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PRESS RELEASE
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YOUTH JUSTICE AGENCIES CONDEMNED FOR UNLAWFUL TREATMENT OF VULNERABLE BOY IN CUSTODY

The jury at the second inquest into the death of 14 year old Adam Rickwood in Hassockfield Secure Training Centre in County Durham on 8 August 2004 today returned a damning narrative verdict criticising failings by Serco, the private company running Hassockfield, the Youth Justice Board, Prison Service restraint trainers and the Lancashire Youth Offending Team.

Following today's verdict, Adam Rickwood's mother Carol Pounder said:

> *Nothing can bring Adam back. I have waited over six years for truth and justice. All I have ever wanted is to find out the truth about what happened to my son and for those responsible for unlawful assaults to be held to account.*

Acting for Carol Pounder, Mark Scott of Bhatt Murphy solicitors, said:

> *It has taken a six year legal battle, including a flawed first inquest and three judicial reviews (one of which went to the Court of Appeal), to finally expose the numerous failings and illegal treatment that Adam, and many other vulnerable children in privatised child prisons, have suffered.*

Deborah Coles, Co-Director of INQUEST, said:

> *This is a vindication of the battle by Adam's family for the truth against a background of denial and secrecy by the Youth Justice Board and Serco. That thousands of vulnerable children were systematically subjected to unlawful restraint in privatised child prisons - and that none of the regulatory or inspection bodies of the state did anything about it - is shameful. The public scrutiny finally afforded by this properly-conducted inquest into Adam's tragic death has highlighted serious failings in the way the state treats children in conflict with the law. The state must now respond and implement meaningful changes in order to safeguard lives in future.*

At the hearing, it was agreed by all the Interested Parties to the inquest that at or about 6.00 pm on 8 August 2004:

1. *The removal of Adam from Association was in breach of Schedule D, M6 of the contract between the Home Office and Serco, contrary to Rule 36 of the STC Rules and therefore unlawful;*
2. *The use of Physical Control in Care (PCC) on Adam to take him to his room was in breach of Schedule D, M5 of the contract between the Home Office and Serco, contrary to Rule 38 of the STC Rules, contrary to the Hassockfield Director's Rules and therefore unlawful;*

3. *The use of the nose distraction on Adam was a pain inducing technique which was unjustified, unreasonable and disproportionate, contrary to Rule 37 of the STC Rules and therefore unlawful.*
4. *Before and at the time of Adam's death, PCC was regularly used at Hassockfield in circumstances not permitted by the contract between the Home Office and Serco, the STC Rules and the Director's Rules.*

On that basis, the jury were asked 16 questions relating to the circumstances surrounding Adam's death, which they answered on the balance of probabilities (i.e. whether more likely than not) in their narrative verdict as follows:

1. *Was Adam appropriately assessed when he arrived at Hassockfield? Yes*

2. *Should a replacement Key Worker have been allocated to Adam when Kevin Bell went off sick? Yes*

3. *Was the HRAT programme implemented appropriately to safe guard Adam between his arrival at Hassockfield and the 29th July? No*

4. *Was Adam's request for a transfer to an establishment closer to his family home appropriately dealt with by:*

   (a) Hassockfield: No

   (b) Lancashire YOT: No

5. *Was it appropriate to close the HRAT book in respect of Adam on 29th July? No*

6. *Should the Care Officers involved in Adam's care have been aware of the entry in the HRAT book on 12th July to the effect that he had previously self harmed when angry? Yes*

7. *Should the HRAT book have been re-opened on*

   (a) 7th August, following the removal of privileges due to him being found in possession of cigarettes and matches: No

   (b) 8th August, following the use of PCC and the nose distraction technique to take Adam to his room: Yes

8. *Should the Care Officers on night duty on 8th August on House Block 2 have known about the use of PCC and the nose distraction technique on Adam? Yes*

9. *Was Adam observed every 15 minutes (as required by the rules) after lockdown on 8th August? No*

10. *At the time of Adam's stay at Hassockfield were the staff adequately trained in:-*

    (a) HRAT: No

(b) *suicide awareness: No*

(c) *behaviour management/de-escalation: No*

11. *Before and at the time of Adam's death, were the PCC Instructors at Hassockfield adequately trained in the use of PCC by the Prison Service? No*

12. *Did the Care Officers employed by SERCO who used PCC on Adam, in order to gain compliance with an instruction, genuinely believe it was lawful for them to do so? Yes*

13. *Before and at the time of Adam's death, was there a serious system failure in relation to the use of PCC at Hassockfield, giving rise to an unlawful regime? Yes*

