

# The Lord Carlile of Berriew QC

An independent inquiry into the use of physical restraint, solitary confinement and forcible strip searching of children in prisons, secure training centres and local authority secure children's homes

"If all do their duty, they need not fear harm"

the Howard League for Penal Reform

---

## **The Lord Carlile of Berriew QC**

An independent inquiry into the use of physical restraint, solitary confinement and forcible strip searching of children in prisons, secure training centres and local authority secure children's homes

"If all do their duty, they need not fear harm"

**the Howard League** for **Penal Reform**

The Howard League for Penal Reform thanks the trusts and individuals who made donations towards the funding of this independent Inquiry. A full list was published in the annual accounts.



# Contents

1	<b>Introduction</b>	<b>9</b>
2	<b>Recommendations</b>	<b>11</b>
	Resolving conflict and reducing violence	11
	Restraint	12
	Strip searching	13
	Segregation	13
3	<b>Legal and human rights framework</b>	<b>15</b>
4	<b>Methodology</b>	<b>21</b>
	Advisory panel	21
	Primary research	22
	Secondary Research	23
	Additional evidence	23
	Seminars	24
5	<b>Children's secure estate</b>	<b>25</b>
	Placement of children	28
	Children in the secure estate	28

---

6	<b>Resolving conflict and reducing violence</b>	<b>29</b>
	Relationships based on respect	29
	Staff education and training	30
	Staffing levels	31
	Exercise and outdoor activity	32
	Respect through responsibility	33
	Restorative justice	33
	Privacy and other matters	35
	Recommendations	36
7	<b>Restraint</b>	<b>37</b>
	Different methods of restraint	37
	Statistical data	39
	Mental health	41
	Death in custody following restraint	41
	Injuries resulting from restraint	43
	Psychological impact	46
	Improper use	48
	Good practice	49
	Issues of concern	49
	Recommendations	51
8	<b>Strip searching</b>	<b>53</b>
	Strip searching practice	54
	Good practice	57
	Conclusions	58
	Recommendations	59

---

9	<b>Solitary confinement</b>	<b>61</b>
	Statistical data	61
	Solitary confinement across the secure estate for children	62
	Length of separation	64
	Conditions in separation	64
	Links with incentives schemes	65
	Inspections and outside scrutiny	65
	Recommendations	65
10	<b>Select Bibliography</b>	<b>67</b>
	<b>Appendices</b>	<b>71</b>
	Appendix A Schedule of Visits	71
	Appendix B Lord Carlile and the Inquiry Advisory Panel	73
	Appendix C List of evidence	77
	Appendix D: Written Evidence supplied by the Youth Justice Board, January 2006	83
	ANNEX 1	91
	ANNEX 2	99
	Appendix E Key extracts from the Statement of Principles developed by the Restorative Justice Consortium, 2004	106



### **The Chimney Sweeper**

When my mother died I was very young.  
And my father sold me while yet my tongue,  
Could scarcely cry weep weep weep weep.  
So your chimneys I sweep and in soot I sleep.

There's little Tom Dacre, who cried when his head  
That curl'd like a lambs back, was shav'd. so I said.  
Hush Tom never mind it, for when your head's bare,  
You know that the soot cannot spoil your white hair

And so he was quiet, and that very night,  
As Tom was a sleeping he had such a sight,  
That thousands of sweepers Dick, Joe Ned and Jack  
Were all of them lock'd up in coffins of black,

And by came an Angel who had a bright key  
And he open'd the coffins and set them all free.  
Then down a green plain leaping laughing they run  
And wash in a river and shine in the Sun.

Then naked and white, all their bags left behind,  
They rise upon clouds, and sport in the wind.  
And the Angel told Tom if he'd be a good boy,  
He'd have God for his father and never want joy.

And so Tom awoke and we rose in the dark  
And got with our bags and our brushes to work,  
Tho' the morning was cold, Tom was happy and warm  
So if all do their duty, they need not fear harm.

**William Blake, *Songs of Innocence and Experience***





# 1 Introduction

I was honoured to be asked by the Howard League for Penal Reform to lead an independent Inquiry into the use of restraint, solitary confinement and strip-searching in penal institutions for children. This Inquiry was launched in the wake of the death of Gareth Myatt, a 15-year-old boy who weighed just seven stone, while being restrained by officers in Rainsbrook Secure Training Centre.

The terms of reference for the Inquiry were:

*To investigate the use of physical restraint, solitary confinement and forcible strip searching of children in prisons, secure training centres and local authority secure children's homes and to make recommendations.*

My Inquiry has considered the various ways that children are treated in penal custody, which I believe would, in any other circumstance, trigger a child protection investigation and could even result in criminal charges. The Inquiry's work was based in England but I believe the general principles apply more widely.

While many of the children held in custody exhibit challenging behaviour and have complex health and social needs, there are over-riding concerns about the forcible stripping of young people, long periods of isolation as punishment and the physical restraint of children.

A further concern for the Inquiry has been the paucity of information and good statistical data about these issues, a pertinent example being the inability of the Inquiry to elicit facts regarding the ethnic origin of children subject to these practices.

This is the report of my investigation. I would like to thank my fellow members of the Inquiry team, the institutions, staff and children who provided me with the evidence and information for this report, and their support.

I would like too to acknowledge especially the support of the staff from the Howard League for Penal Reform.

Lord Carlile of Berriew QC

January 2006



## 2 Recommendations

### To Ministers

- 1 Overall policies and responsibility for all children, including those in custody, should rest with the Children's Minister

### To the Inspectorates

- 2 Unannounced inspections should be carried out in all establishments at least once a year in addition to scheduled inspections

### Resolving conflict and reducing violence

---

#### To the Youth Justice Board

- 3 There should be consistent standards of care, rules and conditions across all establishments
- 4 Staff should be models of good behaviour to the young people
- 5 Staff education and training needs to be consistent and of the highest standard and staff coming into the service should normally be educated to degree standard
- 6 Staff should be trained in core competencies before they start work with children
- 7 All staff working with children in custody should have training in child protection
- 8 More sophisticated and intensive conflict resolution training is needed so that best practices are embedded in daily practice
- 9 Staff ratios to children should be consistent across the secure estate
- 10 Children must be encouraged to go outside every day and participate in outdoor exercise for at least one hour five times a week
- 11 There must be structures to engage and empower children in decision making
- 12 Conflict resolution should be based on restorative principles and techniques
- 13 A staff peer review system should be introduced mirroring that in operation in mental health institutions so that attitudes and actions are questioned daily
- 14 Monitoring of the use of punishments on children from minority ethnic groups needs to be improved
- 15 All children should have easy and confidential access to information, advice and support from appropriate outside agencies
- 16 Staff should not be in uniform

## Restraint

---

### To the Youth Justice Board

- 17 The policy that restraint should never be used as a punishment must be made clear
- 18 Restraint should never be used primarily to secure compliance
- 19 Restraint should never be premeditated, as it is then becomes a punishment not an intervention to ensure safety
- 20 One certified physical intervention technique that is safe for children should be developed as a matter of urgency and be used across the secure estate
- 21 The Youth Justice Board should oversee the use of the disciplinary system so that it is rigorously applied when an allegation is made against a member of staff

### To the establishments

- 22 The resort to restraint should be viewed as a failure to de-escalate conflict
- 23 Pain compliance and the infliction of pain is not acceptable and may be unlawful
- 24 Handcuffs should not be used
- 25 Establishments should not introduce their own methods of physical or mechanical restraints
- 26 Violence reduction and dispute resolution should be afforded much higher priority
- 27 Appropriate and regular training should be given to all staff working in the secure estate
- 28 Promptly after each incident involving physical intervention there should be a dispute resolution conference, based on restorative justice principles, where the participants, including the child with an appropriate advocate, should be able to discuss the incident
- 29 There should be some immediate external and independent scrutiny of every incident of restraint. An incident of physical restraint should be seen as such a serious breakdown that it should be immediately reported and scrutinised by an appropriate independent child care agency
- 30 Record keeping and monitoring should be improved and data published to show the number of incidents, injuries to children and staff, broken down by race, age, gender and disability
- 31 So many of the young people have suffered serious violence and abuse in the past and are not used to making complaints; they must be helped to understand that they may make complaints and that there will be no reprisals

### To the Police and Crown Prosecution Service

- 32 Should be more willing to consider charging and prosecuting members of staff for assaulting children where there is a *prima facie* case

- 33 Should be more willing to consider charging and prosecuting the companies running penal institutions holding children

#### **To Local Authorities**

- 34 Local authority child protection committees should give priority to referrals from penal institutions

### **Strip searching**

---

#### **To the Youth Justice Board**

- 35 Policy, practice and procedure should be the same in all the establishments holding children
- 36 Strip searching is not necessary for good order and safety
- 37 Searches should be conducted based on the good practice the Inquiry found in local authority secure children's homes
- 38 Searches could be reduced by at least 50% by applying a more evidence based approach, without risk to security or safety being significantly increased

### **Segregation**

---

#### **To the Youth Justice Board**

- 39 Policy should be developed for 'time out' practices so it is used, monitored and recorded consistently
- 40 Prison segregation units should not be used for children

#### **To the establishments**

- 41 'Time out' could be a useful technique for easing tension but should never be for more than a few minutes
- 42 It should always be recorded, even if it is elective
- 43 Solitary confinement should never be used as a punishment
- 44 The child should have access to an advocate
- 45 A child's belongings should only ever be removed from their room if they pose a demonstrable risk to the child or others



### 3 Legal and human rights framework

- 1 The rationale for this Inquiry was that the rule of law and the protection of human rights should apply to all children equally, regardless of whether they are detained or in the community.
- 2 Children in custody are often held for relatively short periods. They should expect the same treatment, protection and standards before, during and after detention. Any variation of, or departure from, those parameters could only be justified (if at all) by necessity, but nevertheless compliant with the UK's international law obligations in relation to children.
- 3 The Inquiry used international and domestic law and standards for the treatment of children as the framework and the treatment of children in custody was judged against these standards.
- 4 The key documents that framed the Inquiry were:
  - Working Together to Safeguard Children, 1999
  - National Service Framework for Children, Young People and Maternity Services, 2004
  - Common Core Skills and Knowledge for the Children's Workforce, 2005
  - *The United Nations Convention on the Rights of the Child*
  - *European Convention on Human Rights*
  - *1989 Children Act*
  - *2004 Children Act*
  - *Every Child Matters, 2003*
  - *United Nations Standard Minimum Rules for the Administration of Juvenile Justice, 1985*
  - *United Nations Rules for the Protection of Juveniles Deprived of their Liberty, 1990*
  - *Youth Matters, 2005*



- 5 The Inquiry was established to investigate the use of restraint, solitary confinement and forcible strip-searching of children in custody. The Inquiry was asked to look at these three issues as their use in any other setting could constitute child abuse. We therefore considered whether the policies and practices we saw in the various establishments visited could be considered institutionally abusive.
- 6 The state has a duty to set high standards for three reasons. First, incarceration is the most serious sanction available to the state and should only be undertaken as a last resort; and individuals should retain their civil and human rights in so far as possible within the limits of the loss of freedom. Secondly, when the state restricts the liberty of a child it should set the highest standards of care. Thirdly, children should expect to receive from at least the same services and protection in detention as in the community.
- 7 Clause 26.1 of the UN Standard Minimum Rules requires that the purpose of detention should be “to provide care, protection... with a view to assisting them to assume socially constructive and productive roles in society”.
- 8 Article 20 of the UN Convention provides that: “A child temporarily or permanently deprived of his or her family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the state.”
- 9 The Inquiry was underpinned by international standards, treaties, rules and conventions. These included:

***United Nations Convention on the Rights of the Child:***

*Article 3*

In all actions concerning children the best interests of the child shall be a primary consideration

States parties undertake to ensure the child such care and protection as is necessary for his or her well being

States parties shall ensure that the institutions responsible for the care and protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number of and suitability of their staff, as well as competent supervision

*Article 6*

States parties recognize that every child has the inherent right to life

States parties shall ensure to the maximum extent possible the survival and development of the child

*Article 12*

States parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child

*Article 19*

States parties shall take all appropriate measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation

*Article 20*

A child temporarily or permanently deprived of his or her family environment shall be entitled to special protection and assistance provided

*Article 37*

The arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time; Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age.

*Article 40*

States Parties recognize the right of every child alleged as, accused of, or recognized as having infringed the penal law to be treated in a manner consistent with the promotion of the child's sense of dignity and worth, which reinforces the child's respect for the human rights and fundamental freedoms of others and which takes into account the child's age and the desirability of promoting the child's reintegration and the child's assuming a constructive role in society.

***The European Convention on Human Rights:****Article 3*

No one shall be subjected to torture or other cruel, inhuman or degrading treatment.

*Article 8*

Everyone has the right to respect for his private and family life, his home and his correspondence.

There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

*Article 13*

Everyone whose rights and freedoms as set forth in this Convention are violated shall have an effective remedy before a national authority notwithstanding that the violation has been committed by persons acting in an official capacity.

- 15 The Government's 2003 green paper, *Every Child Matters* set five key outcomes for children; staying safe and being protected from harm and neglect; growing up able to look after themselves; being healthy; enjoying and achieving; and making a positive contribution to the community and to society.
- 16 The Government's 2004 Children's National Service Framework set a standard (number 5) for all agencies to "work to prevent children suffering harm and to promote their welfare, provide them with the services they require to address their identified needs and safeguard children who are being or who are likely to be harmed." Standard 3 provides that children should receive high quality services that are co-ordinated around their individual needs and take account of their views. Standard 9 states that all children and young people, from birth to their 18th birthday, who have mental health problems and disorders should have access to timely, integrated and high-quality multi-disciplinary mental health services to ensure effective assessment, treatment and support.
- 17 The Inquiry took cognizance of the Government's aim of reducing anti-social behaviour and the respect policy agenda. Policies, practices and standards of behaviour by staff in facilities of detention should reflect these objectives so that children learn how to manage conflict, anger, frustration and fear without recourse to violence.
- 18 We support the view that rights generally come with responsibilities. It is especially important, therefore, that young people in detention are encouraged to deal with conflict in a constructive way and that they are helped to learn about civic responsibilities through excellent example. Nevertheless, the basic rights of children, whether prisoners or not, are not conditional or contingent.
- 19 The prisons inspectorate has developed a model to judge a healthy prison, including safety, respect and purposeful activity and the Inquiry found this most useful.
- 20 The Safeguarding Children reports of 2002 and the 2005 review also provided a useful framework for the Inquiry.
- 21 The treatment children receive in custody should not risk making them more dangerous, more likely to commit criminal or anti-social acts, or more violent on release than on reception. The standards we applied were designed to uphold human rights, but also, and just as importantly, to ensure that children learn how to respect others and to avoid resort to conflict and violence. The way they are treated in custody will determine whether they consider violence is an acceptable way to resolve conflict when they are released. All the children we met were going to be released back into the community, some in just a few days and some after a longer time.

- 
- 22 An objective of the Inquiry has been to identify how children could best be assisted to mature into responsible, law-abiding and valued citizens. We recognize that many children in penal custody have substantial needs and their behaviour can sometimes be extremely challenging. Of course, the challenging behaviour by children offers no excuse for abusive policies or bad behaviour by staff if it occurs.
- 23 The Inquiry has addressed very different types of penal institutions. This makes difficult the application of a uniform approach even to critical issues. We anticipate that future legislation will bring the secure training centres, young offender institutions and local authority secure children's homes into a more co-ordinated secure estate. This would allow standards to be consistent.
- 24 The former Chief Inspector of Prisons, Lord Ramsbotham, described four aspects required of a healthy penal establishment in his 2003 book, *Prisongate: the shocking state of British prisons and the need for visionary change*, and these have been used to guide the work of the prisons inspectorate. The Inquiry considered that the first two in particular set a useful benchmark for our work: that everyone who resides or works in the establishment is and feels safe; and that everyone is treated with respect as a fellow human being.



## 4 Methodology

### Advisory panel

---

25 In September 2004 a panel of experts was established to advise my Inquiry, conduct visits to places of custody and meet with groups of children within them. My advisory panel comprised:

<b>Debra Clothier</b>	Chief Executive of the Restorative Justice Consortium.
<b>Hilton Dawson</b>	Chief Executive of Shaftesbury Homes and Arethusa and MP for Lancaster and Wye until May 2005
<b>Dr Barry Goldson</b>	Senior Lecturer in Sociology, University of Liverpool and trustee of the Howard League for Penal Reform
<b>Rob Hutchinson</b>	Independent advisor and former Strategic Director of Housing, Health and Social Well-being at Portsmouth City Council
<b>Mary Marsh</b>	Chief Executive of the NSPCC
<b>Colin Moses</b>	National Chairman of the Prison Officer's Association
<b>Dr Heather Payne</b>	Paediatrician and Senior Lecturer, Department of Child Health, Cardiff University
<b>Lord Ramsbotham GCB CBE</b>	Former Chief Inspector of Prisons
<b>Sue Wade</b>	Independent consultant on penal policy and practice and trustee of the Howard League for Penal Reform
<b>Roy Walker</b>	Manager of Sutton Place secure children's home and former chair of the Secure Accommodation Network
<b>Prof Richard Williams</b>	Professor of Mental Health Strategy, University of Glamorgan and consultant child psychiatrist in the Gwent Healthcare NHS Trust

<b>Carolyn Willow</b>	National Coordinator, Children's Rights Alliance for England
<b>Prof David Wilson</b>	Professor of Criminology, University of Central England, former prison governor and trustee of the Howard League for Penal Reform

## Primary research

### 26 Visits

The Inquiry undertook 12 visits to 11 different institutions.

#### **Young Offender Institutions**

Feltham in West London

Huntercombe in Oxfordshire

Warren Hill in Suffolk

#### **Secure Training Centres**

Hassockfield near Durham

Oakhill in Milton Keynes

Rainsbrook near Rugby (two visits)

#### **Local Authority Secure Children's Homes**

Aldine House in Sheffield

Aycliffe in Co Durham

Orchard Lodge in London

Sutton Place in Hull

Vinney Green in Bristol

27 During the visits the Inquiry team discussed policy and practice with staff and children and were given the opportunity to speak with them in private during some visits. The visits allowed for informal participant observation, albeit of a limited type, but given the experience of many of those visiting the establishments this was a useful method of investigation.

28 We were able to visit the children's living accommodation, segregation arrangements where applicable and other facilities for the children including education and space for outside activity.

**29 Interviews and consultations**

The Inquiry used first-hand testimony as a primary source of information. The Inquiry team interviewed and spoke with more than 80 members of staff from the institutions, including senior managers, operational managers, psychologists, psychiatrists, education managers and teaching staff, care staff and prison officers.

- 30 More than 30 children were consulted during the Inquiry either individually or in groups. The children spoke about their experiences in their current institution and compared, where applicable, their experiences in different institutions in the children's secure estate. In addition six children who had recently left custody were interviewed.

---

**Secondary Research**

---

**31 Literature review**

A broad literature review was undertaken on restraint, strip-searching, and solitary confinement of children and adults in custody to identify previous research and practice. UK and overseas sources were consulted. We sought to identify policy and practice in related fields where children are looked after, including the fields of education and healthcare.

**32 Policy documents and statistics**

The Inquiry sought information directly from the eleven establishments visited, including their policies in general and specifically regarding restraint, strip searching and solitary confinement. Statistical information was also requested relating to the three areas of the Inquiry. Policy documents were received from all institutions. Eight institutions provided the Inquiry with statistical data. To complement this information the Inquiry gathered national data.

---

**Additional evidence**

---

- 33 The Inquiry invited the submission of evidence from the general public, criminal justice and other professionals at the end of April 2005. Staff and children at each of the establishments that we visited were also invited to submit evidence. 47 written and oral submissions were made to the Inquiry.



