelt out and understood with respect to the use of force against children. Hurting children as a disciplinary measure is a controversial subject in any sphere of social life, but especially in newly privatised training centres to be established for the youngest class of offenders. There is every indication that the Home Secretary in promulgating the regime in 1994 thought that there was harmony between the various legislative and contractual provisions. A judgment call had been made that in contracted-out STCs removal of children under 15 from association was

limited to cases of apprehended violence, and very precise limits were laid down for the use of restraint and pain-complaint techniques. This may present challenges for those with responsibility for discipline but the evidence of Mr Collier and the practice of other authorities reviewed by the Court of Appeal demonstrates that other, more patient, techniques could or would have to be employed.

58. Thus the true position of the legality of the measures taken against Adam on the 8th August 2004 was as follows. According to the evidence of Ms. Murray and Mr Gardiner Adam was not causing, threatening or inciting violence to property or others. On that evidence there was no authority to remove him from association and the order that he enter his locked bedroom cell was contrary to Rule 36 of the STC Rules. It was equally wrong for non-violent disobedience to such an order to be visited by the first response procedure, which on the evidence suggested that restraint would be used if disobedience continued. The physical interference with Adam was a breach of Rule 38 and strictly an assault on him. In any event, use of force in support of an unlawful order, and contrary to specified circumstances relating to discipline set out in the STC Rules, was not and could not be authorised by the statutory power under s.9 (3) CJPO 1994. Further the use of a pain-complaint nose distraction technique on Adam was unjustified, disproportionate and a breach of Rule 37 of the STC Rules. On top of all that, in the light of the Court of Appeal analysis in *R (C)*, it can now be seen that not only was there no lawful authority to do any of this to Adam but doing this to him was subjecting him to at least degrading treatment contrary to Article 3 ECHR.

Was the Coroner correct in his ruling about the legality of the force used?

59. The fact that the force used on Adam was unlawful does not necessarily mean that the Coroner's ruling declining to rule on the legality of the force and withdrawing the legality of the force from the jury as an issue was unlawful and has undermined the integrity of this inquisition.

60. I have some sympathy with the position of the Coroner at the time he was conducting the inquest. Despite the very clear terms of the STC Rules and a number of other public statements of the position with respect to when force or restraint could be used on children, he was faced with a position where there was doubt by responsible public authorities as to what the position in law really was. He was further faced with powerfully expressed written submissions from experienced leading counsel for Serco to the effect that the rules were *ultra vires* the statute insofar as they purported to restrict the ability of training officers at Hassockfield in the use of force to secure compliance with good order and discipline. Unfortunately, these submissions and the YJB position in 2004 as set out in the evidence of Mr Bowers were fundamentally flawed. Moreover, he was concerned that ruling on the legality of the force might have an inhibiting effect of the willingness of witness to speak about their actions.

61. However, as the claimant cogently submits in this case, it is impossible for an enquiry to be made into whether the force used on Adam was appropriate or proportionate without a ruling or clear guidance to the jury on whether it was lawful. Physical restraint is prima facie a trespass to the person. Such a trespass may be justified if there is a power to use restraint and the power is exercised reasonably or proportionately. Both at common law and under the ECHR, reasonable and proportionate exercise of the power is a second level of analysis that depends on the existence of the power: see *Holgate-Mohammed v Duke* [1984] I AC 437 at 442E-

443E. In the terminology of Article 8 (1) of the ECHR, if an interference with respect for physical integrity as an aspect of private life is not in accordance with the law, it is incapable of justification and the Court does not proceed to examine whether it was a proportionate exercise of the power for a legitimate reason (see for example *Al Nashif v Bulgaria Application no. 50963/99* [2003] 36 E.H.R.R. 37 20th June 2002 at paragraphs [128] to [129]).

62. The Coroner had decided (without dispute) that the propriety and proportionality of the force used on Adam was an issue for the inquest. Indeed in Question 7 he posed a direct question as to whether first response was an *appropriate* way of dealing with Adam's behaviour where the evidence indicated that this would lead to force to ensure compliance with an order. A restraint can hardly be appropriate if it is unlawful. In my judgment its illegitimacy was flagrantly apparent in the STC Rules, the Directors Rules, the Guidance in the PCC Manual, the training provided by Mr Collier, and every other published statement of policy that preceded Adam's death. The jury were in effect left to form its own policy on how children in detention should be treated without any of the relevant principles being explained to them.