14. *Before and at the time of Adam's death, should the YJB (through their Monitors) have been aware that PCC was being used unlawfully and in breach of the Contract at Hassockfield? Yes*

15. *Was there a serious system failure on the part of the YJB in failing to prevent the regular and unlawful use of PCC at Hassockfield? Yes*

16. *Did any of the following matters more than minimally contribute to Adam taking his own life:-*

    (a) *being in a S.T.C. which was approximately 150 miles away from his home: Yes*

    (b) *his loss of privileges following the finding of the cigarettes and matches on 7th August: No*

    (c) *the news which he received during the evening of 8th August to the effect that there was to be no bail application on the following day: Yes*

    (d) *the unlawful use of PCC on him on 8th August: Yes*

    (e) *the unlawful use of the nose distraction technique on him on 8th August: Yes*

    (f) *his intrinsic vulnerability: Yes*

The family was represented by INQUEST Lawyers Group members Rajiv Menon from Garden Court Chambers instructed by Mark Scott of Bhatt Murphy solicitors.

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Notes to editors

Adam Rickwood was the youngest child ever to die in penal custody. He was found hanging in his room hours after being subjected to a painful, restraint technique known as 'nose distraction'.

INQUEST is the only organisation in England and Wales that provides a specialist, comprehensive advice service on contentious deaths and their investigation to bereaved people, lawyers, other advice and support agencies, the media, parliamentarians and the wider public. INQUEST has supported Adam Rickwood's family since his death in April 2004 including by ensuring the family was legally represented by experienced lawyers and offering them expert guidance during the investigation and inquest process.

Case history
The first inquest into Adam's death took place in May 2007. Andrew Tweddle, HM Coroner for County Durham, had refused to rule on the legality of force used on Adam shortly before his death. Adam's mother judicially reviewed this ruling and the High Court held the coroner's decision had resulted in a flawed inquiry and verdict. The YJB and Serco resisted the application. Mr Justice Blake found that the force used against Adam amounted to "an assault on him;" was in breach of the relevant legal Rules; and violated the prohibition on inhuman and degrading treatment in article 3 of the European Convention on Human Rights. He commented "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." [para 71]. Link to INQUEST press release of January 2009 (PDF)

In parallel, another legal challenge went to the Court of Appeal to resist the government's response to Adam's death in which they sought to widen the law on when children could be restrained. In a highly critical judgment the Court found the government's changes to legal Rules after Adam's death were unlawful and in breach of children's human rights. The Court of Appeal ordered that the new Rules should be quashed (PDF).

A further judicial review in 2010 was taken to ensure that a new coroner presided over the fresh inquest.

Second inquest
The second inquest into Adam's death opened on 10 January 2011 and was heard before HM Assistant Deputy Coroner for the North and South Districts of Durham and Darlington, J.S Freedman. Evidence was heard from, among others, Adam's mother; the officers involved in restraining Adam; senior management of the Youth Justice Board including the previous chief executive Ellie Roy; and Serco, the private company that runs Hassockfield.

The jury heard evidence on, among other issues:

- The circumstances in which restraint can be used against children and he type of restraint that can be used, in particular techniques that are designed to cause pain.
- What was the physical and psychological impact on Adam of the restraint used
- Whether the force used against Adam contributed to his death.
- The role of private company Serco and those with responsibility to supervise and monitor them including the Youth Justice Board and Commission for Social Care Inspectorate

Policy background
There have been 30 deaths of children in penal custody in England and Wales since 1990 and INQUEST has been campaigning for a public inquiry into the treatment of children within the juvenile justice system since the death of 16 year old Joseph Scholes, a deeply disturbed young boy who hanged himself in his cell at Stoke Heath Young Offender Institution in Shropshire in 2002. The deaths of children in custody raise thematic issues that need to be addressed in a joined-up manner through a properly resourced inquiry so that appropriate recommendations are made to ensure that lessons are learned and safeguards put in place to protect the lives of children in the future.

INQUEST has raised the issues highlighted by Adam's death at a national and international level as well as through various parliamentary inquiries (including the Parliamentary Joint Committee on Human Rights, the UN Committee on the Rights of the Child, the Committee on the Prevention on Torture).

In 2005 INQUEST published the first detailed analysis of child deaths as *In The Care Of The State? Child Deaths in Penal Custody in England and Wales* by Barry Goldson and Deborah Coles.

For a detailed overview of the issues raised by the restraint of children see INQUEST's submission to the Ministry of Justice & Department for Children, Schools and Families 'Review of Restraint' (December 2007).

The government finally withdrew the use of the ‘nose distraction’ technique from use in Secure Training Centres in December 2008. The technique is still in use on young people held in Young Offender Institutions.