## Seminars

---

- 34 The Inquiry held two seminars chaired by Lord Carlile to discuss the issues of child protection, conflict resolution and violence reduction strategies. They were held under 'Chatham House Rules'. A range of experts was invited to attend alongside some members of the advisory panel. The following participated in the seminars:

<b>Stephanie Braithwaite</b>	Mediation and Reparation Service
<b>Gill Brigden</b>	HM Prison Service Safer Custody Group
<b>Debra Clothier</b>	Director, Restorative Justice Consortium
<b>Frances Crook</b>	Director, Howard League for Penal Reform
<b>Professor Helen Cowie</b>	UK Observatory for the Promotion of Non-Violence
<b>Christine Daly</b>	Children's Legal Centre, University of Essex
<b>Fay Deadman</b>	HM Inspectorate of Prisons
<b>Kimmett Edgar</b>	Prison Reform Trust
<b>Jon Fayle</b>	Youth Justice Board for England and Wales
<b>John Kemmis</b>	Voice of the Child in Care
<b>Chris Holmes</b>	HM Prison Service Safer Custody Group
<b>Andie Lambe</b>	Howard League for Penal Reform
<b>Mary Marsh</b>	NSPCC
<b>Elizabeth McMahon</b>	Howard League for Penal Reform
<b>Dr Roger Morgan</b>	Children's Rights Director, Commission for Social Care Inspection
<b>Fionnuala Mullin</b>	Training and development consultant specialising in restraint issues
<b>Dr Carrie Myers</b>	UK Observatory for the Promotion of Non-Violence
<b>Barbara Tudor</b>	Victim Liaison Officer and restorative justice expert
<b>Professor David Wilson</b>	Professor of Criminology, UCE and Howard League for Penal Reform

## 5 Children's secure estate

35 There were three different types of custodial institutions within the juvenile, or children's, secure estate in England and Wales: young offender institutions; secure training centres; and, local authority secure children's homes.

### 36 **Young Offender Institutions (YOI)**

In September 2005 the Youth Justice Board placed children in 18 prison service establishments

37 The Prison Service managed 16 of the YOIs, but private contractors managed Ashfield and Parc.

38 There were four dedicated juvenile YOIs for boys:

Huntercombe in Oxfordshire (360 places)

Warren Hill in Suffolk (216 places)

Werrington in Staffordshire (132 places)

Wetherby in West Yorkshire (360 places).

In addition there were eight YOIs that share a split site with young adults males aged 18 to 21:

Ashfield near Bristol (400 places)

Brinsford near Wolverhampton (224 places)

Castington in Northumberland (168 places)

Feltham in West London (240 places)

Hindley near Wigan (192 places)

Lancaster Farms, near Lancaster (130 places)

Stoke Heath in Shropshire (202 places)

Thorn Cross near Warrington (60 places).

Parc, a local prison for adult males and young adults near Bridgend in Wales, had a 36 bed unit for juveniles. Woodhill prison held adult males but was sometimes used to detain juveniles on remand for serious offences and they were usually located on the segregation or medical units.

39 The average length of stay in a YOI for juveniles was 84 days, including time spent on remand.

40 Girls were held in separate units at Cookham Wood prison in Kent (17 places) and Downview in Surrey (16 places). However girls continued to be held in women's prisons at Bullwood Hall in Essex (30 places); Eastwood Park in Gloucestershire (16 places) and New Hall near Wakefield (26 places).

41 YOIs were regulated by Prison Service Orders and were inspected by Her Majesty's Inspectorate of Prisons (HMIP).

### **Secure Training Centres (STCs)**

42 STCs were designed, financed and built by private companies, originally to hold children from 12 to 15 but subsequently young people up to 17 years old. Medway STC was opened in 1999 and by 2005 there were five STCs in England with spaces for 274 children in total. Medway in Kent, had space for 76 children; Rainsbrook in Rugby, also had space for 76 children; Hassockfield in Durham, had space for 42 children; and Oakhill in Milton Keynes, had space for 80 children. Rebound ECD (a subsidiary of Group 4 Falck) ran Medway and Rainsbrook STCs; Premier Training Services (a subsidiary of Serco) ran Hassocksfield; Oakhill was run by Securicor Justice Services.

43 Each STC had an individual operational contract with the Home Office. They were subject to an annual inspection by the Commission for Social Care Inspectorate (CSCI).

44 In September 2005 the STCs held a total of 245 boys and girls. The 96 girls comprised 5 aged 13, 12 aged 14, 25 aged 16, 46 aged 17 and 8 aged 18. The 149 boys comprised 1 aged 12, 8 aged 13, 68 aged 14, 45 aged 15, 23 aged 16 and 4 aged 17. 108 of the boys and girls were sentenced to a DTO, 29 were on remand and 12 were sentenced under Section 90 or 91 for a serious offence. 397 children were received into STCs during 2000, 478 during 2001, 580 during 2002, 788 during 2003, 887 during 2004 and 365 in the first four months of 2005. This makes a total of 3,495 children in five years and four months.

45 It was drawn to the attention of the Inquiry that there had been 1,577 custody and other staff appointed to the STCs since 1988 and that 1,026 had left (Hansard, 28 October 2005, col 596W).

### **Local Authority Secure Children's Home (LASCH)**

46 There were 24 LASCHs in England and Wales with 15 of them under contract to the Youth Justice Board (YJB).

47 LASCHs ranged in size from 6 - 40 beds and had the highest staff to child ratio in the children's secure estate. They were generally used to accommodate children aged between 12-14 years old, girls up to the age of 16 and 15 year old boys who were assessed as vulnerable. The Youth Justice Board (YJB) had contracts with each LASCH for a set number of beds but could spot purchase extra spaces if necessary.

48 They were run by local authority social services departments and were subject to all legislation and regulations pertaining to children. They were licensed by the Department for Education and Science. LASCHs undergo an annual CSCI inspection.

49 The YJB had contracts with 15 LASCHs

Eastmoor	Yorkshire	34	Leeds City Council
Vinney Green	South West	20	Gloucestershire Council
Aycliffe Young Peoples Centre	North East	30	Durham County Council
Redbank	North West	28	St Helens Metropolitan Borough Council
Lincolnshire Unit (Kestevan)	East Midlands	7	Lincolnshire County Council
Swanick Lodge	South West	10	Hampshire County Council
Barton Moss	North West	20	Salford City Council
Sutton Place Safe Centre	Yorkshire	8	Kingston upon Hull City Council
Clayfields House	East Midlands	12	Nottinghamshire County Council
Aldine House	Yorkshire	5	Sheffield City Council
Dyson Hall (Gladstone Unit)	North West	16	Liverpool City Council
Kyloe House	North East	3	Northumberland County Council
Hillside	Wales	14	Neath Port Talbot Borough County Council
Atkinson Unit	South West	10	Devon County Council
London Secure Services (Orchard Lodge)	London	18	London Borough of Southwark

The Inquiry was told by the YJB: “In terms of spot purchases, by their very nature these places were purchased on a spot basis from whomever is offering them at the time they’re needed. Generally though we spot purchase from the 15 units we already have an existing contract with. We have very occasionally purchased from units we do not have a contract with, for example we have used St Catherine’s, Leverton and St Johns in the past 6 months.”

## Placement of children

- 50 The Youth Justice Board was the non-departmental public body established by the Crime and Disorder Act 1998 to advise the Home Secretary and to manage the operation of the youth justice system. Since April 2000 it has had responsibility for commissioning and purchasing places in the secure children's estate for those children sentenced or remanded into custody.
- 51 The YJB ran a seminar to explain its placements service to the Inquiry team. To make a placement decision, the YJB used a vulnerability assessment, surveyed the available places, took into consideration the child's age, and balanced the needs of that child against the needs of other children already in the system.

## Children in the secure estate

- 52 Number of children in custody designated by the Youth Justice Board as vulnerable in September 2005.

<b>Total no of vulnerable</b>	1405	
<b>Total in custody</b>	3423	
<b>Percentage vulnerable</b>	41%	
<b>Age</b>	<b>Number vulnerable</b>	<b>Percentage of vulnerable</b>
11	1	100%
12	11	100%
13	42	79%
14	110	67%
15	229	56%
16	333	40%
17	476	35%
18	203	35%
<b>Total</b>	<b>1405</b>	<b>41%</b>
<b>Gender</b>	<b>Number vulnerable</b>	<b>Percentage of vulnerable</b>
Male	1212	38%
Female	193	72%
<b>Total</b>	<b>1405</b>	<b>41%</b>
<b>Accommodation Type</b>	<b>Number vulnerable</b>	<b>Percentage of vulnerable</b>
YOI	1021	35%
LASCH	196	80%
STC	188	77%
<b>Total</b>	<b>1405</b>	<b>41%</b>

- 53 During 2004 8,110 children were received into prison establishments of whom 6,370 were classed as white, 385 mixed race, 362 Asian or Asian British, 916 Black or Black British, 49 Chinese and 28 unrecorded (14 June 2005, Hansard, col 293W). During the same year 1,797 children were admitted to STCs or LASCHs of whom 1,349 were white, 166 mixed race, 36 Asian or Asian British, 148 Black or Black British, 20 Chinese or Other and 78 unrecorded.

## 6 Resolving conflict and reducing violence

### Relationships based on respect

---

- 54 The Inquiry was mindful that the issue of respect has become a central tenet of public policy over the past year. We believe respect should be the basis of all relationships within closed penal institutions – between children and staff, between children and between staff. The responsibility for engendering and maintaining a culture of respect lies with managers and staff. An understanding founded on respect can be regarded legitimately as the main contributor to resolving conflict in a way that reduces the potential for recourse to violence and sets solid foundations for positive relationships.
- 55 It is the culture of the institution that sets the parameters for policies and practice. We saw local authority secure children’s homes where the culture was child-centred and we felt conflict was dealt with sympathetically and constructively. Sadly, we saw more establishments where the culture was antipathetic to normal teenage development.
- 56 The Inquiry recognises that many of the children and young people detained against their will had chaotic and abusive childhoods and that the lack of clear boundaries and examples of good behaviour meant that they often did not know how to manage their own frustration, sadness, irritation, fear or anger. One objective of the Inquiry was to discover good practice and recommend that this be replicated across the system. The use of physical violence or intervention by staff should only be required in the most exceptional circumstances.
- 57 We were concerned that in some cases there appeared to be a culture where dissent was not tolerated and that physical restraint was used to secure conformity. Whilst firm boundaries and consistency of response by adults in authority are essential, it has to be balanced against a tolerance and appreciation that normal teenage behaviour is testing. Over-reaction, especially if capricious and sudden, can be counter-productive and even dangerous.

- 58 The supervisory relationship should be used as an opportunity for staff to model and reinforce desired pro-social attitudes and behaviours. This principle is enshrined in the Standard Minimum Rules for the Treatment of Prisoners, Rule 48 says

*All members of the personnel shall at all times so conduct themselves and perform their duties as to influence the prisoners for good by their example*

Certainly the obverse is true; a limited repertoire of helpful responses by staff will lead to less compliance, resentment and even, in the case of adolescents in particular, to conflict and violence. It is the contention of the Inquiry that overly punitive and constricting policies, a spartan and impoverished regime, and poor behaviour by staff can give rise to much of the conflict and violence.

- 59 Prison Service Order 4950 states

*Sentence structure and regimes programmes will deliver little unless the staff who establish and maintain the safe and secure environment, who are critically involved in a young person's personal development and in the control of institutional regimes, model consistently positive attitudes and behaviours.*

## **Staff education and training**

---

- 60 The Inquiry was concerned to discover that some staff working in all types of penal institutions lacked appropriate education and training. We consider that this very challenging work requires staff who would normally have degree level education and professional qualifications. In-service training should be used to develop staff. Training should supplement existing ability and expertise. The United Nations Rules for the Protection of Juveniles Deprived of their Liberty, rule 82 says

*The administration should provide for the careful selection and recruitment of every grade and type of personnel, since the proper management of detention facilities depends on their integrity, humanity, ability and professional capacity to deal with juveniles, as well as personal suitability for the work.*

- 61 Staff development in some establishments currently focuses on physical management of aggression and violence rather than developing skills to avert conflict. It is of concern that the only compulsory component of prison officer training is physical control and restraint. The Inquiry suggests that compulsory training should focus on children's human rights, communicating positively with children, child protection and creating positive environments for care and rehabilitation. This can be achieved as one recent CSCI inspection for one of the LASCHs visited said: "Episodes of challenging behaviour were well managed with great emphasis being placed upon diffusion rather than premature alternative intervention. There was evidence to suggest that this approach was bearing operational benefits as the use of single separation and restraints were at a comparatively low level."

## Staffing levels

- 62 There need to be adequate numbers of staff to supervise and interact with children in secure establishments. The differential levels of staffing in the various institutions were a matter of concern to the Inquiry varying ten fold between prisons and LASCHs for example. The United Nations Convention on the Rights of the Child, article 3.3 says
- States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision*
- 63 Hilton Dawson MP provided information to the Inquiry on the staff child ratio
- In a LASCH between one member of staff to two children and six staff to eight children
  - In STCs between two staff to five to seven children and three staff to eight children
  - In juvenile prisons (YOIs) from three to six staff to between 40 and 60 children on the wings.
- 64 The Inquiry visited one YOI where staff said that in order to ensure safety and control there needed to be a reduction of about half the number of children on each unit. The staff said that during a recent refurbishment this had indeed been the occupancy rate and the consequent numbers of incidents and restraints had been significantly reduced. This evidence was supported by the HM Inspector of Prison's report (2003) that observed that the establishment was "only safe because it was operating at close to three-quarters of its maximum capacity...At this level, socialisation of young people and positive work with them can be carried out in a safe environment. At any higher level, they cannot." The report continued: "At the last inspection, we were firmly of the view that units of 60, in establishments of 360, were far too big to run safely, with such a volatile and often disturbed population. This inspection has confirmed that view; and this is a message that needs to be heard by the Youth Justice Board and Prison Service." The Inquiry was told that the subsequent increase in numbers of children resulted in low staff morale and an increase in incidents of conflict.
- 65 It became apparent during the visits that institutions that had good staff retention records were places where the child-staff relationship was better. Management at one establishment alleged that a staff attrition rate of 37% in the previous year contributed to low morale and was identified as a factor in recent incidents. It was asserted that the children sensed an atmosphere of instability. Information provided in a Parliamentary Answer on 28 October 2005 (Hansard, col 596W) indicated a 65% turnover in staff at the STCs:
- Medway STC                      615 custody and other staff appointed 1999 to 31.8.05 412 staff left
  - Rainsbrook STC                      218 custody and other staff appointed 2002 to 31.8.05 177 staff left



- Hassocksfield STC 297 custody and other staff appointed 1999 to 31.8.05 267 staff left
- Oakhill STC 384 custody and other staff appointed 2004 to 31.8.05 170 staff left

## Exercise and outdoor activity

---

66 The Inquiry team was appalled at the lack of physical exercise and outdoor activity available to the children in all of the establishments visited and considers that this must contribute to frustration and pent-up energy being inappropriately expressed. It is extraordinary that these children, predominantly adolescent boys, were cooped up in conditions devoid of outdoor experience and activity. The United Nations Rules for the Protection of Juveniles Deprived of their Liberty states:

*Every juvenile should have the right to a suitable amount of time for daily free exercise, in the open air whenever weather permits, during which time appropriate recreational and physical training should normally be provided.*

67 The children had very little access to fresh air and on the rare occasions they ventured outdoors it was simply to walk from one building to another. None of the institutions visited had proper facilities. There seemed no opportunity for children to run. They rarely felt fresh air, sunshine or rain.

68 There were few facilities for team sports or games, and a distinct dearth of playing fields. The limited exercise equipment provided consisted mostly of indoor gyms focussed in the main on “pumping iron”. According to HM Prison Inspector’s report on Juveniles in Custody (2004) more than 80% of boys in YOIs said they did not go outside for exercise every day and only 25% said they went to the gym once a week. Inspection reports on individual establishments concur. Even when there was a suitable space the regime provided for no scheduled time for exercise in the fresh air.

69 This is almost certainly a contributory factor to conflict. Young people told the Inquiry how restricted they felt and how they had no access to proper exercise or fresh air. The Inquiry considers that children, particularly young boys, need and like regular and energetic exercise which can be in the form of team games like football or individual sports like athletics or skateboarding. Gardens can also provide an outdoor space for peace and quiet.

70 The policy that allows such institutions to be built without appropriate exercise facilities for adolescents was flawed and must be held responsible for regimes that result in frustration and depression. The National Institute for Health and Clinical Excellence (2005) published new guidelines for the treatment of children with depression and recommendation 1.1.59 suggests

*A child or young person with depression should be offered advice on the benefits of regular exercise and encouraged to consider following a structured and supervised exercise programme of typically up to three sessions per week of moderate duration (45 minutes to 1 hour) for between 10 and 12 weeks.*

- 71 The Inquiry considers that the lack of such exercise contributes towards depression and could trigger conflict. The provision of an outdoor playing field, a swimming pool and a garden for quite recreation must be provided in every establishment detaining children.

### **Respect through responsibility**

---

- 72 The United Nations Convention on the Rights of the Child, article 12 says
- States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.*
- 73 The Inquiry took it as a given that policies should foster self-respect and respect for others and that this would form the foundation of all policies aimed at encouraging positive relationships and the avoidance and reduction of conflict. The encouragement of participation and involvement in decision-making was only occasionally embodied in policy and practice in the establishments visited. Too often any consultation attempted was seen to be a perfunctory process that would not result in change. This was particularly true in the YOIs where there seemed to be no structure for involving children in decision making. We recommend wing or group daily meetings and elections of representatives to key committees engaged with policy scrutiny, for example race relations.
- 74 The Inquiry was told that many of the children had never been taught, or found it necessary to learn, self-control. It was therefore surprising that the policies and practices in many institutions were predicated on the assumption that children could manage their own feelings and behaviour and that they had the ability to understand and react appropriately to a complex system of institutional rules and regulations. Children with learning difficulties will find it hard to understand abstract instructions about behaviour and need to be given clear guidance. The Inquiry was given evidence that speech and language therapists could be a help to children to learn negotiating skills.

### **Restorative justice**

---

- 75 The Inquiry was given expert advice by Debra Clothier, Chief Executive of the Restorative Justice Consortium that informed this section. Restorative justice is a process whereby all the parties in a particular event come together to resolve collectively how to deal with its aftermath and implications for the future, and the person responsible has the opportunity to acknowledge the impact of the act and make reparation. Restorative principles (see Appendix F) provide a framework to resolve and transform incidents in custody so that all parties feel their point of view has been dealt with respectfully and amends can be made if appropriate. The principles can be applied in various structures and proportionately. When looking at secure institutions for young people with the emphasis on the treatment of those children whilst there, restorative practices can provide some clear benefits for reducing conflicts and the need for punitive solutions for dealing with the aftermath of any conflict.

76 Evidence submitted to the Inquiry suggested that the emphasis in children's secure establishments appeared to be very much on physical intervention. The need for alternatives to be available to staff and children was clear. Restorative practices used in a 'whole prison approach' might offer one solution to this problem.

77 Merely to punish children does not teach them how to behave differently and in fact can leave them angrier and more likely to respond in an aggressive way in future. If staff are seen to respond in a physical way to conflict this will be 'modelled' by the children. The Inquiry was told by staff that they can feel festering anger or fear if they have to continue to work with a child who has been violent towards them. There are different restorative justice models that can be used in a secure setting and flexibility should be maintained so that all needs are catered for. The list below describes some of the possible models:

### **Circles**

78 Inquiry visits elicited evidence from individual children that not everyone felt that they had access to a complaints procedure or that their complaints were not acted on.

79 Conflict is a natural part of life and it can often spring up in a closed community from seemingly minor frustrations. Methods for 'nipping them in the bud' can be useful for preventing escalation. A regular opportunity for children and staff safely to discuss issues in a respectful way, where everyone is heard can reduce future conflicts and might also provide staff with warnings of any potential problems. It can also reduce the number of formal complaints.

### **Conferences or Mediation**

80 These can be informal or more formal and involve a facilitator working with parties to deal with conflict. These questions can be used in adjudications, disputes between children and staff/children as well as staff conflicts. This can be done in an indirect way as well as in a meeting, through a facilitator 'shuttling' between the participants.