63. In my judgment, if the inquest was going to explore a matter that may have contributed to Adam's death, it needed to do so properly. The fact that examination of the legality of the restraint used may have led to witnesses being warned of their right not to answer questions that may incriminate them, and thus potentially deprive the inquest jury of the benefit of the answer, could and should not drive the proper scope of the ambit of the investigation that needs to be made. There are many cases where juries may be considering possible verdicts of unlawful killing in one form or another, where warnings may have to be given to individuals but that does not prevent or deter inquiry into the legality of the force used in all the circumstances of the case. It is to be noted that such a verdict is not a breach of Rule 42 of the Coroners Rules because no criminal liability of an individual is attributed and such a verdict does not determine or purport to state any question of civil liability.

64. In any event, by the time the Coroner gave his ruling on legality, the risk of witnesses refusing to answer questions was somewhat remote. All the key actors had been questioned by the police and a decision taken not to bring proceedings. Refusing to answer questions does not prevent questions being asked, and what the witnesses said in interview or earlier statement would in any event be put in evidence. At the outset of the inquest, leading counsel for Serco expressly invited the Coroner not to give a warning as his witnesses were understood to be anxious to give a full account and explain their actions before the jury. Whilst this is not a decisive consideration as to whether any warning should be given, it is perhaps a pointer to the limits of the weight that should be attached to this consideration. Moreover, in the light of the attitude of the YJB to what the staff were doing at Hassockfield, it is unlikely that the primary responsibility for the failure to act in accordance of law was that of the individual officers.

65. Counsel for the interested parties, responded to the claimant's submissions by a new submission that in reality there had been no need to examine the proportionality of the force used on Adam and the earlier concessions were withdrawn in the light of what Article 2 required by way of inquiry. Further it was pointed out that the contribution of the force to the death was marginal and at the periphery of inquiry and by the jury's findings it was not held to be a contributory factor.

66. I cannot accept either of these submissions. The fact that in other Article 2 cases less intrusive investigations into a death than those conducted by the Coroner in this inquest have been held to satisfy Article 2 does not assist. The starting point is what this Coroner considered he ought to investigate by way of potentially relevant causative factors, rather than what Art 2 required abstractly. In my judgment the Coroner was plainly right to explore whether, what and how the force applied to Adam contributed to his death and thus formed part of the circumstances in which he came by his death. It may not have been the only factor affecting Adam, but it was a recent and unpleasant experience that had made him very angry and upset only hours before he died, he complained of it to staff, his solicitor and wrote a statement left in his cell about it.

67. Moreover of all the potential contributory factors it was a factor, proper investigation of which may lead to prevention of repetition. It was clear from the evidence that the way Adam was treated was not unique in Hassockfield. The records before the inquest and this court showed that in the month before Adam's death alone, there had been some 37 instances of use of PCC for non compliance. In the lengthy log of injuries to trainees for the 12 months before Adam's death, the court has identified 26 occasions where injuries caused by the nose distraction technique were recorded; on 7 of these occasions the record was of painful nose only, on the remaining 19 occasions nose bleeds due to distraction technique were recorded. According to Mr Collier's evidence the technique should have been employed without causing bleeding. This was not a one-off error of understanding but a persistent practice, duly recorded, in dealing with children in detention in breach of the law, the rules, the STC contract and the training manual as well as the in-house rules. Astonishingly, none of this seems to have aroused any query or concern by the YJB who had an officer monitoring the returns, and yet the YJB was supposed to be ensuring that the STC operated in accordance with its contract and both the contract and statute required it to operate in accordance with the Rules.

68. Mr Bowers' evidence at the inquest as to the consequences if children were being routinely assaulted now needs revisiting in the light of the conclusions already reached. In my judgment, he was right to accept that if his understanding of the law was wrong, there was a failure by the YJB and a breach of his duty. In my judgment it was a very serious breach of duty that had the potential to undermine the whole delicate balance between the best interests of the child and the legitimate requirements of the community with respect to the punishment and training of juvenile offenders. Given the clarity of the terms of the STC Rules, and the consistent statement of the position in all the documents to which he was referred when he gave evidence, and the available records kept by the STC of what they were doing and why, this failure by the YJB can only be characterised as a gross failure. Given the limits placed on the inquiry by the Coroner it is not possible to understand more about how this failure had come about, when it arose, and what it was based on. Some investigation and understanding of these matters may be important if the YJB are to continue to be vested with the significant public duties of monitoring compliance with the law.

