

INQUEST PRESS RELEASE

For immediate release 28 June 2007

GARETH MYATT INQUEST VERDICT – FAILINGS OF THE YOUTH JUSTICE BOARD CAUSE DEATH OF A CHILD

The five week inquest into the restraint-related death of 15 year old Gareth Myatt, who died in the privately run Rainsbrook Secure Training Centre (STC) in April 2004, finished today. The inquest was held before HH Richard Pollard, a retired circuit court judge sitting as a coroner at the Rushden and Diamond Conference Centre in Irthlingborough, Northamptonshire opened in February 2007, and was adjourned from early May until 26 June 2007 while legal arguments were heard at the High Court.

The jury returned a verdict of accidental death and made sweeping criticisms about the conduct of the Youth Justice Board. In answers to eight questions which form part of their verdict they said:

- 1. If you are satisfied that there was no adequate assessment of the safety of Physical Control in Care, and the Seated Double Embrace in particular, before it was introduced, then did that inadequate assessment cause or contribute to Gareth's death?*
Yes. There was information available and concern here and abroad about positional asphyxia but this was not considered when the first or second panels were assembled.
- 2. Did any failure to undertake a medical review of the safety of Physical Control in Care, and the Seated Double Embrace in particular, by the Home Office or the Youth Justice Board, before Gareth's death cause or contribute to Gareth's death? Yes*
- 3. Did any inadequacy in the system of training the staff at Secure Training Centres in the use of Physical Control in Care prior to Gareth's death cause or contribute to his death?*
No – Not all members of staff had a copy of the PCC manual and training did not include adequate discussion and learning of the theory of the 'medical advice'. However the real dangers of positional asphyxia were not known to the trainers or national instructors.
- 4. If there was nobody at the Youth Justice Board with specific management responsibility for the safety of Physical Control in Care prior to Gareth's death did this cause or contribute to Gareth's death?*
Yes
- 5. Did any inadequacy in the response by the Youth Justice Board to the National Children's*

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Bureau Report as to the urgent need for the medical review of Physical Control in Care cause or contribute to Gareth's death?

Yes

6. *Did any inadequacy in the response by the Youth Justice Board to the Tuck letters of 12 June 2002 and 2 July 2003 cause or contribute to Gareth's death?*

Yes

7. *Did any inadequacy in the monitoring of the use of Physical Control in Care at Rainsbrook by the Youth Justice Board cause or contribute to Gareth's death?*

Yes – there was a problem with the lack of response and action by the YJB to the reports from Rainsbrook.

8. *Did any inadequacy in the monitoring of the use of Physical Control in Care at Rainsbrook by Rebound management cause or contribute to Gareth's death?*

Yes there was a problem with the lack of response and action by Rebound to the information from Rainsbrook

Following the verdict, Gareth's mother Pam Wilton said:

"What I have heard has deeply upset, angered and shocked me. I loved Gareth so much and my life will never be the same. When he went to Rainsbrook I expected him to get the help he needed. At the end of all of this he is still dead and no-one has been held accountable.

Deborah Coles, Co-director of INQUEST said:

"The jury's verdict is a shameful indictment of a catalogue of failure by Youth Justice Board (YJB) and its failure to protect children in the custody and care of the state. The jury accept that these failures directly caused Gareth's death. He died a most horrific and violent death while being restrained by custody officers. His death was entirely preventable and was a disaster waiting to happen. The evidence that has been presented to inquest has revealed a catalogue of errors that have penetrated to the heart of the conduct of the YJB, the privately run institutions in whose care vulnerable children are entrusted and the individual custody officers employed to deal with vulnerable children on a daily basis. It is deeply shocking that it is the determination of a bereaved family that has exposed dangerous practices that the monitoring and inspection bodies who are supposedly there to protect children failed to do. As a result of these gross errors the safety of children within Secure Training Centres can be said to have been put at risk on a daily basis. Warning signals went unheeded; protests from the children were muffled.