### **Restorative Conversations**

81 These are a short conversation used for any minor breach of rules or unacceptable behaviour. They are intended to be a learning experience rather than merely telling someone off. It encourages the person to look at how their behaviour affects others and to look at alternative ways of responding.

82 These developments need not be resource intensive. But it is crucial that management and staff have an awareness of the aims and are supportive of them.

83 The use of these methods have until now been 'patchy' in England and Wales. One prison that has possibly come closest to this model, and includes these methods, is Grendon therapeutic prison, which works with adult prisoners who have committed serious crimes. Within the juvenile secure setting there were few, if any, establishments that have implemented restorative justice into their structure or policies, and there seems to be a general misunderstanding about what restorative justice and mediation comprise.

- 84 The Inquiry recommends that further research be commissioned by the Youth Justice Board into good practice in other institutions dealing with children. Some schools, local authority residential homes and pupil referral units, for example, have whole institution programmes for conflict resolution that obviate the need to resort to punishment.

### **Privacy and other matters**

---

- 85 Children should have ready access to bathing facilities that provide privacy and are preferably attached to their rooms. Communal showering has too often been associated with bullying, intimidation and abuse. The Inquiry was concerned to see that in one STC the door viewing panels to the bedrooms were often left open and staff walking in the corridors could easily observe children having showers since there were no doors on the bathrooms.
- 86 Children complained to the Inquiry about room searches when they were not present and that they returned to their room to find that some of their personal possessions had been removed or lost. Children told us, when staff empty their room, everything is removed, including posters, photographs and educational certificates attached to the walls. Children described this process as being done in great haste and with little care.
- 87 Children benefit from having telephones in their rooms. Free phone numbers to services like the Samaritans, ChildLine and advocates were beneficial, together with in-coming calls. They should be unlimited save in specific circumstances connected with the security of the institution or the prevention of crime. This good practice was in evidence in one establishment visited where the children could keep in regular contact with their families. This is vital to their sense of well-being in custody and to their successful re-integration into the community.

## Recommendations

---

### To the Youth Justice Board

- There should be consistent standards of care, rules and conditions across all establishments [rec 3]
- Staff should be models of good behaviour to the young people [rec 4]
- Staff education and training needs to be consistent and of the highest standard and staff coming into the service should normally be educated to degree standard [rec 5]
- Staff should be trained in core competencies before they start work with children [rec 6]
- All staff working with children in custody should have training in child protection [rec 7]
- More sophisticated and intensive conflict resolution training is needed so that best practices are embedded in daily practice [rec 8]
- Staff ratios to children should be consistent across the secure estate [rec 9]
- Children must be encouraged to go outside every day and participate in outdoor exercise for at least one hour five times a week [rec 10]
- There must be structures to engage and empower children in decision making [rec 11]
- Conflict resolution should be based on restorative principles and techniques [rec 12]
- A staff peer review system should be introduced mirroring that in operation in mental health institutions so that attitudes and actions are questioned daily [rec 13]
- Monitoring of the use of punishments on children from minority ethnic groups needs to be improved [rec 14]
- All children should have easy and confidential access to advice and support from appropriate outside agencies [rec 15]
- Staff should not be in uniform [rec 16]

## 7 Restraint

88 The Inquiry was established following the death of Gareth Myatt who died in Rainsbrook secure training centre whilst being restrained by staff in 2004.

89 The Parliamentary Joint Committee on Human Rights on Deaths Custody (2004) stated:

*A number of Convention rights provide a framework in which Article 2 rights must be protected in the use of restraint. Use of physical restraint engages Article 8, the right to physical integrity, and Article 3, the freedom from inhuman and degrading treatment. Article 3 provides particularly strong protection for people in detention, and there is a presumption that unnecessary physical force against a detainee reaches the otherwise high threshold required to establish inhuman and degrading treatment. Particular vulnerabilities of which the detaining authorities knew or ought to have known, such as a history of past physical abuse, may therefore contribute to a finding of an Article 3 violation in the use of restraint.*

### Different methods of restraint

---

90 The use of force was sanctioned in Young Offender Institutions (YOIs), Secure Training Centres (STCs) and Local Authority Secure Children's Homes (LASCHs). The guidance, monitoring and use of restraint differed across and between the different institutions. Methods of restraint had not been developed for use with children. However, it was clear that restraint was regarded as a part of the strategy to manage children's behaviour.

91 Across the eleven establishments the Inquiry found six different methods of restraint being used. There was therefore no consistency across the various institutions, and more importantly, there was no consistency for the children who often moved between different institutions and were subjected to different rules and practices.

92 The Inquiry was particularly concerned to learn that handcuffs were being used on children in the secure training centres. The STCs have apparently started using mechanical restraints following the banning of the "double seated embrace" that was used on Gareth Myatt to fatal effect. A 14 year-old boy told a member of the Inquiry team that the handcuffs used on him hurt his wrists, because they are too tight. He held out his

arms to show how ‘thick’ his wrists are. When asked whether he felt humiliated by being put in handcuffs, he said he was a Gypsy and was used to being degraded.

### **Control and restraint (C&R)**

- 93 The method used within the Prison Service was termed Control and Restraint (C&R). It had been originally designed for adults but was deployed in the YOIs in respect of children. It was a pain compliant technique, which immobilized the arms by employing joint locks, using wrist flexion. It was designed for use by a minimum of three members of staff. C&R training comprised a collection of physical techniques derived from the ‘martial arts’ of Aikido (Gilbert 1988). Training was compulsory for the prison officers and was refreshed at least annually by approved trainers. C&R was in use at Huntercombe, Feltham and Warren Hill YOIs. However, training was not focussed on techniques appropriate for children.

### **Physical control in care (PCC)**

- 94 PCC was the method of restraint introduced when the first of the four STCs was opened in 1997. It was based on the PRICE technique (see below) and was designed by the Prison Service. It was described as non-pain compliant but used methods of “distraction” which in fact were pain-inflicting techniques. It had three escalating phases based on a series of holds with increasing numbers of staff involved in each phase. This allowed staff to escalate or de-escalate the use of force as necessary. The initial training course lasted four days with a refresher a minimum of every six months. PCC was used in Hassocksfield, Oakhill and Rainsbrook STCs. The Inquiry was told that PCC could be applied for up to half an hour.

**Distraction techniques:** these are pain-compliant techniques available and used within the PCC method of restraint approved for use in the STCs. There are three distraction techniques:

- using the thumb – fingers are used to bend the upper joint of the thumb forwards and down towards the palm of the hand;
- using the ribs – involves the inward and upward motion of the knuckles into the back of the child exerting pressure on the lower rib; and
- using the nose – staff use the outside of their hand in an upward motion on the septum.

### **C&R general services (C&R (GS))**

- 95 This was a non-pain compliant technique, which has been described as a modified version of ‘C&R’ for Health and Social Services in the UK (McDonnell & Gallon 2002). It was designed to enable one member of staff to control a person but advised the use of a minimum of two staff wherever possible. The training course lasted two days with one-day annual refreshers for management. It taught a range of techniques including wrist holds and techniques to avoid punches and kicks. The Inquiry was told this method was used in Vinney Green and Orchard Lodge LASCHs.

### **Management of actual or potential aggression (MAPA)**

- 96 This method was a non-pain compliant technique, which could be used on children by one to three staff. The training included holding skills and disengagement techniques; the dangers of positional asphyxia; and the legal context in which it may be used. The technique was derived from a healthcare setting and emphasised de-escalation. The Inquiry was told that MAPA was used in Aldine House.

### **Protection and rights in care environments (PRICE)**

- 97 The Prison Service developed this system of restraint following injuries sustained by children at Aycliffe Secure Children's Home (Howard League for Penal Reform 1993). It was specifically designed for children aged between 12 to 14 years old. The technique was divided into four phases: prevention; restraint, holding and breakaway. It can be used with up to three members of staff. Staff undertake a four-day training course with refreshers every six months. The Inquiry came across PRICE in Aycliffe LASCH.

### **Therapeutic crisis intervention (TCI)**

- 98 TCI was developed by Cornell University in the USA in the early 1980s. The full course lasted 5 days with a minimum 24 hours training. The TCI programme included training in crisis intervention, crisis de-escalation and post-crisis intervention as well as training in restraint techniques, including team restraint (Bell & Stark 1998). Staff were expected to have a 2 day refresher at least every 6 months. This method of restraint was used at Sutton Place LASCH.

## **Statistical data**

---

- 99 In the course of the Inquiry statistics were sought to illustrate the use of restraint across the children's secure estate. Unfortunately the Inquiry was unable to secure truly comparative data for all the institutions and indeed some failed to provide any information. The Inquiry was concerned about the quality of monitoring of the use of restraint varied across the estate.
- 100 Prior to the establishment of the Inquiry Questions in Parliament had elicited the information that restraint had been used on 622 occasions in the 11 months between 1 January and 31 November 2003 in Stoke Heath, Huntercombe and Castington YOIs (Hansard, 26 January 2004, col 197W).
- 101 Restraint was used 3,289 times in 2003 in four STCs (Guardian 2 November 2005). A Parliamentary Answer showed that between January 1999 and June 2004 restraint was used 11,593 times in STCs (Hansard, 24 June 2004, col 1522W). Medway used restraint 4,675 times between 2000 and 2004; Hassocksfield 3,822 between September 1999 and May 2004; and Rainsbrook 3,096 times in the same period.
- 102 Only seven institutions provided information regarding restraint to the Inquiry.



Institution	Number of restraints	Number of children restrained
Prison 1	857	730
Prison 2 (six months data only)	106	94
STC	974	451
LASCH 1	422	76
LASCH 2	688	108
LASCH 3	166	27
LASCH 4	159	114

103 Data were also requested regarding injury resulting from restraints: five institutions provided the Inquiry with information.

Institution	Number of injuries to staff
Prison 2	40
STC	208
LASCH 1	12
LASCH 3	50
LASCH 4	40

104 One prison supplied information about injuries sustained by children during restraint during the period May 2004 to April 2005 and this showed one cut lip, a bruised toe, a grazed forehead, a break to the wrist bone, grazed hand, scratch to the upper arm and a scratch to the ear. There were three child protection referrals relating to restraints.

105 One eight bed local authority secure unit expressed concern about the request for data. They pointed out that there was no set definition of what restraint actually was and that each unit had its own operational definition. Their statistics provided to the Inquiry showed that restraint was used 422 times in 18 months. It had often been used on multiple occasions on one child, for example in October 2004 restraint was used 39 times on 5 children. Staff appeared to have incurred more injuries than children, with 12 recorded staff injuries and only two injuries to children.

106 A second, 10 bed local authority unit provided statistics to show that restraint was used 166 times, involving 27 children in 18 months and that this resulted in 50 injuries to staff and 29 injuries to children. The injuries mostly comprised bites or kicks to staff, and bumps or bruises to children.

107 The Inquiry examined the records in detail in one secure training centre. There had been 43 uses of PCC over a six month period and 16 in the subsequent five months, 49 of the 59 involved the double embrace hold and 4 used distraction in addition. Two children accounted for nearly half the incidents with one girl experiencing the restraint 5 times in one month and a boy being restrained 22 times in three months.

108 Statistics supplied to the Inquiry from an STC show 55 incidents of PCC involving 26 children in January 2004, of whom 15 were male and 10 were black or minority ethnic children. A year later, in January 2005 there were 60 PCC incidents involving 25 young people, of whom 18 were male and 6 were black or minority ethnic children. During an 18 months period, PCC was used 929 times but often it was used multiple times on one child.

## Mental health

---

109 The Inquiry considers that the various authorities are well aware of the significant issue of mental disorders that are experienced by children in custody. The report *Mental Health Needs and Effectiveness of Provision for Young Offenders in Custody and in the Community* published by the Youth Justice Board in 2005 provides a comprehensive survey and analysis of the issue. These children have a wide range of educational and social problems as well as a mental disorder and many have used or misused substances. Based on the Youth Justice Board's report, it would be uncommon for any child who enters the secure estate to have a single problem and so most have a panoply of needs. The different strands of evidence that were submitted to Inquiry provide varying estimates of the prevalence of mental disorder and need but the Youth Justice Board's own research shows that it was at least three times the national average. Also, many more children experience symptoms of disorders. All children in all settings have needs that must be met if they are to be and remain mentally healthy; this applies in full, if not increased, measure to those children who enter the secure estate. The risk factors that lead to mental disorder and those that lead to the use of restraint and segregation are probably similar. Information provided to the Inquiry by the Prison Service following a review of the policy on restraints in one London Specialist CAMHS Trust drew the following conclusions::

- The overall duty to care informs clinical practice
- Physical intervention is supported only as an option of final resort. Other management approaches, such as de-escalation, pharmacological treatments, and the use of time out rooms, must always be exhausted first
- Physical restraint must never be a punishment or to assert control without justification
- If restraint is used, there should be an adult present who is calm and capable of defining clear limits for that young person.

## Death in custody following restraint

---

110 The impetus to establish this Inquiry was the death of Gareth Myatt at Rainsbrook secure training centre in April 2004. Gareth Myatt died at Rainsbrook Secure Training Centre on 19th April 2004 whilst being restrained. An inquest was opened and adjourned and a police investigation was still being conducted as this Inquiry report was being written. A Part 8 Serious Case Review was being conducted by Joanna Dodson QC It is possible that criminal prosecutions may be forthcoming, and so the case is *sub judice* and this Inquiry does not intend to comment in any detail. Rather, we set out briefly the circumstances surrounding Gareth Myatt's death as far as is possible.

111 Gareth Myatt was 15 years old when he died. He was a boy of mixed race. He had been at the STC for four days when three members of staff restrained him. During the restraint Gareth collapsed and was taken to hospital where he was pronounced dead.

112 The police investigating Gareth Myatt's death advised the YJB that the double-seated embrace should be discontinued and instructions to that effect were issued.

113 Research into deaths in custody following or during restraint was limited. There had been five instances where prisoners in England and Wales became ill or died while subject to control and restraint techniques between 1991 and 1995 (Hansard 9 January 1996, col 181).

114 Restraint in the prone position (i.e. the person is on their front) has been identified as contributory factor to the death of people during restraint. The Government's response to the Parliamentary Joint Committee on Human Rights report (2004) acknowledged "*the use of prone restraint should be avoided if possible and, if used, be for as short a length of time as is possible*". However the Inquiry notes that the prone position was still part of restraint practice in the secure children's estate.

115 In the course of the Inquiry visits children spoke about restraint in the prone position and we saw children who had carpet burns or abrasions on their face which were the result of such restraint.

116 Heather Payne, a member of the advisory panel, has advised the Inquiry as follows:

*It is well recognised that restraint may be associated with a fatal outcome, and this has been identified an area requiring urgent attention in nursing as well as child care settings (Mohr & Mohr 2000; Jones & Timbers 2003). There is a profound lack of an evidence base about restraint, so it is essential that serious adverse outcomes be closely examined.*

*The Police Complaints Authority report 'Safer Restraint' (Police Complaints Authority 2002) identified seven deaths (all adults) between 1993 and 1997 attributed to 'positional asphyxia'. The face down prone position is identified as unsafe.*

*The use of prone restraint and the onset of 'excited delirium' (a state of sustained mental and physical activity, hypothermia, and cardiovascular collapse) have been associated with a fatal outcome in a number of reports and investigations (Morrison et al 2002). The relationship between prone restraint, positional asphyxia and excited delirium is unclear and requires research. The possibility that death is caused by hypoxia and consequent metabolic acidosis has been suggested and investigated in post mortem and experimental situations, but the situation remains unclear (Laur 2004).*

*The National Institute for Clinical Excellence (2005) has produced evidence based guidelines for short term management of violent behaviour in psychiatric settings and emergency departments. These are not fully transferable to the secure setting but contain some useful principles. They state that physical intervention carries real dangers in any position, should be avoided if possible, should not be prolonged, should be monitored, and no pressure should be applied to neck, thorax, abdomen, back or pelvic area. The deliberate use of pain should be avoided and is only justified for immediate rescue situations.*

*The use of physical restraint for children and young people in secure custodial (as opposed to health based) settings has very little evidence base. Information from psychiatric and other health care settings indicates that strategies to promote reduced use of physical restraint can be successful.*

*Prone restraint, excited delirium and positional asphyxia may be associated with fatal outcomes.*

## Injuries resulting from restraint

---

- 117 Article 19 of the UN Convention on the Rights of the Child highlights the State's obligation *to protect the child from all forms of physical or mental violence, injury or abuse*. However in the course of the Inquiry many children spoke about injuries they had received as a result of restraint.
- 118 Information about the extent of injury caused by restraint in the secure children's estate was patchy. Parliamentary sources provide conflicting evidence. In 2004 the Home Office Minister, Baroness Scotland suggested that such information was not centrally collected but in 2002, Beverley Hughes, the then Home Office Minister, reported that between April 2000 and February 2002, 296 children sustained injuries resulting from control and restraint in prison. In 2004, during a Parliamentary debate (13 September 2004) Hilton Dawson MP stated that there had been 200 injuries to children in 11 months following restraint in prisons.
- 119 Evidence to the Inquiry provided by the various institutions suggested that up to one in five instances of restraint either resulted in an injury to the child or staff member.
- 120 Martha's<sup>1</sup> testimony provided the Inquiry with evidence of the type of injuries sustained as a result of restraint. Martha was a girl in her early teens held in an STC. We interviewed her when we visited the STC during the Inquiry.

### Martha

*I got PCCd from education because I would not go to a tutorial. I really liked the lesson I was already in and I didn't want to go. I was PCCd by a female and male staff member. The man got my head down and pushed me against the wall. Two people on response were holding my arms. The man had my head and pushed my nose up and it was bleeding. The woman was saying "Again Martha, this is stupid". I got walked from education to the [residential] unit. My trousers were half way down. My knickers were showing. I asked the female staff member to pull up my trousers and she said "no". Nothing happened about the nosebleed. I didn't see the nurse. I never see her because I'm always angry. They push your nose right up here. I put in a complaint but they are allowed to use force.*

---

<sup>1</sup> A pseudonym. All names of children in case studies in this report are pseudonyms.

121 The Inquiry requested information from the institutions visited about injuries sustained by children during restraint. Eight of the eleven provided information. The following list shows the range of injuries that were reported:

- Abrasions and swelling
- Abrasion to left arm
- Abrasion to left cheek
- Break to wrist bone
- Bruise on cheek
- Bruise on chest bone/  
breathing difficulties
- Bruise to right foot
- Bruised toe
- Bruises to lips
- Bruising to left eye
- Bump to head
- Carpet burns to face
- Cut lip
- Finger injury
- Friction burns to cheek
- Graze on shoulder
- Grazed forehead
- Grazes on hands
- Hurt wrist
- Laceration to elbow
- Left shoulder hurting
- Mark to neck
- Nosebleeds
- Pain to knee
- Pain to right knee
- Pain to wrist
- Red marks on arm
- Red marks on  
shoulder
- Scratch to ear
- Scratches to  
right shoulder
- Scratch to upper arm
- Sore elbows
- Soreness to right wrist
- Small graze to  
right eye
- Sprained wrist

122 The Inquiry was keen to hear from children who had been in penal custody but had since been released. A representative of the Inquiry met with Lewis who had spent time in two Young Offender Institutions and a Secure Training Centre. He was 14 years old when he was first sent to custody.