69. It is futile for the Secretary of State for Justice to accept the recommendations of the Smallridge and Williamson review that the YJB should have in place a range of effective support and sanctions to back its Assurance Monitoring of restraint in the secure estate (Recommendation 33 in its summary of Recommendations which was

based on the erroneous assumption that the amended STC Rules were legitimate) when, if the evidence of Mr Bowers at the inquest is accepted, it so conspicuously and inexplicably failed to do so in the past. If the YJB did not understand and enforce the much clearer Rules as they were before the proposed amendments, why should the public expect it to do so in the future, absent some recognition, acknowledgement and explanation of its failures? As Lord Bingham pointed out in *Amin* one of the reasons for an intrusive inquiry into a death required by Article 2 is to prevent future repetition of mistakes.

70. Nor are the interested parties assisted by the jury's answers to question 11, if those answers were the product of an impermissibly confined investigation. It is submitted that the jury could have concluded that the restraint had affected Adam's death irrespective of whether it was lawful or not and did not do so. Further it is submitted that if he was affected by it at all, Adam was concerned merely with the fact that he had been restrained and not with whether he had been lawfully restrained. Mr Hermer by contrast submits that on a proper construction of his directions and the use of the word "other" in question 11, the Coroner had excluded the impact of the restraint techniques because it was an issue addressed in questions 7 and 9. It is not necessary to decide whether that view of the directions is correct or not because the interested parties' submissions fail for a more general reason. In my judgment the legality and propriety of force is material to whether a use of such force hours before a self-inflicted death made a material contribution to that death. As a matter of common sense it seems to me that it is more likely that recent application to the deceased of unlawful force used routinely on trainees in similar circumstances and without any intervention or expression of concern by the director of the prison or the monitoring bodies, would contribute to a decision to self-harm more than a perfectly clear use of authorised force for some obvious reason such as preventing a fight. The sense of helplessness and any despondency that may be generated based on a perception that members of staff were a law unto themselves when dealing with vulnerable children of 14 or so is very much greater than where the sanction was justified and clearly spelt out in the rules. If the jury had been directed to consider whether unlawful and degrading treatment may have contributed to the decision Adam took to kill himself, it is inherently more probable that the answer would be in the affirmative than in the case of a lawful, appropriate and proportionate application of force to a child. That is one reason why the general propriety and proportionality of such treatment was indeed a question for the jury.

71. Moreover, there was cogent evidence adduced at the inquest that Adam *was* concerned with the legitimacy of how he had been treated. He had expressed an intention to make a formal complaint about it. That is a clear indication he considered he had been wrongly treated. In the letter he left for his family in his bedroom cell Adam started by saying :

> "lately over to the past two months or so things have been very hard for me and its all just got to the point where my head goes".

In his statement written in the same window of opportunity of approximately 6 hours, he describes how he queried the order to go to his room, the response of the staff, the physical restraint, the pain to his nose and how he tried to bite back because they were really hurting him.

> "My nose started bleeding and swelled up it didn't stop bleeding for about one hour and afterwards it was swelled badly and really sore and hurting me a lot 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 draw blood* and they said it was a restraint" (emphasis supplied)

If Adam's question had been answered by the Coroner or left open to the jury to consider with appropriate directions, the answers would have been clear. There was no right to hurt such a child in these circumstances. In my judgment it is fanciful to suppose that such an answer could have had no impact on the jury's consideration of factors contributing to the death.

72. There are other difficulties in the interested parties' submissions on causation. If the matter is not one of common sense then I would have expected a consultant psychiatrist with expertise in the detention and treatment of vulnerable juvenile offenders to have been capable of offering some relevant evidence. In this case Dr Bailey was stopped from giving evidence that might well have led to some information on the question. The fact that she was called to give information as to the development of YJB policy was no reason for her not to be asked questions within her expertise. I anticipate that her particular contribution to the formation of policy was precisely based on her expert knowledge and understanding as a psychiatrist. Nor is it an answer that she did not examine Adam personally on the evening of the 8th August. Whilst she could not explain what was in his mind when he took his own life, a competent expert may well be able to assist a jury with no specialist expertise as to the potential impact of unlawful, unfair and painful treatment on a vulnerable 14 year old with a history of low self-esteem and threats of self harm.