*"Gareth's mother appreciates the coroner's commitment to explore as fully as the inquest process allowed the circumstances of Gareth's death and to make recommendations to ensure that lessons are learned. We have heard nothing during this inquest that has convinced us that those with responsibility have properly heeded what has been exposed and that necessary and appropriate changes have or will now be made to safeguard children. Further, while the inquest has been a full investigation into Gareth's treatment at Rainsbrook and his death there, it has merely touched on the issues of how vulnerable children are treated in the criminal justice system. **We remain convinced that the only way to prevent the suffering of children in custody and to ensure that more children do not die or are not injured is to conduct a holistic inquiry in public of the juvenile justice system with the proper involvement of families, children and those working within it.***

"On paper the mission statement of the YJB remains to ensure that custody for children is safe, secure and addresses the causes of their offending behaviour. The issues that the jury found directly causative of Gareth's death have not been rectified by the YJB and it is against

this background that far from learning the lessons they now support a change in the law to make it more permissible to use restraint – and in circumstances where the restraint techniques are being executed up to 3,000 times per year by poorly trained, unskilled, unqualified staff. The YJB and Ministry of Justice have displayed a ruthless intent to change the law to make it more permissible to restrain children without public accountability or debate and with no consideration as to whether this is in the best interests of ensuring the safety, security and overall welfare of the children. The demonstrated intent of the YJB to legalise restraining children for compliance without proper debate flies in the face of its stated intentions both before this inquest and in its mission statement and code of practice on behavioural management.”

Mark Scott, of Bhatt Murphy solicitors said:

“We need to carefully consider both what has emerged at the inquest and the jury's conclusions. We need to reflect on what action we will be taking but certainly we will be seeking to ensure that those with the charged with the care of Gareth take full responsibility for the catalogue of failures that led to Gareth's tragic death.”

The coroner has indicated that he will be using his power under rule 43 of the Coroners Rules 1984 to make a report to those authorities who have the power to take action to prevent the recurrence of similar fatalities. The family's legal team and INQUEST have been invited to make submissions to the coroner to on this.

INQUEST will also be seeking an urgent meeting with the new Minister of Justice, Jack Straw, to discuss the issues arising from this inquest and that into the death of 14 year old Adam Rickwood and to urge him to withdraw Statutory Instrument 2007 No 1709 proposing changes to the Secure Training Centre Rules 1998 which are due to take effect on 6 July 2007.

The amendments permit a widening of the circumstances and personnel that can remove a child from association and the circumstances in which force can be used against children in STCs. The current physical restraint methods used were explicitly approved for use only when it was necessary to prevent the child from escaping from custody, injuring themselves or others or damaging property and not simply when they refuse to comply with an order, as the amendments will permit.

It has been stated that the reason for the amendment has been necessary to 'clarify' the law and bring the rules into line with other institutions that detain children. However, the government recently accepted at the inquest into the death of Adam Rickwood, that it was currently unlawful to restrain children in STCs for reasons of good order or discipline (i.e. for non compliance). In addition to this, other institutions such as Local Authority Secure Children's Homes (LASCHs) similarly do not have the power or a practice to restrain children or remove them from association for reasons of good order or discipline and the amendments would not, therefore, have the effect of unifying these practices across similar establishments.

There has been a completely flawed consultation process which appears to have been conducted in private exclusively with the private contractors who run the STCs. The YJB/Ministry of Justice has failed to consult the Children's Commissioner or any other agency with particular expertise in child care and child protection. Many of these agencies have subsequently written to the Secretary of State to express their concerns about the possible changes. In addition to this, the government also failed to consult their own panel of experts who approved the restraint methods currently used in STCs where it was known that they would have serious concerns about what was proposed.

INQUEST will also be preparing a detailed report on the inquests into the deaths of Gareth Myatt and Adam Rickwood and the issues arising from them both.

The family was represented by INQUEST Lawyers Group members Dexter Dias and Brenda Campbell from Garden Court Chambers and Mark Scott from Bhatt Murphy solicitors.

Detailed briefings on the death of Gareth Myatt and on the restraint of children and the proposed changes to Secure Training Centre Rules are available on the INQUEST website.

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Notes to editors:

INQUEST is the only non-governmental organisation in England and Wales that works directly with the families of those who die in custody. It provides an independent free legal and advice service to bereaved people on inquest procedures and their rights in the coroner's courts.

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