### Lewis

*Lewis said he had been strip searched on arrival at the STC, he had previously been strip searched in police custody. He also reported being restrained 'loads' and that sometimes it was "quite rough, like in the stairwells where there are no cameras; they would be quite rough there. Like the pressure points for quick release, when they bend your thumb and things like that... when they take you back to your cell they pull your nose back and hold your head down to stop you spitting. They can be a bit rough". He told us that during restraints he had been bruised and had carpet burns. During one restraint when he was 14, six members of staff had held him down. He also talked about a friend who had to have a metal bar put in to his arm following an incident of restraint. Violence was also endemic within the institutions Lewis was held in, he told us that another child had smashed his head with a plate, an incident that had caused him to 'kick off'. Paradoxically, Lewis told us that being restrained failed to have a positive, long-term impact, upon his behaviour, and that on occasion he would behave badly 'just for a laugh'.*

*Lewis told us that he was aware of others being restrained and that "some people came back with cuts on their lips, like they've been banged into a wall." He estimated that he witnessed two restraints every week. There appeared to be little faith in the complaints system. Each wing had a complaints box, but even if complaints were made the general feeling was that nothing would get done. Replies took several weeks, by which time the feeling was that it would not be worth pursuing.*

*He discussed his personal experience of segregation where he had spent three days for damaging his cell. Although there were some books in the segregation cell he did not read them and spent most of his time sleeping. Lewis talked about the staff on segregation; some, he said, were good, others did not want to talk to the children on segregation, others were "well out of order".*

*Lewis also talked to us about being transported to courts whilst being held on remand. Each time a child is taken to and from the courts they are strip searched. He told us that the transport was like a 'sweatbox' and on one occasion he had a round trip of six hours as the transport went around various prisons and courts. With no sanitation he had been given a bag to use.*

- 123 A 16 year old boy from Manchester, interviewed during a visit to a secure training centre, told the Inquiry that he had seen children with black eyes following restraints and that he had witnessed a member of staff head-butting a boy during a restraint.
- 124 The Chief Inspector of Prisons, Anne Owers, has been a persistent critic of the consequences of using restraint on children in prisons. In her 2005 inspection report on Wetherby YOI, she commented:

*For the second time in recent inspections, inspectors found evidence of the damage that can be done to young bones in the course of control and restraint. Although there was no evidence that staff had acted inappropriately ... inspectors remain concerned about the appropriateness of the nationally authorised holds and inconsistent recording, compounds this across the juvenile estate, of what does or does not constitute use of force.*

## Psychological impact

125 Children in the secure children's estate are all vulnerable, needy and challenging. Evidence from the joint inspectorates' report on safeguarding children (2005) showed that 45% of 10-17 year olds on YOT caseloads had been recognised as having emotional or mental health problems. 37% of children in YOIs had experience of being in local authority care prior to their imprisonment (Challen and Walton 2005). The ONS (Lader et al 2000) found that in their sample of young people in prison, 96% had experienced at least one stressful life event and two-fifths had experienced five or more such stressful events. The events most commonly reported were being expelled from school and running away from home. The same report found that two-fifths of girls and a quarter of boys had experienced violence at home and that one in three girls and one in twenty boys had suffered sexual abuse. Julie, A 16 year old girl in an STC told the Inquiry:

### Julie

*I don't think it's fair. The offence I did, I did [in February 2004]. I was 15 then, I was still immature and I was selfish. In September, I turned 16 and I grew up a lot. Not just being in here. I just came to realise I need an education and I can't go round treating people like that. I don't think it's fair after so long and me wanting an education and I want to try for me GCSEs. My mum had seen the change in me. I could have been on tag; I would have stuck to it. I would have had community service and I would have stuck to it. I went to all my meetings with a psychiatrist. It's just done me no good because I'm still sent here. If he'd [the judge] saw me now I think he wouldn't have sent me here. I need to be out there helping me mum and me dad. My mum and dad were drug addicts since I was little.*

126 Given the vulnerabilities and abused backgrounds that many of the young people have experienced prior to custody, the Inquiry sought to establish the impact that restraint could have on them.

127 Children in a residential care in Scotland cited feelings of violation and abuse following restraint (Kendrick and Steckley 2005); while patients of mental health services who had histories of abuse often related restraint to previous traumas (Lee et al 2001).

128 It has also been suggested that restraint of a child can also impact on those children who witness the restraint (DOH 1993). Observing a child being restrained can be traumatic and lead to divisive "them and us" relationships between staff and children.

- 129 This was exemplified by a story told to the Inquiry by a 16 year old boy in a STC who witnessed a restraint on another child. Tom told us:

**Tom**

*There was an incident where one of the staff called one of the boys... sissy, poof or queer... one of those names... everyone else joined in and started picking on this kid, he freaked out and charged at the member of staff that called him this. The door opened and about three, four other members of staff came in... It was like a jump, one person grabbed him and was forcing him out of his room. He was struggling and after I didn't see what else, but all I heard was "get off me get off, me, I can't breathe, get off me". They locked him in his room and he was screaming and shouting for about half an hour. Then he just stopped.*

- 130 The Inquiry found evidence that the restraint of children was counter productive in terms of managing children's behaviour. Some children who spoke to the Inquiry actively courted restraint as a kind of badge of honour. There appeared to be a number of reasons why this might be so and the Inquiry received corroborative evidence from submissions and from discussions with staff, which substantiated these concerns.
- 131 There was no legitimate means for young boys and girls to express anger or passion in penal custody. The restrictive environment of penal custody and the intense regulation of children the Inquiry saw in some of the institutions meant that children, who often have poor self-control, have few options available to express anger.
- 132 Some more complex issues were raised during the Inquiry that need careful consideration by the various authorities. Many children in custody have experienced past sexual abuse, often by adults ostensibly in positions of authority. All sexual contact in penal institutions was prohibited, yet they are adolescents who are developing sexually. It was suggested that the young people would seek physical restraint by staff to gratify their sexual needs and that the restraint compounded their abusive experience. It was suggested to the Inquiry that some children were so damaged that abuse was something they could not do without. It is possible that the only way they had ever experienced physical contact was by force from an adult, and this experience was then replicated in the institution. If there was any truth in this argument, it raises extremely serious issues. Certainly the relationship between the use of restraint and sexual development needs serious research.
- 133 The desire to engage in physical contact may not be confined to children. The Inquiry received one submission alleging that some staff would "bait" children into situations that would result in restraint for their own gratification. However, the Inquiry met many staff with high standards of behaviour, dedication and real motivation. Taking into consideration the revelations concerning some care homes and child abuse over the past few years, it would be surprising if some staff were not working in the closed environment of custodial centres holding children for dubious reasons. This was a delicate issue and a difficult management challenge but is all the more reason to ensure that physical restraint of young people is restricted to an absolute minimum.



## Improper use

---

134 In 2001, the European Court of Human Rights found against the UK in the case of Keenan, laying down the general principle that:

*In respect of a person deprived of his liberty, recourse to physical force which has not been made strictly necessary by his own conduct diminishes human dignity and is in principle an infringement of the right set forth in Article 3.*

135 Recourse to restraint must be regarded as a last resort by staff and management, yet the Inquiry made some uncomfortable findings.

136 The Inquiry was contacted by one member of staff from a local authority secure children's home who said that whilst the policies were acceptable, staff forget their training and resort to their own methods, leaving young people and the staff at risk of injury

137 The Inquiry received evidence that restraint was used by staff simply to secure compliance. Both staff and children reported that disobedience or refusal to comply with an instruction could result in physical restraint. This was particularly an allegation made about regimes in the secure training centres. One member of staff said that he feared that too often staff did not ask the young people to do something but started using force to make them. One staff member interviewed during a visit to a secure training centre said that there was a lot of screaming during a restraint because of the adrenalin rush. The Inquiry saw evidence recorded in the records for the use of force in one YOI that clearly stated that control and restraint was used as a punishment for a child failing to respond to an instruction: "told to go to x unit and refused so restraint used".

138 Daniel, aged 14, in an STC told the Inquiry:

*If you don't go to your room, they press the red button on radio and people come. Loads of them – at least 10. It's like back-up really. They restrain you. They take everything out of your room. They kick your clothes out, they go in the corridor. They lock your door so you can't go in the bathroom, and they take your curtains.*

*Someone's got your arm and head down like that. It makes you want to struggle cos it hurts. Someone has their leg in front of your leg, and your heads like that. It puts pressure on your neck. I get aches on my neck from being restrained... About a month ago or a month and a half ago I had a bad neck [from being restrained] and it only just gone a couple of weeks ago. I told the staff "I've got a bad neck, I need to talk to the nurse". The nurse said "Getting restrained makes your bones more fragile". I still have bad necks but there's no point in complaining.*

16 year old Lucy told us:

*Sometimes it depends on your size. To start off, there'll be two [staff restraining you]. They'll just hold your arms. They try not to hurt your arms. They take off your shoes and hold down your head. Sometimes if there's too much pressure you get blood shot eyes and little red marks on your cheek. They do a little distraction like a thumb distraction and they swipe your nose. They push it in and then up. It's like a distraction to help calm you down.*

*The child was asked 'Did it calm you down?'*

*No it made me more angry. It hurts so you want them to stop it... Some of the staff get abusive towards you, like say "Shut the fuck up" and "You're making a prat of yourself you little shit". Others calm you down.*

Natalia who was 16 years old told the Inquiry:

*This girl had been PCCd once. She said she couldn't breath and told staff repeatedly. The answer was "if you can't breath, why are you speaking". When her head was held down, a member of staff told her "We are the boss, we have control. When they send you here you have no control." The girl broke down in tears and said there were two people in the world that terrify her - her mum and this member of staff.*

*The girl said to get a PCC all you need to do is slam a mug onto a table.*

*She said "I feel like I have to be good every minute".*

- 139 The Inquiry was concerned that handcuffs were being used in secure training centres. Handcuffs were used on children 29 times in Hassockfield from April to September 2005 and 17 times in Oakhill during the same period (Hansard, 1 November 2005 col 943W). The Inquiry was told that handcuffs were being used in Rainsbrook but was given no evidence to support this allegation. The Inquiry considers that the use of handcuffs on children in secure institutions is inappropriate.

## Good practice

---

- 140 In one local authority unit, the Inquiry was told that each episode of restraint was reviewed within 24 hours by staff, the young person and a team manager. An independent monitor examines trends. We consider this to be an example of good practice that should be replicated across the estate. The same centre had a counsellor on the staff team whose role included conflict resolution and reduction and the staff told the Inquiry that they believe that physical interventions had been reduced since he started work.
- 141 The Inquiry found that in one YOI a full time co-ordinator monitoring the use of force had reduced it by 30 - 40%. The co-ordinator also held de-briefing meetings with boys following any incident of restraint.
- 142 In one of the LASCHs the Inquiry found a culture of positive reinforcement and reward rather than punishment that obviated the need for physical intervention. Young people had ownership of their own points cards and could gain points for good behaviour with rewards accruing. Importantly, points were not deducted for bad behaviour.

## Issues of concern

---

- 143 Child protection policies, procedures and training tend to focus on issues arising from children disclosing historic abuse but ignore the question of whether treatment in custody could be interpreted as abusive. This appears to be a major structural weakness.

The Inquiry was told by one expert that a number of referrals had been made to the local child protection committee concerning injuries to children inflicted during restraints but no action had been taken.

144 There often appear to be discrepancies between institutional policies and what staff told the Inquiry. The Inquiry appreciated that managers were keen to show the best of the institution but there were still worrying variations between the official version and what front-line staff and children said was happening.

145 The Inquiry received evidence from one secure training centre suggesting that the length of the restraint using the double-standing embrace could be up to 30 minutes.

146 When allegations of assaults by staff on children are reported to the police, prosecutions rarely result. The Inquiry was told in one LASCH that four assaults by staff had been reported to the police in the previous year but no charges had been brought, despite the fact that one child had the imprint of a footprint on his back.

147 It was particularly worrying that there was no ethnicity monitoring with regard to the use of restraint. The Inquiry was particularly sensitive to the possibility of the disproportionate use of force and other punishments against black and minority ethnic children but was simply unable to gather any detailed information from the various establishments. Nor did it appear to be something that was being monitored nationally by the private companies running the secure training centres, the local authorities running their units, the prison service or the Youth Justice Board.

## **Tony**

*The Inquiry met 17 year old Tony whilst he was on remand at a young offender institution. Tony had spent the majority of his childhood in care. From the age of 14 he had been in and out of Local Authority Secure Children's Homes and YOIs and had spent his last four birthdays and three Christmases in penal custody.*

*Tony has been subject to a full care order since the age of seven, he told us that 13 different social workers had worked with him during this period.*

*Tony discussed with the Inquiry a number of restraints he had experienced throughout his various sentences. He told us about one incident that he alleged had taken place during the first week at one YOI. Whilst being walked back to a wing an officer had placed his hands on Tony's shoulder. Tony pushed the officer away. At this point Tony said that the officer grabbed him from behind and twisted his arm behind his back. Again pushing the officer away, the officer then punched the side of his head. He told us that he was then restrained by five members of staff and forced to the concrete floor. One guard was holding his head, one on each arm and one on each leg. He was then carried to the segregation unit where a nurse visited him to check on the damage caused by the punch and bruising on his body. He spent two hours in segregation before being taken back to his cell.*

*Although Tony reported to us that he had asked to speak to a child protection officer; he told us that the officer had said that nothing could be done, as it was his word against the prison officer.*

*Tony told us that during his time in LASCHs and YOIs he had been restrained on numerous occasions, mainly for refusing to do something that was requested of him or for fighting. He reported that during restraints he had received a broken wrist, broken arm, broken little toe and bruising.*

## **Recommendations**

---

### **To the Youth Justice Board**

- The policy that restraint should never be used as a punishment must be made clear [rec 17]
- Restraint should never be used primarily to secure compliance [rec 18]
- Restraint should never be premeditated, as it is then becomes a punishment not an intervention to ensure safety [rec 19]
- One certified physical intervention technique that is safe for children should be developed as a matter of urgency and be used across the secure estate [rec 20]
- The Youth Justice Board should oversee the use of the disciplinary system so that it is rigorously applied when an allegation is made against a member of staff [rec 21]

### **To the establishments**

- The resort to restraint should be viewed as a failure to de-escalate conflict [rec 22]
- Pain compliance and the infliction of pain is not acceptable and may be unlawful [rec 23]
- Handcuffs should not be used [rec 24]
- Establishments should not introduce their own methods of physical or mechanical restraints [rec 25]
- Violence reduction and dispute resolution should be afforded much higher priority [rec 26]
- Appropriate and regular training should be given to all staff working in the secure estate [rec 27]
- Promptly after each incident involving physical intervention there should be a dispute resolution conference, based on restorative justice principles, where the participants, including the child with an appropriate advocate, should be able to discuss the incident [rec 28]
- There should be some immediate external and independent scrutiny of every incident of restraint. An incident of physical restraint should be seen as such a serious breakdown that it should be immediately reported and scrutinised by an appropriate independent child care agency [rec 29]
- Record keeping and monitoring should be improved and data published to show the number of incidents, injuries to children and staff, broken down by race, age and gender [rec 30]
- So many of the young people have suffered serious violence and abuse in the past and are not used to making complaints; they must be helped to understand that they may make complaints and that there will be no reprisals [rec 30]

### **To the Police and Crown Prosecution Service**

- Should be more willing to consider charging and prosecuting members of staff for assaulting children where there is a *prima facie* case [rec 31]
- Should be more willing to consider charging and prosecuting the companies running penal institutions holding children [rec 32]

### **To Local Authorities**

- Local authority child protection committees should give priority to referrals from penal institutions [rec 33]

## 8 Strip searching

148 Article 37 of the UN Convention on the Rights of the Child states that:

*Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age... No child shall be subjected to torture or other cruel inhuman or degrading treatment or punishment*

149 The Inquiry appreciates that some system of making sure that young people do not bring dangerous articles or illegal drugs into an institution is essential. We recognize that establishments need rules about what and how goods can be brought in. The Inquiry considered three key questions: whether strip searching was the only method of achieving this; how much force or coercion was being applied; and what were the effects of the policies and practices.

*What is the rationale or the proportionality of routinely strip-searching children on arrival in prison, particularly for a population more likely than the average to have experienced abuse? And if a child resists, can you justify him or her being held down by adults, in painful wristlocks, and forcibly undressed? (Owers 2003)*

150 The Inquiry was also cognizant of the sensitive issues surrounding adults in positions of authority compelling a child to remove his or her clothes so as to render them wholly or partially naked. Many of the children sent to penal institutions have been sexually abused, often by adults, in their past. Figures from the ONS (Lader et al 2000) suggest that one in three girls and one in twenty boys in custody had experienced sexual abuse.

151 Girls might find being stripped particularly distressing. One 16 year old girl told the Inquiry that she had been recently strip searched. Her sanitary pad, which was “full of blood”, was examined in front of her. Staff were wearing plastic gloves. The girl was not given a clean pad to wear afterwards.

*Where women or girls are menstruating and are using sanitary protection in the form of pads, the prisoner removes the pad from her underwear herself and places it in a specially provided sanitary bin. The search is then conducted swiftly and fresh pads are available to the prisoner once the search is completed. (Hansard 1 September 2003, col 1004W).*

## Strip searching practice

---

152 The Inquiry found considerable variation in the way in which children were searched both on arrival and during their detention.

### Young Offender Institutions

153 The Prison Service's own guidance directs that YOIs must:

*make arrangements which ensure that each young person who is received into our custody is treated humanely so that their safety and dignity are safeguarded particularly during the first 48 hours after their arrival*" (HM Prison Service PSO 4950).

154 The Inquiry was told that in YOIs children were required to submit to a full strip search in the prison reception. This meant that one of the very first experiences for a child going into a prison was to be asked to strip and reveal their bodies to an unknown adult. It was undertaken by two officers of the child's own sex and out of sight of other prisoners and staff of the opposite sex. Two officers had to be present and the search recorded. First the child had to remove clothing from their top half. The clothing was searched and returned to the child to put the clothes back on. The process was repeated with clothing from the child's bottom half. While the child's bottom half was naked they were required to stand with their legs apart and then to take one step to the side to make sure they were not standing on anything.

155 Children in YOIs could be required to submit to a 'cavity search'. This meant that officers checked the child's ear, nose and mouth routinely.

156 Lower body cavity searches were permitted if officers deemed there to be reasonable suspicion that something was concealed. A lower body cavity search required the child to bend over or squat. During one of the prison visits staff told the Inquiry that children were only required to squat when staff "have a reason to believe it is necessary". Health care professionals could undertake an internal or intimate cavity search when it was deemed there were clinical reasons. The Inquiry was told that the child had to give consent.

157 This procedure was repeated should a strip search be sanctioned at other times of a child's custodial experience, for instance following a visit.

158 Statistics supplied by one prison indicated that 3,379 strip searches had been undertaken at reception from January 2004 to June 2005. It was not clear whether any contraband had been found. A further 165 strip searches were carried out "due to information" and 30 items were found. 265 strip searches were carried out after visits and 10 items were found.

159 In theory prison officers have the power to strip search a child under restraint. No prisoner consent was required. The Inquiry was told by one of the prisons visited that in that establishment restraint had not been used to secure a search in the last two years. Instead, if a child refused to comply he would be moved to a holding cell until he consented.

- 160 *“Policy and what is done are two different things,”* said one boy in a YOI who spoke to the Inquiry, a comment that illustrated our findings of discrepancies between policy and practice.

### **David**

*17 year old David told the Inquiry about being strip searched when he arrived at a YOI. He explained that he was “scared” and that he did not like as if he felt it was abnormal to have men staring at him, really concentrating on his body. He told us that the strip search seemed to take a lifetime.*

*David explained that he was expected “to get fully naked - the order is to take off your trousers, top, boxers and then you are asked to squat then you are passed back your boxers and trousers”. No one explained what was going to happen. He told us that the officers always shouted their orders at the boys.*

*David also talked to us about being forcibly strip searched while he was already being held on the segregation unit. He told us he was banging on his cell door. He was bored and upset. Staff told him to stop but he didn’t. He said that the next thing he knew was a group of officers wearing full riot gear and carrying plastic shields were bearing down on him. He told us that he saw seven or eight men storming into his cell. They pushed him up to the window using their shields.*

*David was then restrained and taken down to the floor. He said he felt angry. The officers held him face down on the stone floor and controlled his arms. His clothes were taken off by force so that he was naked.*

- 161 The Inquiry was told by staff at all the establishments visited that children were never expected to squat or bend over. However, children in YOIs contradicted this. One child told us, when he was asked to describe a strip search, that he was told to keep on his t-shirt and pull it over his knees while he squatted.