73. I, therefore, conclude that a proper inquiry into factors that might have contributed to Adam's death and formed a material circumstance as to how he came by his death, required consideration of whether the force used on Adam was legitimate, and whether the staff of the STC were operating in accordance with law in their use of force on the children assigned to their care. If this turned on a dispute of fact, it would be a matter for the jury with appropriate directions to decide what the disputed facts were. As the trigger for the order to cease association and the events that lead to the use of restraint and the application of force thereafter were based on the unchallenged evidence of Officers Murray and Gardiner, it could and should have been the subject of a ruling in law before the jury retired to reach their conclusions.

Fresh inquest

74. The defendant and the interested parties have submitted powerfully that whatever the rights and wrongs of the rulings given at the inquest, there is no good reason to require a new inquest to be convened, and every reason by way of time, expense and the anxiety and uncertainty created to all interested parties to re-opening matters over four years after Adam's death. I recognise the force of these submissions and have given anxious consideration to whether some declaratory judgment of this court would suffice. In all the circumstances I have reluctantly reached the conclusion that it would not.

75. First, as Mr Perks who appeared for the Coroner realistically and helpfully recognised at the conclusion of his oral submissions, the issue of legality of what was done infects the answers that the jury gave to the inquisition. At the least the answers with respect to the adequacy of the training in PCC Q 6 (iii) simply cannot stand. I reach the same conclusion with respect to propriety of first response (Q7) and systems failures (Q9). If Hassockfield were persistently operating an unlawful regime in breach of the STC Rules and its contract then the system, the response and the training its staff received in PCC and the implementation of that training within the institution cannot be considered to be satisfactory. If staff were trained as Mr Collier says they were, then it is simply baffling how these practices and understandings came about.

76. Second, the jury's narrative of events and its decision not to record the incident as a material contributory factor in the death, are, in my judgment, likely to have been materially affected by the errors with respect to directions on legality. It is sufficient to set aside this part of the inquisition that this court could not conceivably be satisfied that the answers would have been the same irrespective of proper directions on the question.

77. Third, having had the opportunity since the hearing to read more extensively the transcript of the evidence of some of the key witnesses, I entirely accept that the Coroner was right to conclude in his ruling refusing an adjournment (see [21] above) that a direction on the illegality of the restraint would be relevant to the jury's assessment of the credibility or reliability of some of the witnesses who gave evidence about these events. Whilst I can see no reason to doubt the honesty of Mr Bowers as a witness, for reasons already given I conclude that what he was telling the jury seemed so extraordinary that some explanation of how this came about was relevant to the inquiry and the meaning of his evidence. More particularly, there were aspects of both the evidence of the Director of the STC (Mr Wilson-Smith) and the officer responsible for the nose restraint (Mr Hodgson) that might legitimately be challenged as untrue by reference to the true meaning and applicability of the STC regulations, as might aspects of the evidence of Mr Clark as to his training. It is difficult to see why Mr. Wilson Smith should have failed to put his understanding of the law into the Directors Rules and state this was merely an omission; or why Mr. Hodgson gave an account of information about incitement by Adam that might be said to bring the facts within the ambit of the Rules. These are, of course, all matters for a properly directed jury and not this court.

78. Fourth, it is apparent that the causal nexus between Adam's response to the incident and his self-harm, remains controversial and again would be a matter for a fresh jury to consider and not for this court or the Coroner sitting alone. I have already indicated that expert evidence from Dr Bailey or some similarly qualified person would be admissible on this question, if there were was a dispute between the parties. Either with the assistance of expert evidence or the consensus of common sense, the jury would need some instruction about how to approach the evidence as a whole. Mr Hermer points out that the policy activity generated since this death has proceeded on the basis of the jury's conclusions that there was no link between the force applied and the death, and that may temper the recommendations made or the ministerial response to them. If a properly directed jury found that there was a contribution to the

death caused by Adam's unlawful treatment that adds urgency and poignancy to the lessons that remain to be learned from the death.

79. Overall I conclude that this was not some technical failure in the inquisition that could be retrospectively corrected by this court or the Coroner or would have made no difference to the fact finding and the lessons that may be available to be learned. It may be that fresh factual conclusions will be reached on what happened and why.

Conclusions

80. I therefore allow this application for judicial review. I will quash the inquisition reached by the jury and remit the matter to the Coroner to conduct a fresh inquiry in accordance with this judgment. The remit and scope of that inquiry will be for the Coroner having heard the submissions. I merely express the hope that the parties may be able to agree that certain matters are now not so controversial or unclear as to require extensive live evidence and cross- examination, and that there may be scope for an agreed statement of facts to be read or put to the jury. I am grateful to all counsel for their considerable assistance in this sad and challenging case.