- 162 This Inquiry was not the first to find that policy does not necessarily reflect practice. The Chief Inspector of Prisons (Owers 2003) explained in a recent lecture *“We have reported to at least two governors that, without their knowledge and against prison service orders, incoming prisoners were routinely squat-searched while stripped naked for strip searching; and that included children.”* The use of squatting during strip searches was also indicated in a recent Independent Monitoring Board report from a YOI stating, *“young people were instructed to squat as part of their strip-search”* (IMB 2005).

- 163 One prison establishment visited strip-searched all children after every external or family visit.

### **Secure training centres**

- 164 In STCs the rules stated that strip searching should be undertaken in a manner consistent with that in YOIs. However the Inquiry found that practice deviated from this



primarily in that dressing gowns were issued to the children for use throughout the search. Children were routinely searched every time they entered or left the centre and at other times during their stay.

165 Children removed all of their clothes and passed them to officers, replacing their clothes with a dressing gown. Then the children would be asked to expose parts of their body. We were told that this meant a child could be required to expose their outside upper thigh or their genitalia.

166 Cavity searches and intimate searches would be carried out in the manner described in YOIs.

167 The Inquiry found its own evidence of intrusive searching at one STC. A 15 year old boy who was entering custody for the first time told of how he was stripped naked, asked to part his buttock cheeks and retract his foreskin.

### **Karim**

*Karim was serving his first custodial sentence in a Secure Training Centre (STC). When the Inquiry team met Karim he described his experiences of being on remand, about being strip searched on arrival at an STC and of his experience of violence.*

*He told us how he did not arrive at the STC until after midnight due to the long journey from his home area to where the STC was. Having been told about the rules of the establishment he was then informed that he would be strip searched. Not having ever experienced anything like this before Karim questioned why he was to be strip searched and what would happen if he failed to comply. He told us that he was informed that if he did not voluntarily strip he would be forcibly stripped. Feeling that there was no alternative Karim removed all his clothing and when he attempted to cover himself with his hands he was told to put his hands by his side. Karim told us that although he is circumcised he had been asked to retract his foreskin. Reflecting on his experience of strip searching he told us of his feelings of "loss of dignity", "embarrassment", and being "shocked".*

*After a couple of days in the STC Karim became overwhelmed by the situation, he told us that he became depressed: "I just nearly cracked up, actually I almost went suicidal" he started self harming and described how he had scratched very hard at his hand trying to get at a vein. He thought that his distress was made worse by the situation he was in: "I haven't even been proven guilty".*

168 In one of the STCs visited the Inquiry was told that force had been used to strip a child but normally if a child refused to comply they would be segregated and the idea was to "wear them down" that way.

169 Statistics supplied by one STC revealed that in 18 months more than 1,500 searches had been carried out.

- 170 The Inquiry was told that it was unusual to find anything during a strip search, and, an estimate was offered that less than 10% of the searches resulted in 'finds'. The majority of finds were cigarettes.

### **Local Authority Secure Children's Homes**

- 171 There appeared to be no comprehensive official guidance from the Youth Justice Board or CSCI regarding strip searches in LASCHs. The only guidance found by the Inquiry was provided by the Secure Accommodation Network and was designed to encourage a more consistent approach. Therefore each LASCH had developed its own practice. In one LASCH children were never subjected to a strip search while other LASCHs would strip search children on reception and at other points, for example following visits.
- 172 In one of the larger LASCHs the Inquiry was told that when children were received into the establishment and come back from external visits or outings they go immediately to the showers and hand out their clothes for searching. The young people were given a dressing gown and a metal detector is used. There was a written policy that children should not be searched using force but would be excluded from communal areas if they refuse a search. Staff conceded that this was not a fool-proof system but said that they relied more on relationships to bolster security and that they had never had any real problems. Young people interviewed concurred with this assessment and said that stripping was "embarrassing".
- 173 In another of the LASCHs visited the Inquiry was told that there was no strip searching as it was deemed unnecessary. Any searching was done with a pat down and a metal detector and the only clothing to be removed were shoes. The Inquiry was told that the lack of searching had not had any deleterious impact on safety or security.

### **Good practice**

---

- 174 The Inquiry was told by some establishments that when the children arrived they were taken straight to a small lounge to talk with one member of staff about what was going to happen. There was no time limit for this. There was a shower room attached to the lounge and when the child was ready, he or she was asked to go in to the bathroom alone and take off their outer clothes leaving their underwear on. There were dressing gowns in the bathroom. They were given a pat down search by a staff member of the same gender and a wand search for metal. Their clothes were searched. They can put their own clothes back on, or if they were dirty, new clothes were provided. The manager told the Inquiry that if a child refused to be searched, the staff would just sit it out until the child consented. The longest time he could remember was nine hours. No child was ever coerced.
- 175 *There was no evidence that establishments using this system had greater problems with security or contraband than those establishments that relied on strip-searches.*
- 176 Staff from these establishments told the Inquiry that they felt there was "no safety for a child if you have to strip search." They emphasised that they would feel uncomfort-

able having to strip-search children. They felt there was “*absolutely no reason to strip search.*” One member of staff said they would refuse to do it and would leave their job if the management insisted on a practice of strip searching.

## Conclusions

---

177 The Inquiry regards all children in the secure children’s estate as vulnerable under the terms of the Children Act 1989 by virtue of their incarceration. Whilst the original terms of reference specified forced strip searching, the Inquiry considered that the practice was inherently coercive.

178 The Inquiry was given no substantial evidence from any of the establishments that strip searching as carried out in the young offender institutions or secure training centres was necessary for security reasons. Finds tended to be tobacco rather than weapons or drugs. A member of the Advisory Panel said in his report following a visit to a LASCH:

*As always the main concern of staff was the introduction of drugs, but I found, as I had expected, that the full, purposeful and active day was the best antidote to the boredom that gives rise to their use in other establishments and institutions. Of course no one can be 100% sure that drugs cannot be brought in, or used. But the design of the units, the close contact between the plentiful staff and the boys, around the clock, suggested that they – and any misuser – would be quickly detected.*

179 The Inquiry came across staff who were clearly aware of the potential negative effect a strip search can have on children held in custody. On a visit to a LASCH that did not strip search children, the Inquiry was told by staff how they could see the “*anxiety on the children’s faces*” when they asked if they had to be strip searched and the “*relief*” when they were assured it was unnecessary.

180 Within the custodial context a strip search is more than just the removal of clothes for a visual inspection. It is a manifestation of power relations. A strip-search involves adult staff forcing a child to undress in front of them. Forcing a person to strip takes all control away and can be demeaning and de-humanising. This power is compounded by the threat, or actual use of, force to those showing any reluctance to strip.

181 According to a LASCH staff member reporting to the Inquiry, strip-searching was “*counterproductive to the relationship [you are] trying to build with kids.*” If a strip-search is imposed, particularly by force, any trust built up between staff and children, will be lost and is likely to be irrecoverable.

182 The Inquiry noted that different members of staff were often involved each time a child was strip-searched. As a result, particularly if children were on remand various members of staff saw them naked. As one girl at an STC put it, “*six staff have seen me now. .... It’s not nice for the whole centre to see you in the nude.*”

## Recommendations

---

### To the Youth Justice Board

- Policy, practice and procedure should be the same in all the establishments holding children [rec 35]
- Strip searching is not necessary for good order and safety [rec 36]
- Searches should be conducted based on the good practice the Inquiry found in local authority secure children's homes [rec 37]
- Searches could be reduced by at least 50% by applying a more evidence based approach, without risk to security or safety being significantly increased [rec 38]



## 9 Solitary confinement

183 A range of international instruments provides that solitary confinement should not be used other than in the most exceptional circumstances. The European Committee for the Prevention of Torture (CPT 1987) states:

*Solitary confinement can, in certain circumstances, amount to inhuman and degrading treatment; in any event, all forms of solitary confinement should be as short as possible.*

184 The Inquiry found the terms solitary confinement, segregation, single separation and isolation used across the juvenile secure estate. The practices varied from the possibility of spending several weeks in prison punishment cells to a few minutes alone in a bedroom or office. The terms used to describe the practice varied from segregation (the term used in the prison system) to single separation and time out (used in secure training centres and local authority units). Segregation and separation can follow the use of physical force.

185 The Inquiry acknowledges that “time out” of actual or potential conflict could be a useful and constructive mechanism for deflecting tension. It is a technique employed by parents and teachers, and indeed by children themselves. The concern was to investigate whether the practice in the secure estate was consistent, proportionate and useful in reducing conflict.

186 The Inquiry found that isolation was used primarily to punish poor behaviour as opposed to dealing with an immediate threat. In some institutions it was seen as a primary tool whereas others relied more heavily on incentives and incrementally removing them.

### Statistical data

---

187 Information was provided by eight of the eleven institutions visited. However only six provided information about solitary confinement: two YOIs; one STC, and three LASCHs. Between January 2004 and June 2005 these institutions used solitary confinement 2,329 times. Only five of the institutions gave information about the number of children segregated, which showed that 519 children had been placed in solitary confinement. Information from one LASCH revealed that solitary confinement was used 946 times

over 18 months of which 184 were elected separation, 645 directed separations and 117 enforced separations. If children elect to go to their room there is a qualitative difference. Indeed it could be seen as children taking responsibility for and managing their own behaviour and environment.

## **Solitary confinement across the secure estate for children**

---

### **Segregation in a young offender institution**

188 Segregation units are now known by a range of euphemisms across the prison estate. We came across the following descriptions for segregation units: Intensive Supervision Unit; Reorientation Unit; Care and Separation Unit; and, Separation and Care Unit. There had clearly been attempts in the prisons to respond constructively to criticism about the use of solitary confinement; yet the Inquiry found that most segregation units in prisons were little more than bare, dark and dank cells which in effect were inducements to suicide.

189 The Inquiry was told in one YOI that the maximum a child was held in the segregation cells was 20 days at a time. When the Inquiry visited there were eight young people held in the cells only one of whom was a juvenile. He had been removed from normal location under the Good Order or Discipline rule because he was a very high profile case and he had exposed himself to female members of staff.

190 In a second prison the unit was known as the Intensive Support Unit and was part of Healthcare. There was no child in the unit when the Inquiry visited although we were told that a child had been held there in the morning and the records showed that there were usually two or three children held on the unit at weekends and five during the week. Staff reported that children were normally held for between seven to ten days although the maximum was 14 days. Conditions were very poor with a bleak and dilapidated cell, an old and rusty metal bed frame. Education took place in the cell. Children were allowed up to one hour of exercise in a tiny courtyard but this was optional and as there was nothing to do many children did not take it up. There was an unfurnished room which was exactly that – a stone room with only a blanket on the floor with no washing facilities or toilet. The Inquiry was told that children would normally only be held in this cell for up to 15 minutes and then be moved to the regular cells. The general fabric of the unit was very bleak, although the Inquiry was informed that any child identified as suicidal would not be held there.

191 The third YOI visited appeared to have sound procedures for use of segregation but the facilities were also spartan and designed originally for adult male prisoners. The Inquiry team observed that once again an isolation cell within the segregation block was used, which had a raised concrete plinth for a bed and was otherwise bare. Members of the Inquiry were seriously concerned about the use of such cells for children.

192 The Inquiry became aware that the Incentives and Earned Privileges Regime operating throughout the prison system could effectively mean that children on the lowest, basic level, will endure conditions on their wings that were to all intents and purposes the same as those experienced by children on segregation units.

193 The number of self-harm incidents in prison segregation units was a major concern. There were 117 incidents of self injury recorded by prisons (5 July 2004, Hansard, col 552W). In January 2005, sixteen year old Gareth Price took his own life whilst in the “care and separation unit” of Lancaster Farms YOI.

194 Anne Owers (2003), the Chief Inspector of Prisons, has described solitary confinement as a prison within a prison. She regards solitary confinement as having a pervasive effect on the entire prison despite the fact that it usually only directly affects a small number of those living and working in a prison.

### **Single separation in the secure training centres**

195 The rules allowing separation in a STC were more limiting than those pertaining to prisons. In STCs children should not be separated in any form whether elected, directed or enforced, for more than three hours in every 24 hours and for no more than 1 hour at a time.

196 The practice in the STCs visited by the Inquiry varied. In one establishment the Inquiry team was informed that directive separation meant that the child was told to go to their room and the door was locked but they could come out on request. Elective separation meant that the child chose to go to their own room to cool off and the door was locked behind them but they could come out on request. Single separation meant that the door was locked and the child was not permitted to come out. Only the last form of separation was recorded and so it was not possible to determine how frequently, or for how long, the other forms of separation were used.

197 Staff in a second STC reported that the contract with the Youth Justice Board specified that no child could spend more than 3 hours a day in “time out” but that one hour was the maximum allowed at any one time and at 45 minutes the duty manager had to be called. On the day of the visit the log showed that six children had been separated that day, five of the separations were enforced and one elective. The Inquiry team happened to witness an incident that stemmed from a misunderstanding about the choice between playing football and watching a film. When the child was given the chance to explain that he had already seen the film he was allowed to go and play football. It appeared to the Inquiry team that the incident illustrated the concern that punishments were resorted to precipitately.

198 One STC visited by the Inquiry team had two rooms set aside for the purpose of separation: one was located in the health care area and the other in the education block. If these rooms were already in use children would be put in their rooms. The other STC did not have these dedicated facilities and so the children were confined to their own rooms. Generally confinement in this manner required the use of restraint.

199 One STC provided statistical information relating to enforced single separations from January 2004 to June 2005. During the 18 month period, single separation was used 285 times.



### **Separation in local authority secure children's homes**

- 200 One of the larger LASCHs visited provided separation rooms on at least two of the units. The rooms had basic furniture but no personal belongings. The children reported that they spent as little as five minutes and as long as eight hours in these rooms. Some of the children said that they had spent time separated in their own rooms.
- 201 A second local authority secure home reported that it based its single separation practice on a special hospital policy. It was aimed at the shortest possible time with anything over 15 minutes authorized by a manager. There was no special isolation room so a child was taken to their own bedroom.
- 202 Statistics provided to the Inquiry from one LASCH revealed that from January 2004 to June 2005 single separation was used 946 times, of which 184 were elected, 645 were directed and 117 were enforced. The breakdown of information provided for the 117 enforced separation shows that it was used on 43 occasions on one young person who was in the secure unit for welfare reasons, on 19 occasions on a young person who was sentenced, and 15 occasions on a young person who was on remand.
- 203 A third LASCH reported that time out had only been used eight times in five months, although this was a unit holding a maximum of only ten children. The young people the Inquiry interviewed said they had no recollection of separation being used.
- 204 Another LASCH reported that it had more informal practice. If a young person was in their room and being checked regularly this did not imply any form of enforced or elective separation. Children were kept in their own bedrooms.

### **Length of separation**

---

- 205 The Inquiry identified two principal problems relating to the length of time children are held in isolation: variations in the rules and non-conformity to the rules. The length of time that a child can spend in solitary confinement was regulated but varies between the different institutions. It appears to range from a matter of hours in the secure training centres to almost a month in prisons. This was confusing to children who move between institutions and was hardly conducive to good order or good practice.
- 206 Evidence gathered by the Inquiry indicated that practice sometimes contradicted the rules. For instance staff at one YOI reported that the limit on solitary confinement was twenty days. The children reported that some boys were kept in solitary confinement for as long as twenty-eight days. The management stated that the maximum time spent in solitary confinement was normally 7-10 days. The rules governing YOIs stipulate the maximum time a child can be held in solitary confinement was 14 days.

### **Conditions in separation**

---

- 207 The Inquiry was seriously concerned about the conditions in the YOIs, particularly as children could be held in segregation for days and even weeks at a time.

- 208 The Inquiry considers that the use of segregation units in prisons is wrong on moral grounds and is a particularly inappropriate response to those children and young people who have a mental health disorder. The use of segregation is wholly inappropriate as an institutional response to their mental disorder and it should not be used or its use justified as a replacement for proper treatment.

### **Links with incentives schemes**

---

- 209 The Inquiry saw evidence that well developed incentives schemes designed to encourage good behaviour exist across the juvenile secure estate, but they were sometimes ignored or negated by too-ready a resort to punishments like isolation. Good child care should be based on clear incentives that give the young person control over their treatment. Too often the incentives schemes appeared to the young people to be capricious, as they were not told clearly what had happened or how to remedy it.

### **Inspections and outside scrutiny**

---

- 210 As with all the issues considered by this Inquiry, outside scrutiny and inspection by experts is critical in order to ensure that the establishments adhere to best practice. The prison inspectorate visits YOIs regularly and carries out occasional unannounced visits. This is an extremely important process. The Inquiry was concerned to learn that whilst CSCI visits each of the secure training centres annually, it has only carried out three unannounced inspections since 2000. Any changes to inspection arrangements must incorporate unannounced visits, including weekends and evenings.

### **Recommendations**

---

#### **To the Youth Justice Board**

- Policy should be developed for ‘time out’ practices so it is used, monitored and recorded consistently [rec 39]
- Prison segregation units should not be used for children [rec 40]

#### **To the establishments**

- ‘Time out’ could be a useful technique for easing tension but should never be for more than a few minutes [rec 41]
- It should always be recorded, even if it is elective [rec 42]
- Solitary confinement should never be used as a punishment [rec 43]
- The child should have access to an advocate [rec 44]
- A child’s belongings should only ever be removed from their room if they pose a demonstrable risk to the child or others [rec 45]



## 10 Select Bibliography

**Bell L & Stark C** (1998) *Measuring Competence in Physical Restraint in Residential Child Care*, Social Work Research Findings, No21, The Scottish Office

**Challen M and Walton, T** (2004) *Juveniles in Custody. A unique insight into the perceptions of young people held in the Prison Service custody in England and Wales*, UK: Her Majesty's Inspectorate of Prison

**CRAE** (2002) *Rethinking Child Imprisonment*, CRAE

**Committee for the Prevention of Torture**, Treaty, Council of Europe, 26 November 1987

**Department for Education and Skills** (2005) *Common Core Skills and Knowledge for the Children's Workforce*

**Department for Education and Skills** (2005) *Youth Matters, Green Paper CM6629*, The Stationery Office

**Department of Health** (1993) *Guidance on Permissible Forms of Control in Children's Residential Care*, The Stationery Office, London

**Department of Health, Home Office and Department for Education and Skills** (1999) *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, Stationery Office, London

**Department of Health** (2000) *The Protection of Children Act 1999 – A Practical guide to the Act for all organisations working with children*, The Stationery Office, London

**Department of Health** (2004) *National Service Framework for Children, Young People and Maternity Services*

**Fenwick, S** (2004) *The Impact of Working in Segregations*, Prison Service Journal 2005 158 pp3-8

**Gilbert, P.** (1988) *Exercising some Restraint* Social Work Today, 30 pp16-18

**Goldson, B** (2002) *Vulnerable Inside: Children in secure and penal settings*, The Children's Society, London

- Goldson, B, and Coles, D** (2005) *In the Care of the State? Child deaths in penal custody in England and Wales*, London: Inquest
- Hart, D. and Howell, S.** (2004) *Report on the Use of Physical Intervention across Children's Services*, National Children's Bureau, London
- HM Chief Inspector of Prisons**, Inspection report on Huntercombe YOI, 2003
- HM Chief Inspector of Prisons**, Inspection report on Wetherby YOI, 2005
- HM Treasury** (2003) *Every Child Matters*, Green Paper, CM 5860, The Stationery Office
- House of Lords and the House of Commons Joint Committee on Human Rights** (2004) *Deaths in Custody; Third Report of Session 2004–05*, The Stationery Office, London
- Howard League for Penal Reform** (1993) *Banged up, beaten up, cutting up*, Howard League for Penal Reform, London
- Howard League for Penal Reform** (2000) *Barred Rights*, Howard League for Penal Reform, London
- Howard League for Penal Reform** (2005) *Children in Custody, Promoting the legal and human rights of children*, Howard League for Penal Reform, London
- Independent Monitoring Board report** (2004) HM YOI Ashfield
- Independent Monitoring Board report** (2004) HM YOI Lancaster Farms
- Independent Monitoring Board report** (2004) HM YOI Werrington
- Independent Monitoring Board report** (2004) HM YOI Wetherby
- Independent Monitoring Board report** (2005) HM YOI Stoke Heath
- Jones R J & Timbers G D** (2003) Jones RJ, *Minimising the need for physical restraint and seclusion in residential youth care through skill-based treatment programming*, Families in Society 2003 84(1): 21-29
- Kendrick, A & Steckley, L** (2005) *Physical Restraint in Residential Child Care: The Experiences of Young People and Residential Workers*, Conference paper July 2005
- Laur D** (2004) *Excited Delirium and its correlation to sudden and unexpected death proximal to restrain*, Victoria Police Department [www.cprc.org/tr/tr-2005-02\\_e.pdf](http://www.cprc.org/tr/tr-2005-02_e.pdf)
- Lee, S, Wright, S, Sayer, J, Parr, A, Gray, R, Gournay, K** (2001) *Physical restraint training for nurses in English and Welsh psychiatric intensive care and regional secure units*, Journal of Mental Health Vol 10, No 2
- Lader D, Singleton N, Meltzer H** (2000) *Psychiatric morbidity among young offenders in England and Wales*, ONS London
- McDonnell, A and Gallon, I** (2002) *Teaching physical skills to psychiatric nurses: Towards better practice*, Paper presented at the 7th European Mental Health Nursing Conference: Copenhagen: 15-16th February 2002

- Mohr W K, Anderson J A** (2002) *Reconsidering punitive and harsh discipline*, *The Journal of School Nursing*, 18(6), 346-352
- Mohr W K & Mohr B D** (2000) *Mechanisms of injury and death proximal to restraint use*, *Arch Psychiatric Nurse* 14(6): 285-95
- Morgan, R** (2004) *Safe from Harm - Children's Views Report*, London, CSCI
- Morgan, R** (2004) *Children's Views on Restraint: The views of children and young people in residential homes and residential special schools*, London, CSCI
- Morrison L, Dureya PB, Moore C, Nathanson-Shinn** (2002) *The lethal hazard of prone restraint: positional asphyxiation* Protection and Advocacy Inc Investigation Unit, USA
- National Institute for Clinical Excellence** (2005) *The short time management of disturbed/violent behaviour in psychiatric in patient settings and emergency departments* NICE, London
- Owers, A** (2003) *Prison Inspection and the Protection of Human Rights* Lecture at British Institute of Human Rights
- Police Complaints Authority** (2002) *Safer Restraint: report of the conference held in April 2002* www.pca.gov.uk
- Ramsbotham, D** (2003) *Prisongate: The shocking state of British prisons and the need for visionary change*. London: Free Press
- Secure Accommodation Network** (2005) *The Physical Searching of Young People in Secure Children's Homes (England and Wales)* SAN UK
- Social Services Inspectorate, Commission for Health Improvement, Her Majesty's Inspectorate of Constabulary, Her Majesty's Crown Prosecution Service Inspectorate, Her Majesty's Magistrates' Courts Inspectorate, Ofsted, Her Majesty's Inspectorate of Prisons, Her Majesty's Inspectorate of Probation** (2005) *The second joint Chief Inspector's Report on arrangements to Safeguard Children* CSCI UK
- Wilson, D** (2005) *Death at the Hands of the State*, Howard League for Penal Reform, London
- Youth Justice Board** (2004a) *Restorative Justice in the Secure Estate*, YJB London
- Youth Justice Board** (2004b) *Youth Justice Annual Statistics 2003/4* YJB London
- Youth Justice Board** (2005a) *Managing Children's Behaviour in the Secure Estate for Children and Young People: A Code of Practice* Consultation Document, YJB, London
- Youth Justice Board** (2005b) *Secure Facilities - Placement Policy*, YJB, London
- Youth Justice Board** (2005c) *Strategy for the Secure Estate for Juveniles* Consultation document YJB London
- Youth Justice Board** (2005d) *Corporate and Business Plan 2005/06 to 2007/08* YJB London

**Youth Justice Board** (2005e) *Mental Health Needs and Effectiveness of Provision for Young Offenders in Custody and in the Community* YJB London

**Zinger, I & Wichmann, C** (1999) *The Psychological Effects of 60 days in Administrative Segregation*, Research Branch Correctional Service of Canada, March 1999  
[http://www.csc-scc.gc.ca/text/rssrch/reports/r85/r85\\_e.pdf](http://www.csc-scc.gc.ca/text/rssrch/reports/r85/r85_e.pdf)

# Appendices

## Appendix A Schedule of Visits

Establishment	Date	Inquiry team
Aldine House LASCH Sheffield 8 beds	11 March 2005	Lord Carlile Frances Crook
Huntercombe YOI Henley, Oxon 360 beds	15 March 2005	Lord Carlile Frances Crook Andie Lambe Sue Wade
Warren Hill YOI Woodbridge, Suffolk 220 beds	18 March 2005	Lord Carlile Rob Hutchinson Andie Lambe Mary Marsh
Feltham YOI London 761 beds	23 March 2005	Lord Carlile Debra Clothier Andie Lambe
Hassocksfield STC Durham 42 beds	1 April 2005	Hilton Dawson Andie Lambe Roy Walker Carolyne Willow
Orchard Lodge LASCH London 24 beds	27 April 2005	Debra Clothier Andie Lambe Lord Ramsbotham
Aycliffe LASCH Darlington 38 beds	3 May 2005	Hilton Dawson Anita Dockley Andie Lambe
Sutton Place LASCH Hull 10 beds	5 May 2005	Andie Lambe
Vinney Green LASCH Bristol 24 beds	12 May 2005	Debra Clothier Andie Lambe Heather Payne



<b>Establishment</b>	<b>Date</b>	<b>Inquiry team</b>
Rainsbrook STC Rugby 76 beds	26 May 2005	Debra Clothier Andie Lambe Sue Wade Carolyne Willow
	24 June 2005	Lord Carlile Andie Lambe Carolyne Willow
Oakhill STC Milton Keynes 80 beds	1 July 2005	Lord Carlile Barry Goldson Andie Lambe David Wilson

---

## Appendix B **Lord Carlile and the Inquiry Advisory Panel**

---

### **Chair**

#### **Lord Carlile of Berriew QC**

---

Alex Carlile was born in 1948. He was brought up in north Wales and Lancashire, and was created a Life Peer in 1999. He was called to the Bar by Grays Inn in 1970, became a QC in 1984, and is now head of chambers. In 1986, he became a Recorder of the Crown Court and in 1996 a Deputy High Court Judge and Honorary Recorder of the City of Hereford. His Parliamentary career began when he was elected Liberal MP for Montgomery from 1983 to 1988, and Liberal Democrat MP from 1988 to 1997. He was Commons spokesman on many subjects at various times. From 1980 to 1982, he was Chairman of the Welsh Liberal Party; Leader of the Welsh Liberal Democrats from 1992 to 1997 and President of Liberal Democrats Wales from 1997 to 1999. In the autumn of 2001, Lord Carlile was appointed Independent Reviewer of terrorism legislation. Outside Parliament, he was a Lay Member of the General Medical Council from 1989 to 1999. He is a Non-Executive Director of Wynnstay Group plc, and a Fellow of the Institute of Advanced Legal Studies. In 2000, he chaired the Review of the Safeguards for Children and Young People treated by and cared for by the NHS, commissioned by the National Assembly for Wales. The report was published in 2002 and all 150 recommendations were accepted.

### **Advisory Panel**

#### **Debra Clothier**

---

Debra Clothier is Chief Executive of the Restorative Justice Consortium. Previously, Debra worked for Nacro, managing a number of restorative justice projects starting with the reparation pilots in 1999. She has also practised as a victim/offender mediator. For the last 22 years, Debra has worked within various criminal justice settings including probation, police and the voluntary sector. Debra recently reviewed and published the Principles for Restorative Processes 2004 and was part of the Home Office Training and Accreditation group to publish the Best Practice Guidance for Restorative Practitioners.

#### **Hilton Dawson**

---

Hilton Dawson is the newly appointed Chief Executive of Shaftesbury Homes and Arethusa having left Parliament in May 2005 to help bring about 'change for children' on the ground. Formerly the M.P. for Lancaster & Wyre, Hilton is proud to be a registered social worker as well as a politician committed to children's rights and empowerment.

#### **Dr Barry Goldson**

---

Barry Goldson is a senior lecturer in Sociology at the University of Liverpool, where he is also Director of Research. His teaching and research interests include the sociology of childhood and youth, criminology and criminal justice (particularly youth crime and youth justice), and state welfare policy. Dr Goldson has published extensively in each of these areas and his books include: '*Youth Justice: Contemporary Policy and Practice*' (1999);

*'The New Youth Justice'* (2000); *'Children, Welfare and the State'* (2002); *'Vulnerable Inside: Children in secure and penal settings'* (2002); *'In the Care of the State? Child deaths in penal custody in England and Wales'* (2005); *Comparative Youth Justice* (2006); and *Youth Crime and Justice* (2006). He has presented over 100 papers at conferences in the UK, Europe, Australia and the USA, and he is the editor of *'Youth Justice'*, the leading peer-reviewed journal in the UK specialising in youth crime and youth justice. Dr Goldson is a trustee of the Howard League for Penal Reform.

---

### **Rob Hutchinson CBE**

Rob Hutchinson has worked in social services since he moved from industry in the early seventies. He was responsible for child-care services in Hampshire for 9 years before becoming director of Portsmouth Social Services for eight and a half years. Nationally, he chaired the Association Directors of Social Services Children's committee for 3 years and played a significant part in national work on adoption, young offenders, multi-agency protection panels; he was one of five advisers to the DFES regarding the formulation of the Children Act. He is currently acting as an independent adviser to government and local authorities on a variety of child-care matters.

---

### **Mary Marsh**

Mary Marsh has been Director and Chief Executive of the NSPCC since September 2000. In the 1990s, she was head of two comprehensive schools. In 2001, Mary helped establish the inter agency group that has brought together senior representatives of statutory and voluntary agencies working with children. The group has contributed to the development of the Government's policy, and legislation 'Every Child Matters' now being delivered in the Change for Children programme. Mary is a member of the National Council of the Learning and Skills Council and a member of the Joseph Rowntree Committee on Governance in Public Services. She co-chairs the voluntary sector alumni interest group 'GRIT' at the London Business School.

---

### **Colin Moses**

Colin Moses joined the Prison Service and Prison Officers Association (POA) in 1986. He has served as a Prison Officer at Castington, Holme House, Feltham and Low Newton prisons. He was elected onto the National Executive Committee of the POA in 1996, and became National Chairman in August 2002. In 2002, Colin received a Man of Merit Award from the Executives and Professionals Network. This award is given to those from ethnic minorities who have achieved recognition in their chosen professions.

---

### **Dr Heather Payne**

Heather Payne is a consultant paediatrician in Caerphilly and has been a senior lecturer in the Department of Child Health at the Wales College of Medicine since 1996. Her clinical and research special interests are child development, child protection, and children in substitute care. She is also co-course director (with colleagues from the School of Nursing and Midwifery) of a new Masters programme in Interprofessional Child Protection Studies at Cardiff University

and since August 2003 an associate dean in the Postgraduate School at Cardiff University, with a Wales wide remit for supporting doctors with disability or with educational problems.

---

### **Lord Ramsbotham CBE**

David Ramsbotham was commissioned into the British Army 1958 and retired in the rank of General in 1993, having served in the UK and abroad. In 1995, he was appointed Her Majesty's Chief Inspector of Prisons, retiring in 2001. He published a thematic review *Young Prisoners* in 1997 and is currently chairing an Inquiry into the role of arts and sport in engaging young people in purposeful activity. He was appointed a life peer in 2005.

---

### **Sue Wade**

Sue Wade is a former deputy chief probation officer, a former business manager for a local criminal justice board and has also managed youth justice teams. She works as an advisor to a police authority and has directed juvenile detention reform projects in the US, Syria and the UK. She has an MPhil from Southampton University Law School and is the author of a number of articles on juvenile justice and on young adult offenders. She is a vice chair of the Howard League for Penal Reform.

---

### **Roy Walker OBE**

Roy Walker is Principal Child Care Manager (Secure Services) employed by Hull City Council. In this role, Roy has managed Sutton Place Safe Centre, a secure children's home for thirteen years. Prior to this, he worked as a residential worker, social worker and team manager. Roy is an active member of the Secure Accommodation Network (SAN), which represents secure homes in England and Wales. He was its chair for 4 years during which he worked closely with various government departments ensuring that the role and importance of secure care was recognised.

---

### **Professor Richard Williams**

Richard Williams is Professor of Mental Health Strategy in the Welsh Institute for Health and Social Care in the University of Glamorgan and a consultant child and adolescent psychiatrist in the Gwent Healthcare NHS Trust. Currently, he is also chair of the Academy of Medical Royal Colleges in Wales, Director of Conferences in the Royal College of Psychiatrists and heads that College in Wales, and is chair of the cross-sector, voluntary agency the Wales Collaboration in Mental Health. Recently, Richard has led a review of the roles and values of psychiatrists. Much of his current research relates to workforce development and user and carer participation in service design, cultural diversity and capability, and continuing professional education. He has published widely on healthcare strategy and evidence and values based service design and is co-editor of a new book on this subject.

---

### **Carolyn Willow**

Carolyn Willow is national co-ordinator of the Children's Rights Alliance for England. She has worked with children and young people for 20 years, specialising in children's rights advocacy since 1992. She has been a children's social worker, a children's rights officer for children in

residential and foster care, and was chair of CROA (Children's Rights Officers and Advocates) for several years. Carlyne has written widely on a range of children's rights subjects, particularly relating to children's and young people's participation in decision-making. She is a member of the Children's Minister's Board of Stakeholders, the Foreign and Commonwealth Office's Child Rights Panel and the Government's equalities and discrimination law reviews' reference group. She lives in Nottingham and has two young children.

---

**Professor David Wilson**

---

David Wilson is Professor of Criminology at UCE in Birmingham and a former prison governor. He is the editor of the Howard Journal of Criminal Justice and vice chair of the Howard League for Penal Reform. He has written numerous books about crime and punishment generally and prisons specifically - his latest is called "*Death at the Hands of the State*" and is concerned with deaths in prison custody. He is a noted broadcaster and commentator and as such presented Crime Squad and Too Young to Die for BBC1, Hard Cell for Channel 4, On the Eurobeat for BBC2 and is currently filming Leave No Trace for BBC1.

## Appendix C List of evidence

---

### Primary sources:

#### A Written evidence submitted by

<b>Staff member</b>	Aldine House LASCH
<b>Rob Allen</b>	International Centre for Prison Studies
<b>Maggie Blythe</b>	Head of Practice, Youth Justice Board
<b>Francis Boylan</b>	BASW
<b>Commission for Social Care Inspection</b>	
<b>County councillor</b>	Eastgate
<b>Dr Barry Goldson</b>	The University of Liverpool
<b>HM Chief Inspectorate of Prisons</b>	
<b>Lancashire Area Child Protection Committee</b>	
<b>Neil McIntosh</b>	Chief Executive, Centre for British Teachers
<b>Dr Roger Morgan</b>	Children's Right' Director, National Care Standards Commission
<b>Martin Narey</b>	Chief Executive of NOMS
<b>National Youth Advocacy Service</b>	
<b>Sir Peter Lloyd</b>	National Council of Independent Monitoring Boards
<b>Dame Denise Platt</b>	Chair, CSCI
<b>Staff submission</b>	Orchard Lodge LASCH
<b>Rights and Participation Project</b>	
<b>Bob Reitmeier</b>	The Children's Society
<b>Professor Phil Scraton</b>	Edge Hill College of Higher Education
<b>Laura Steckley &amp; Andrew Kendrick</b>	
<b>Ian Taylor</b>	Bordesley Institute Positive Experiences
<b>Roy Walker</b>	Manager, Sutton Place LASCH
<b>YOT worker</b>	Warren Hill YOI
<b>Nine submissions from individuals who wish to remain anonymous</b>	
<b>Minutes of the Serious Case Overview Committee Re: Gareth Myatt</b>	

#### B Oral evidence

<b>Eric Baskind,</b>	Chair, Centre for Physical Interventions, British Self Defence Association, Brent Pupil Referral Unit
<b>David Haddick</b>	Darlington YOT, Rapiscan, Sutton Place LASCH
<b>Four oral statements made by individuals wishing to remain anonymous</b>	
<b>Interviews with six children in the community recently released from custody</b>	

## Secondary sources

### Policy documents, evaluation reports and reporting forms

#### Aldine House LASCH

---

Assessment and management of risk form  
 Education and life long learning  
 Incident report form  
 Information for parents and carers  
 Information for placing agencies and authorities  
 Record of significant event form  
 Single separation policy and practice guidelines  
 The use of physical restraint and control within Aldine House policy and practice guidelines

#### Aycliffe LASCH

---

Anti bullying flow chart  
 Diversity Directory  
 Exit interview report  
 Family guide  
 Interim evaluation study of the 1st year of the introduction of the school based counseling service  
 Policy documents and guidance on restraint strip searching and separation  
 Prevention of violence - personal safety and awareness training  
 PRICE aims and objectives  
 Risk assessment forms  
 Stage one and two of peer anti bullying leaflets  
 Visitors' information  
 Young people's anti bullying and harassment policy

#### Feltham YOI

---

Action plan for reduction in use of force  
 Cell searching for juvenile populations  
 Figures for full search's under restraint  
 Figures for removal from unit  
 Form for registering use of special accommodation /mechanical restraints  
 Governors notice to staff re use of force support manual, use of C&R, use of force debrief  
 Governors Orders re: completing use of force reports, unlocking prisoners, photographing injuries, use of force documentation, video camera recording, C&R refresher training, searching strategy, routine cell searching for juveniles

Juvenile safer restraints pilot project plan  
Memo re adjudications  
Memo re reducing use of force statistics  
Protocol for locating YO or trainees in the segregation unit  
Record of event form  
Reports re use of C&R  
RFU information and induction pack  
RFU numbers  
Safer prison meeting timetables  
Segregation - prisoner information and induction  
Segregation forms - governors' authority, reason for initial segregation, segregation review board  
Reward and behavioural targets  
Staff accidents  
Staff injuries numbers  
Use of task force minutes

---

**Hassocksfield STC**

Extended time out form  
HRAT observation book  
HRAT team book  
Officers' statement form  
Search report form  
Time out observation form  
Use of force report form

---

**Huntercombe YOI**

Howard House Induction Policy  
Intensive support unit - operational instructions  
Reception Procedures  
Report of use of control and restraint and ISU

---

**Oakhill STC**

Searching procedures  
Time out and single separation policy  
Use of force, physical restraint and mediation procedures



---

**Orchard Lodge LASCH**

---

Anti-harassment and anti-bullying policy  
Behaviour management policy and guidance  
Escalating incidents, civil disturbances and natural disasters procedures  
SAN's Practice guide on the physical searching of young people  
Search procedures  
Secure garage procedures  
Security checks (external) procedure  
Single separation procedure  
Supervision of clients procedure

---

**Rainsbrook STC**

---

Management of the use of physical control  
Managing Challenging Behaviour: Good order and discipline  
Managing Challenging Behaviour: The Use of Physical Control in Care  
Permissible Control: Rewards, sanctions and removal from association  
Positive Control  
Removal from Association (single separation) and bedroom monitoring  
Searches: Personal

---

**Sutton Place LASCH**

---

Behaviour management policy  
Policy on restraint  
Policy on restraint in the event of damage  
Practice guidance notes on single separation  
Statement of purpose and function

---

**Vinney Green LASCH**

---

Annual report of education service April 2004 – 2005  
Annual review of service April 2004- 2005  
Annual Review of Services April 2002 – 2003  
Annual Review of Services April 2003 – 2004  
Control and restraint - training safely  
Critical incident report form  
Critical incidents procedure  
Diffusion and de-escalation presentation

Golden rules

Management report 2005

Managing episodes of self harm and suicide prevention

Menu samples

Personal searches of YP and their room

Restraint, restriction of liberty and single separation

Statement of purpose and function

The recording of critical incidents and incidents of single separation

---

### **Warren Hill YOI**

Carlford unit regime

Guidance for use of force report writing

Kidscape in partnership with Warren Hill

Policy for searching of trainees located in Butley unit

Searching trainees in Butley unit

Use of special cells

Warren Hill regime

---

### **CSCI inspection reports**

Aldine House September 2004

Aycliffe February 2004

Hassocksfield March 2004

Orchard Lodge February 2005

Rainsbrook February 2004

Rainsbrook January 2005

Vinney Green October 2002

---

### **HM Chief Inspector of Prisons reports**

**Report of a full announced inspection of Feltham YOI,**

15-20 May 2005, published 10 November 2005

**Report of a full announced inspection of Huntercombe**

**YOI,** 23-27 June 2003, published 4 November 2003

**Report on follow up inspection of Warren Hill YOI** 2-3 December 2003

**IMB reports**

---

Feltham May 2002

Huntercombe December 2003

Warren Hill May 2004

YJB Monitors briefings

Aldine House

Aycliffe

Feltham

Hassocksfield

Oakhill

Orchard Lodge

Rainsbrook

Sutton Place

Vinney Green

Warren Hill

## Appendix D: **Written Evidence supplied by the Youth Justice Board, January 2006**

---

### **Introduction**

1. Annex 1 of this paper sets out the principal requirements in relation to the use of physical restraint, separation and physical searching and the methods used by the YJB to monitor developments. The main mechanism for monitoring incidents is the YJB Effective Regimes Monitoring Framework. As noted, information is available at the local level through the framework and this is used to inform the work of our monitors who are required to scrutinise the data, monitor trends and where there are concerns seek further information about individual incidents. The framework is used to identify the issues of highest concern in individual establishments in order to focus monitoring activity, including risk indicators relating to the use of restraint and separation. The Effective Regimes Monitoring Framework is currently being reviewed and this may lead to increased national collation of the data.
2. It should be noted that for much of the information provided in this note it is not possible to make direct comparison between different types of establishment. This is due to the different definitions and recording practices that are currently in place. In some respects, recording methods can vary across different establishments within the same sector, also making simple sector wide analysis difficult. Clearly the number of different types of incidents that occur in an individual establishment will partly depend on the number of children and young people held there. As well as the total capacity of the establishment, throughput also can be significant including the proportion of short term placements.
3. The YJB is working to develop the national counting rules for this type of information. In particular to develop the information available from Secure Children's Homes and to have consistent recording across the sectors. The counting rules we have developed for discussion with the providers are set out in Annex 2.
4. While the number of incidents in different establishments will vary for the reasons set out above, including the size and nature of the establishment and the recording methods used, the YJB continues to want to ensure that there is a greater consistency in practice and that good practice in individual establishments is disseminated. Our work programmes on behaviour management and on reviewing our monitoring and recording requirements are designed to address this issue.

### **Use of Physical Restraint since January 2004**

#### **Secure Children Homes**

5. We do not hold centrally statistics for all Secure Children's Homes on the use of physical restraint during the period requested. However, the following information gives an indication of the level of use for eight of the Secure Children's Homes from January 2004 to October 2005.

6. The definition used for these statistics is: A Restrictive Physical Intervention (RPI) should be recorded whenever force is used to overpower a young person (i.e. as opposed to simply leading them away from an incident or splitting up a dispute in order to prevent escalation). This is a separate and narrower definition to that used for Secure Training Centres.

Aldine House – 446

Atkinson Unit – 560

Barton Moss – 229

Hillside – 342

Lincolnshire – 454

Red Bank – 687

Sutton Place – 203

Swanwick Lodge – 438

**Total = 3359**

#### **Young Offender Institutions**

7. Statistics provided by the Prison Service indicate that the total number of interventions in YOI juvenile sites (planned Control and Restraint interventions, spontaneous Control and Restraint Interventions and restraints under Rule 52 of the YOI Rules) was 5,133 for the period January 2004 to September 2005.
8. Statistics for each establishment for the six month period April to September 2005 are contained in the attached tables. (Unfortunately there are a few months for individual establishments where figures are not available)

#### **Secure Training Centres**

9. The total number of Physical Control in Care interventions used in Secure Training Centres during the period January 2004 to August 2005 was 7,020. As noted above a different definition is used for STCs compared to Secure Children's Homes. Statistics for each of the four Secure Training Centres are set out below:

Medway	3282
Rainsbrook	1081
Hassockfield	1719
Oakhill (from August 2004)	938*

\*Oakhill has not been at full capacity during this period.

#### **Restraints recorded by ethnicity**

10. We do not have centrally information on restraints use by ethnicity for Secure Children's Homes, Secure Training Centres and Young Offender Institutions.

### **Different Methods of Physical Restraint**

11. The information below sets out the different types of restraint in use across the secure estate for children and young people
12. As the Howard League will be aware, the Youth Justice Board has consulted on a single Code of Practice on Behaviour Management for use across the estate. As well as ensuring that physical restraint is managed within an overall strategy to promote positive behaviour, this will set out a single set of principles for the use and management of physical restraint techniques across the secure estate.
13. The method of restraint in Young Offender Institutions is known as Control and Restraint.
14. The method of restraint in Secure Training Centres is known as Physical Control in Care.
15. In the Secure Children's Home sector, for the 15 units we contract with, there are several methods in use (Source 'Report to the Youth Justice Board on the use of physical intervention within the juvenile secure estate, NCB). These are known as:
  - T.C.I
  - 'Aidan Healey' Method
  - Ethical Escape and Caring Control
  - 'Control & Restraint' training (NB: this will be a different method to that used in Prisons)
  - Method taught by Psychiatric Senior Nurses, North Staffordshire Health
  - P.R.I.C.E.
  - Team Teach
  - Other in-house approved training
  - D.I.V.E.R.T.
  - General Services Control and Restraint Services

### **Total amount of time spent in separation (segregation, single separation and time out)**

16. The YJB does not centrally collect information on the amount of time spent on 'separation'.
17. At all establishments the YJB Performance Monitors review the number of instances of single separation/segregation occurring in each month but they do not record the duration of each separation. However, the YJB monitors do have access to the establishments' records which detail the reasons for, and the duration of, any particular incident of single separation. While the information requested is not routinely collected centrally the following information has been compiled in response to this request.

### Secure Training Centres

18. Information provided by Secure Training Centres for the total amount of time children spent in single separation is set out below. As explained below there are different methods and recording practices used:

Medway January 2004 to June 2005	572 hours
Rainsbrook January 2004 to June 2005	74 hours
Hassockfield January 2004 to June 2005	784.7 hours
Oakhill September 2004 to August 2005	117 hours

19. Medway and Hassockfield record single separation and ‘time out’ as one statistic. This is separated out within the Rainsbrook statistical analysis. It is likely that in 2006 Medway will record this the same way as Rainsbrook.
20. 90% of Medway’s single separations were of less than 15 minutes duration. The STC uses these short periods of separation to allow children and young people to calm down and to prevent more serious incidents.
21. Approximately 50% of instances of single separation at Rainsbrook were of less than 15 minutes in duration.
22. Hassockfield use what they term “time-out” as part of the behaviour management planning for certain children and young people. In a similar approach to Medway, the STC will ask children and young people to go to their room to calm down at certain moments to prevent incidents occurring. When the child agrees to go, they are free to return to association once they feel more calm. Hassockfield do not record separately when a child agree to go to their room or is taken to their room. As a result their figure includes single separation and time-out combined.
23. Oakhill STC were not in the position to break down their figures for the proportion under 15 minutes in duration, but a sample check indicates that again a relatively high proportion are for short periods.

### Young Offender Institutions

24. Information on the use of segregation units per establishment for the six month period April to September 2005 is contained in the attached table.

### Secure Children Homes

25. Information on the use of separation is not available centrally.

Total number of physical searches (‘strip searches’)

26. The YJB does not routinely collate this information. However the following information has been compiled.

### **Secure Training Centres**

27. Information provided by Secure Training Centres shows the following was the total number of full searches

Medway January 2004 to September 2005	1507
Hassockfield January 2004 to September 2005	1399
Oakhill September 2004 to August 2005	738

28. Rainsbrook STC does maintain records of all the searches carried out and they are kept on each child's file but they do not currently keep a numerical tally of the number of searches. This year Rainsbrook will record all full searches in accordance with the procedure adopted at Medway.
29. STCs carry out full body searches of children and young people admitted to the centres and when they return to the Centres following court appearances or other absences. In addition searches can be made at other times, for example if the centre has concerns that an item or substance, which could cause harm to the child or others, is held on them. During these searches children are not left completely naked at any point and two staff members of the same gender as the child being searched must be present at all times.

### **Young Offenders Institutions**

30. Information on the number of searches is not available centrally.

### **Secure Children's Homes**

31. Information on the number of searches is not available centrally.

## **Injuries received as a result of restraint (staff and children)**

### **Secure Training Centres**

32. The following information has been provided on injuries to children

#### **Medway Jan 04 - Jun 05: 1818**

Medway have developed a central system for recording injuries which lists separately all injuries sustained even when they have occurred from a single incident. The detailed system includes all levels of injuries that includes examples such relatively minor injuries as redness, scratches, scabs being knocked off. Such injuries would be recorded at other centres on the relevant incident report form but may not be fed into a central database of injuries in the way they are at Medway.

When introducing the detailed recording system at Medway it was considered resource intensive and it was decided that the system needed to be examined before it could be replicated. Rebound have informed us that following successful establishment of the system they do intend to implement it at Rainsbrook in 2006.

We are informed that none of the injuries at Medway resulted in treatment by anyone other than the on-site nursing team.



---

**Rainsbrook Jan 04 - Jun 05 : 118**


---

103 minor injuries requiring no treatment;

13 injuries requiring treatment (none of these 13 injuries involved a visit from a GP or paramedic, and all were dealt with by on-site nursing team.)

2 injuries requiring hospital treatment.

---

**Hassockfield Jan 04 - Jun 05 : 177 injuries**


---

1 injury required hospital treatment in 2004 (an injury to nose. This was not due to a nose distraction); none in 2005

None of the injuries required attention by a paramedic or GP. All other than the one mentioned were treated by the on-site nursing team.

---

**Oakhill Sep 2004 - Aug 2005 : 48 injuries**


---

No further details available at present

33. The following information has been provided on injuries to staff

---

**Medway Jan 2004 – Sept 2005 : 216**


---

As with injuries to children, Medway uses its comprehensive system to record injuries sustained by staff. As noted, the system will be extended to Rainsbrook.

There have been 12 staff who sustained injury on duty during restraint incidents that have required a visit to their own GP and an Occupational Health assessment. Of those 12, 8 were injuries to back, shoulder or arm as a result of the strength of the young person which has caused the injury. These injuries preclude the staff from undertaking custodial duties as they are unable to participate in PCC. Of the other four two relate to lacerations and kicks to staff's legs and two relate to a member of staff having their foot broken and their shin broken by a trainee who stamped and then kicked the member of staff.

---

**Rainsbrook Jan 2004 – Jun 2005 : 43**


---

The figures of staff injuries only include those sustained whilst carrying out PCCs and does not include any resulting from assault – i.e. deliberate kicks, punches, bites, etc.

**Types of injuries typically sustained by staff in the above figures are:-**

Strains/sprains; Striking against objects; Struck by trainee's leg; Struck by trainee's foot; Struck by trainee's hand; Struck by trainee's arm

Being struck by part of the trainee's body is generally as a result of the trainee struggling rather than a deliberate attempt to injure staff as holds are applied.

Of the above total of 43 injuries, four required treatment at a medical facility outside Rainsbrook and a total of four resulted in "lost time accidents" and were reported to the HSE.

---

### **Hassockfield Jan 04 - Sept 05 : 120**

Jan 04 - Sept 05 : 10 members of staff attended hospital

### **Oakhill Sep 2004 - Aug 2005 : 56**

No breakdown is currently available but future records will include detail of whether treatment was needed and whether it was provided internally or externally.

### **Young Offender Institutions**

34. The information is not available centrally. The Prison Service inform us that revised forms have been introduced that will enable it to be collated in the future.

### **Secure Children's Homes**

35. Records of injuries are maintained by SCHs. However, information has not been made available centrally to aggregate in the form requested. A sample of five Secure Children's Homes indicates 73 recorded injuries to children and 253 injuries to staff during the period January 2004 to August 2005. It is likely that there was some differences in the recording methods used.

## **Information on the number of child protection referrals**

### **Secure Training Centres**

36. The following information is available

#### **Medway**

Jan 04 - Sep 05

- a) Restraint 61
- b) Strip search 0
- c) Segregation 0

Total : 63

#### **Rainsbrook**

Jan 04 - Sep 05

- a) Restraint 8
- b) Strip search 0
- c) Segregation 0

Total : 23

#### **Hassockfield**

Jan 04 - Sep 05 :

- a) Restraints 43
- b) Strip search 0
- c) segregation 0

Total : 56

**Oakhill**

Sep 04 - Oct 05

a) 22 restraint

b) 1 full body search

c) 0 single separation

Total: 23

**Young Offender Institutions**

37. Information on child protection referrals is not held centrally by the Prison Service or YJB.

**Secure Children's Homes**

38. Records of referrals are maintained, information has not been made available centrally to aggregate in the form requested. A sample of five Secure Children's Homes indicates there were 24 child protection referrals following restraints during the period.
39. For all establishments, to some extent the number of referrals will be dependent on the local arrangements with the Area Child Protection Committee and their requirements.

---

## ANNEX 1

---

### Physical Restraint

#### YOIs

8. The YJB's Service Specification for YOIs states:

#### **Use of Restraint**

Physical restraint must be used only as a last resort and then following approved, accredited methods. The minimum necessary force must be applied and incidents documented, recorded and audited. (National standards 10.20)

Staff using force must have had appropriate up to date training. (National Standards 10.21) Force must only be used after all de-escalation techniques reasonable in the circumstances have been exhausted

9. Further, the Prison Service Order 4950, that covering juveniles, states:

Force must only be used as a last resort and no more force than is necessary may be used. The Control & Restraint (C&R) syllabus emphasises the importance of de-escalating violent situations by using interpersonal skills. Staff must be competent in C&R techniques and should be sensitive to their use on young people.

10. The Use of Force in the Prison Service is covered by PSO 1600. This covers such issues as procedures for recording use of C&R, the need for health care staff attendance at a restraint where possible and examination by a doctor when force has been used.

#### **STCs**

11. The YJB Contracts for STCs state:

Each trainee in custody at the STC will only be subject to physical restraint as a last resort when no alternative is available and only to prevent him/her from escaping or from harming him/herself or others or from damaging property, or to prevent him/her from inciting another trainee to harm him/herself or others or to damage property. Physical force will not be used at the STC on any trainee for any other purpose nor will it be used on any trainee simply to secure compliance with staff instructions.

12. The above needs to read in conjunction with Section 9 (3) of the Criminal Justice and Public Order Act 1994 which states that:

A custody officer performing custodial duties at a contracted-out secure training centre shall have the following duties as respects offenders detained in the secure training centre, namely –

- a) to prevent their escape from lawful custody;
- b) to prevent, or detect and report on, the commission or attempted commission by them of other unlawful acts;
- c) to ensure good order and discipline on their parts; and
- d) to attend to their wellbeing

the powers conferred by subsection (3) above, shall include power to use reasonable force where necessary

13. Whilst the YJB contract is clear that staff may not use force simply in order to secure compliance with staff instructions, it may be the case that a refusal to follow instructions impacts on the order and discipline of the Centre. In these circumstances it will ultimately be for the staff concerned using force to make the case that it is necessary in the circumstances to do so.
14. In addition, it should be noted that the contract states that incident reports must be completed for each restraint and copied to the YJB monitor within 12 hours.

### **SCHs**

15. The YJB Contracts for SCHs state\*:

Providers in England will comply with the 'Guidance on Permissible Forms of Control in Residential Children's Care (Dep't Health 1999), as well as guidance outlined in Children's Homes Regulations. Welsh Providers should comply with any relevant Assembly guidance on approved methods of restraint and physical intervention and NMS 15.

Physical restraint must be used only as a last resort and then following approved, accredited methods. The minimum necessary force must be applied and incidents documented, recorded and audited. Staff using force must have had appropriate up to date training. Medication should never be used as a method of control.

Refresher training for staff in physical restraint techniques should be given at regular intervals not exceeding three years.

16. Further, National Minimum Standards for Children's Homes (which our specification cross-references) state:

Physical restraint is only used to prevent injury likely to the child concerned or to others, or likely serious damage to property. Restraint is not used as a punishment, as a means to enforce compliance with instructions, or in response to challenging behaviour which does not give rise to reasonable expectation of injury to someone or serious damage to property.

17. Finally, the Secure Accommodation Network (of SCHs) has developed their own Good Practice Guidance on Use of Restrictive Physical Interventions. This provides the following information on the appropriate situations in which to use force:

Restrictive physical intervention can be defined as the positive application of force with the intention of overpowering the young person to prevent them from:-

- Harming themselves or others
- Causing significant damage to property
- Inciting other young people to cause physical harm or damage to property
- Absconding both from within and outside of the Unit

\*While YJB standards indicate that accredited methods should be used it has not been for the YJB to oversee the accreditation. At present both YJB and DfES expect the relevant local authority to approve the methods they use.

### **YJB Monitoring of Physical Restraint**

19. The current Effective Regimes Monitoring Framework contains a series of 'risk screens' to assist monitors to focus their monitoring activity based on areas of highest concern to the YJB. The Order and Control Risk Screen in the ERMF asks monitors to examine the use of physical restraint in their establishments (i.e. look at establishment records), with stated risk indicators being:

- Locally high or increasing use of physical restraint
- Frequent or repeated use of restraint against particular young people
- Establishment or external investigation into staff use of physical restraint
- Young people's complaints /allegations about inappropriate use of physical restraint

### **YJB Code of Practice for Behaviour Management**

20. In June 2005, the Board released for consultation a code of practice in relation to the behaviour management of children and young people held in the secure estate. The range of consultees was extremely broad. The consultation period ended on August 31st 2005 and a revised Code was considered by the Board in December. All units/

establishments will be asked to evaluate their practice against the code and will be given three months to conduct this evaluation. Following this 'self audit' our monitors will validate (or not) the audit information. Where the practice is not compliant, action plans will be agreed to move towards compliance.

## **Separation ('solitary confinement')**

### **YOIs**

21. The YJB's Service Specification for YOIs states:

Governors must strictly control the use of separation (segregating of young people), whether by reason of good order or discipline, own protection, or prior to an adjudication in a serious case or removal from unit. Segregation must only be used when necessary and must always be accompanied by a strategy of intervention through advice and counselling, the objective of which is to return the young person to ordinary accommodation as soon as possible. Governors must also ensure that, while in segregation (and Healthcare) , every young person is afforded as full a regime as possible. All such activities must be documented. The Process of Segregation and the Principles of the Segregation Unit outlined in PSO 1700 must be followed at all times. Local policies must be approved by the Area Manager

If a young person is segregated for more than 72 hours, their supervising YOT worker shall be contacted.

The Establishment shall ensure that the following people shall be invited to segregation review conferences:-

- LA Social Worker (or Leaving Care worker if appropriate)
- Supervising YOT Worker
- Personal Officer
- Young Person's family or carers where appropriate.

This list is not exhaustive.

The purpose of the review shall be to consider the most appropriate location for the young person, which may involve a transfer to another Establishment. Either the YJB Placement Team or the Section 92 Unit of the Prison Service shall be made aware of all the decisions

If a young person is subject to adjudication, Governors must facilitate access to the advocacy service (should the young person so wish) as appropriate. Governors must give due consideration to the benefits of using the minor report procedure with this age group in order to expedite the disciplinary sanction.

22. The YJB have recently requested the commencement of a piece of work by the Women's Team & Juvenile Group in the Prison Service to analyse the uses of various segregation

facilities, such as 'separation & care units', 'calm down rooms' and 'time out rooms' in order to define how they are currently used for juveniles and to issue a juvenile-specific PSO on their use.

### **STCs**

23. The YJB contracts for STCs state:

Except at night when he/she is locked in his/her bedroom, a trainee in custody at the STC will only be separated from other trainees and placed in a locked room in exceptional circumstances to prevent him/her from harming him/herself or others from damaging property and only where other appropriate methods of control have failed.

Any trainee separated from other trainees...must be checked by appropriate staff at least once every 15 minutes.

No trainee will be kept separated from other trainees in a locked room for more than 3 hours at a time except at night when he/she is locked in his/her bedroom.

Incident reports must be completed and provided to the YJB monitor.

### **SCHs**

24. The YJB Contracts for SCHs state:

Single separation, which will be defined by the SSI, should only be used in exceptional circumstances to prevent young persons from harming themselves or others, from damaging property or compromising security and only when other appropriate methods of control have been tried and failed. Any young persons placed in a single separation room must be observed at frequent intervals not exceeding fifteen minutes. The Provider must keep a full record of such single separations including the reasons and observation log. This record should be available for inspection. The period of single separation must be kept to the minimum possible and should be for a period not exceeding 3hrs in any 24-hour period.

Young people should only spend additional time locked in their room if it is an authorised period of single separation. Young people may choose to spend time in their rooms unlocked. This should be facilitated where it is not in conflict with the requirements of the programme. In addition to regulatory requirements to record sanctions, any time that a young person spends against their will locked in their bedroom, taking the time out of room below the daily requirement, should be recorded, with reasons and times clearly stated. (The definition of time in room may change based on the forthcoming SSI Definition of Single Separation.)



25. The YJB's approach to Secure Children Homes has taken into account that they are also regulated and monitoring by CSCI (formally SSI) and that their definitions should be used. However there is recognition that further work needs to be undertaken in this area and we are now taking a lead role in working with DfES and CSCI to agree common definitions.
26. Finally, the Secure Accommodation Network (of SCHs) has developed their own Good Practice Guidance on the Use of Single Separation in SCHs (March 2005). Their definition of single separation is:

Single separation refers to the confining of a young person in his/her bedroom or another room or area as a means of control and without the young person's permission or agreement, without a member of staff being present and with the door locked in order to prevent exit or to further restrict their liberty in excess of that permission already granted by a court...

There are three categories of single separation:-

**Enforced separation** – when a young person is locked in a room

**Directed separation** – when a young person is asked to take 'time out' in their room, but it is not locked (note it only applied when young people are on their own); and

**Elected separation** – when a door is locked at the request of a young person

### **YJB Monitoring of Single Separation**

27. The YJB's Effective Regimes Monitoring Framework includes in its risk screen for 'Order & Control' a requirement for monitors to examine the use of single separation in SCHs and STCs and segregation in YOIs, by examining establishment records. The risk indicators they are asked to look for are:
- Locally high or increasing use of single separation
  - Frequent or repeated used of separation against particular young people
  - Establishment or external investigation into staff use of separation
  - Young people's complaints / allegations about inappropriate use of single separation

### **Physical Searching ('Strip Searching')**

#### **YOIs**

28. The YJB's Service Specification for YOIs states:

If the Establishment maintains that a full search of the young person at reception is necessary, officers must conduct the search with consideration and courtesy. The searching procedure to be followed must be explained to the young person prior to the search taking place. This is particularly important with this age group because of their youth and the possibility that they may have been subject to some form of abuse... Rub down body searches may only be performed by a staff member of the same sex in the presence of another staff member. Intimate body searches may only be conducted by a medical practitioner, authorised by the Provider

29. Further, the Prison Service Order 4950, that covers juveniles, states:

#### **Full Searches**

The National Security Framework sets out the procedure for searching. For young people, particularly those new to custody, a full search is an undignified and stressful experience. Whilst recognising that it is an essential and very important part of the reception procedure, officers must conduct the search with consideration and courtesy. The searching procedure to be followed must be explained to the young person prior to the search taking place. This is particularly important with this age group because of their youth and the likelihood of them having experienced physical or sexual abuse. Following a full search, all young people must be offered a bath or a shower and the opportunity to change into clean clothes.

#### **STCs**

31. The YJB Contracts for STCs state:

If a trainee in custody at the STC is subject to a body search of any form, it will be carried out by a Custody Officer of the same sex accompanied by one other member of staff of the same sex and out of sight of any members of the opposite sex and trainees. Physical force should not be used in searching the trainee unless there is reason to believe that such force is necessary.

#### **SCHs**

32. The YJB contracts for SCHs state:

Rub down body searches may only be performed by a staff member of the same sex in the presence of another staff member. Intimate body searches may only be conducted by a medical practitioner, authorised by the Provider.

33. The Secure Accommodation Network (of SCHs) has developed their own Good Practice Guidance on the Physical Searching of Young People in SCHs (March 2005). Their definition of 'personal searches' is 'any procedure, which involves a physical or visual examination of a young person'. The guidance states that a search will be undertaken only to ensure that prohibited or controlled items are not in the possession of a young person and that it should never be carried out as a punishment, sanction, or behavioural control. Two members of staff must be present – one to search and one to observe the search process. In addition, the guidance outlines 5 levels of searches, stating that it is up to the SCH to decide which levels they carry out:

**Level 1** – no contact with the young person, or removal of clothes, e.g. emptying pockets

**Level 2** – minimal contact with no request to remove clothing, e.g. hand held metal detector

**Level 3** – a) increased contact with the young person, e.g. a pat search; b) young person asked to remove their clothing and asked to wear something else, e.g. a dressing gown whilst their own clothes are searched

**Level 4** – the young person will be asked to remove their cloths and a visual search of their body will be made, no physical contact will be made with the young person

**Level 5** – this will be an intimate search and must be carried out by an appropriately qualified person

### **YJB Monitoring of Physical Searches**

34. Whilst the core Effective Regimes Monitoring Framework requests that monitors ensure appropriate policies and searching procedures are in place in an establishment (in the 'Reception' module), it does not currently suggest that monitors examine levels or individual incidents of searches, as part of the risk screen process or in the core framework. This is an issue that will be considered in the work to revise ERMF.

## ANNEX 2

---

Extract from proposed new counting rules for data to be collected by YJB

### **Single Separation**

- A single separation must be recorded whenever a young person is removed from association with peers as a form of control, and where he or she is not able to re-join the group of his or her own volition. In recording a single separation, it is not necessary that the bedroom door be locked. It may be the case, for example, that a young person is placed in his room but the door left open and a member of staff present to prevent him or her from leaving. What is at issue here is whether the young persons are free to rejoin their peers if they want. Taking a young person away from an incident in order to prevent escalation should NOT be recorded as single separation.

Single separation should not be used to cover the following categories.

- Calm down or time out, where a young person is briefly (no more than five minutes) separated in order to calm down, for instance to avoid a minor incident becoming more serious;
- Elective Separation, where a young person elects to go to their room (for instance to do homework, make a telephone call, write a letter and so on);
- Staff intervention, where young person is with a member of staff who is conducting one-to-one work with that young person.

Recording for YJB should show:

- Time into separation
- Time out of separation
- Reason for the separation
- Name of the person authorising the separation.

### **Restrictive Physical Intervention**

A Restrictive Physical Intervention (RPI) should be recorded whenever force is used to overpower a young person (i.e. as opposed to simply leading them away from an incident, or splitting up a dispute in order to prevent escalation).

This may be for a number of reasons, including preventing a young person from harming themselves or others, or damaging property. Where this is done the YJB would wish to see recorded:

- Number of staff involved in the incident
- Antecedents – what caused the incident and what strategies were used to try and avert the use of force.
- Why the decision was made to lay hands on the young person.
- Record of any injury to the young person and, if possible, which hold caused the injury.

Types of hold used during the restraint –

- Treatment given
- Record of any injuries to staff.
- Duration of restraint
- De escalation and resolution of restraint
- Debriefing (both staff and young person)

### Assault

Units should record any incident in which one young person intentionally strikes another, or where a member of staff intentionally strikes a young person, as an assault on a young person. This includes incidents in which a fight takes place.

Records should show

- Date and time of the incident
- The nature of the incident
- Any follow-up action (for instance police involvement, prosecution, sanctions given etc.)
- What happened beforehand
- Description of the incident, weapons used etc.
- Any injuries sustained
- The level of seriousness of the assault

▼ BRINSFORD	Apr-05	May-05	Jun-05	Jul-05	Aug-05	Sep-05
<b>C&amp;R / RESTRAINT</b>						
The number of planned C&R interventions in the month.	7	5	0	1	1	0
The number of spontaneous C&R interventions in the month.	15	13	13	10	10	18
The number of trainees subject to restraint under Rule 52 of YOI Rules.	19	18	13	11	11	18
<b>SEGREGATION UNITS</b>						
The number of trainees held in segregation units for less than 7 days.	19	10	5	7	8	7
The number of trainees held in segregation units for longer than 7 days.	4	4	5	4	4	1
The number of trainees held in segregation units for longer than 28 days.	0	1	0	0	0	0

<b>▼ BULLWOOD HALL</b>	<b>Apr-05</b>	<b>May-05</b>	<b>Jun-05</b>	<b>Jul-05</b>	<b>Aug-05</b>	<b>Sep-05</b>
<b>C&amp;R / RESTRAINT</b>						
The number of planned C&R interventions in the month.	0	8	1	0	0	2
The number of spontaneous C&R interventions in the month.	3	11	1	1	2	0
The number of trainees subject to restraint under Rule 52 of YOI Rules.	0	4	1	1	0	2
<b>SEGREGATION UNITS</b>						
The number of trainees held in segregation units for less than 7 days.	1	2	3	1	10	7
The number of trainees held in segregation units for longer than 7 days.	3	3	1	2	3	2
The number of trainees held in segregation units for longer than 28 days.	1	1	0	0	0	1
<b>▼ CASTINGTON</b>	<b>Apr-05</b>	<b>May-05</b>	<b>Jun-05</b>	<b>Jul-05</b>	<b>Aug-05</b>	<b>Sep-05</b>
<b>C&amp;R / RESTRAINT</b>						
The number of planned C&R interventions in the month.	0	0	2	0	0	0
The number of spontaneous C&R interventions in the month.	25	9	7	15	10	21
The number of trainees subject to restraint under Rule 52 of YOI Rules.	4	3	4	2	2	1
<b>SEGREGATION UNITS</b>						
The number of trainees held in segregation units for less than 7 days.	7	9	5	5	4	8
The number of trainees held in segregation units for longer than 7 days.	9	1	2	2	0	1
The number of trainees held in segregation units for longer than 28 days.	0	0	0	0	0	0
<b>▼ DOWNVIEW</b>	<b>Apr-05</b>	<b>May-05</b>	<b>Jun-05</b>	<b>Jul-05</b>	<b>Aug-05</b>	<b>Sep-05</b>
<b>C&amp;R / RESTRAINT</b>						
The number of planned C&R interventions in the month.	0	0	0	0	0	0
The number of spontaneous C&R interventions in the month.	11	11	9	15	19	1
The number of trainees subject to restraint under Rule 52 of YOI Rules.	0	0	0	0	0	0
<b>SEGREGATION UNITS</b>						
The number of trainees held in segregation units for less than 7 days.	0	0	0	0	0	0
The number of trainees held in segregation units for longer than 7 days.	0	0	0	0	0	0
The number of trainees held in segregation units for longer than 28 days.	0	0	0	0	0	0

<b>▼ EASTWOOD PARK</b>	<b>Apr-05</b>	<b>May-05</b>	<b>Jun-05</b>	<b>Jul-05</b>	<b>Aug-05</b>	<b>Sep-05</b>
<b>C&amp;R / RESTRAINT</b>						
The number of planned C&R interventions in the month.	1		1	0	0	0
The number of spontaneous C&R interventions in the month.	1	2	0	0	0	0
The number of trainees subject to restraint under Rule 52 of YOI Rules.	0	2	0	0	0	0
<b>SEGREGATION UNITS</b>						
The number of trainees held in segregation units for less than 7 days.	0	1	1	0	0	0
The number of trainees held in segregation units for longer than 7 days.	0	0	0	0	0	0
The number of trainees held in segregation units for longer than 28 days.	0	0	0	0	0	0
<b>▼ FELTHAM</b>	<b>Apr-05</b>	<b>May-05</b>	<b>Jun-05</b>	<b>Jul-05</b>	<b>Aug-05</b>	<b>Sep-05</b>
<b>C&amp;R / RESTRAINT</b>						
The number of planned C&R interventions in the month.	10	10	10		8	16
The number of spontaneous C&R interventions in the month.	9	12	15		21	18
The number of trainees subject to restraint under Rule 52 of YOI Rules.	0	0	0		0	0
<b>SEGREGATION UNITS</b>						
The number of trainees held in segregation units for less than 7 days.	5	7	7		6	14
The number of trainees held in segregation units for longer than 7 days.	0	2	1		0	0
The number of trainees held in segregation units for longer than 28 days.	0	0	0		0	0
<b>▼ HINDLEY</b>	<b>Apr-05</b>	<b>May-05</b>	<b>Jun-05</b>	<b>Jul-05</b>	<b>Aug-05</b>	<b>Sep-05</b>
<b>C&amp;R / RESTRAINT</b>						
The number of planned C&R interventions in the month.	5	7	4	1	4	6
The number of spontaneous C&R interventions in the month.	26	21	43	7	30	28
The number of trainees subject to restraint under Rule 52 of YOI Rules.	0	0	0	0	0	0
<b>SEGREGATION UNITS</b>						
The number of trainees held in segregation units for less than 7 days.	3	3	0	0	8	7
The number of trainees held in segregation units for longer than 7 days.	0	1	0	0	3	1
The number of trainees held in segregation units for longer than 28 days.	0	0	0	0	0	0

<b>▼ HUNTERCOMBE</b>	<b>Apr-05</b>	<b>May-05</b>	<b>Jun-05</b>	<b>Jul-05</b>	<b>Aug-05</b>	<b>Sep-05</b>
<b>C&amp;R / RESTRAINT</b>						
The number of planned C&R interventions in the month.	3	8	14			3
The number of spontaneous C&R interventions in the month.	5	21	13			18
The number of trainees subject to restraint under Rule 52 of YOI Rules.	0	0	1			0
<b>SEGREGATION UNITS</b>						
The number of trainees held in segregation units for less than 7 days.	19	26	21	30	14	19
The number of trainees held in segregation units for longer than 7 days.	0	4	2	2	1	4
The number of trainees held in segregation units for longer than 28 days.	0	0	0	0	0	0
<b>▼ LANCASTER FARMS</b>	<b>Apr-05</b>	<b>May-05</b>	<b>Jun-05</b>	<b>Jul-05</b>	<b>Aug-05</b>	<b>Sep-05</b>
<b>C&amp;R / RESTRAINT</b>						
The number of planned C&R interventions in the month.	0	1	2	1	2	2
The number of spontaneous C&R interventions in the month.	8	18	13	15	16	16
The number of trainees subject to restraint under Rule 52 of YOI Rules.	8	0	0	0	0	0
<b>SEGREGATION UNITS</b>						
The number of trainees held in segregation units for less than 7 days.	15	21	16	19	31	23
The number of trainees held in segregation units for longer than 7 days.	1	1	2	0	1	1
The number of trainees held in segregation units for longer than 28 days.	0	0	0	0	0	0
<b>▼ NEW HALL</b>	<b>Apr-05</b>	<b>May-05</b>	<b>Jun-05</b>	<b>Jul-05</b>	<b>Aug-05</b>	<b>Sep-05</b>
<b>C&amp;R / RESTRAINT</b>						
The number of planned C&R interventions in the month.	3	7	21	24	1	3
The number of spontaneous C&R interventions in the month.	0	2	10	9	4	8
The number of trainees subject to restraint under Rule 52 of YOI Rules.	3	9	31	2	5	11
<b>SEGREGATION UNITS</b>						
The number of trainees held in segregation units for less than 7 days.	0	1	0	2	0	2
The number of trainees held in segregation units for longer than 7 days.	0	1	4	1	1	2
The number of trainees held in segregation units for longer than 28 days.	0	0	0	0	0	0



<b>▼ STOKE HEATH</b>	<b>Apr-05</b>	<b>May-05</b>	<b>Jun-05</b>	<b>Jul-05</b>	<b>Aug-05</b>	<b>Sep-05</b>
<b>C&amp;R / RESTRAINT</b>						
The number of planned C&R interventions in the month.	3	1	7	2	5	0
The number of spontaneous C&R interventions in the month.	12	6	14	22	10	12
The number of trainees subject to restraint under Rule 52 of YOI Rules.	0	0	0	0	0	0
<b>SEGREGATION UNITS</b>						
The number of trainees held in segregation units for less than 7 days.	19	9	15	17	4	9
The number of trainees held in segregation units for longer than 7 days.	2	3	4	2	6	1
The number of trainees held in segregation units for longer than 28 days.	0	3	1	0	0	0
<b>▼ THORN CROSS</b>	<b>Apr-05</b>	<b>May-05</b>	<b>Jun-05</b>	<b>Jul-05</b>	<b>Aug-05</b>	<b>Sep-05</b>
<b>C&amp;R / RESTRAINT</b>						
The number of planned C&R interventions in the month.	0	0	0	0	0	0
The number of spontaneous C&R interventions in the month.	0	0	0	0	0	0
The number of trainees subject to restraint under Rule 52 of YOI Rules.	0	0	0	0	0	0
<b>SEGREGATION UNITS</b>						
The number of trainees held in segregation units for less than 7 days.	8	12	5	8		
The number of trainees held in segregation units for longer than 7 days.	0	0	0	0	0	0
The number of trainees held in segregation units for longer than 28 days.	0	0	0	0	0	0
<b>▼ WARREN HILL</b>	<b>Apr-05</b>	<b>May-05</b>	<b>Jun-05</b>	<b>Jul-05</b>	<b>Aug-05</b>	<b>Sep-05</b>
<b>C&amp;R / RESTRAINT</b>						
The number of planned C&R interventions in the month.	9	3	5	2	3	1
The number of spontaneous C&R interventions in the month.	13	12	17	13	10	13
The number of trainees subject to restraint under Rule 52 of YOI Rules.	0	0	0	0	0	0
<b>SEGREGATION UNITS</b>						
The number of trainees held in segregation units for less than 7 days.	7	16	22	19	21	20
The number of trainees held in segregation units for longer than 7 days.	2	3	4	1	4	4
The number of trainees held in segregation units for longer than 28 days.	3	0	0	0	0	0

▼ WERRINGTON	Apr-05	May-05	Jun-05	Jul-05	Aug-05	Sep-05
<b>C&amp;R / RESTRAINT</b>						
The number of planned C&R interventions in the month.	13	2	4	5	1	3
The number of spontaneous C&R interventions in the month.	12	12	11	11	8	12
The number of trainees subject to restraint under Rule 52 of YOI Rules.	29	16	19	20	15	23
<b>SEGREGATION UNITS</b>						
The number of trainees held in segregation units for less than 7 days.	0	0	0	0	0	0
The number of trainees held in segregation units for longer than 7 days.	0	0	0	0	0	0
The number of trainees held in segregation units for longer than 28 days.	0	0	0	0	0	0
▼ WETHERBY	Apr-05	May-05	Jun-05	Jul-05	Aug-05	Sep-05
<b>C&amp;R / RESTRAINT</b>						
The number of planned C&R interventions in the month.	0	1	1	0	6	0
The number of spontaneous C&R interventions in the month.	21	46	33	38	42	27
The number of trainees subject to restraint under Rule 52 of YOI Rules.	0	0	0	0	0	0
<b>SEGREGATION UNITS</b>						
The number of trainees held in segregation units for less than 7 days.	9	7	11	11	6	7
The number of trainees held in segregation units for longer than 7 days.	12	8	9	10	8	0
The number of trainees held in segregation units for longer than 28 days.	1	0	0	0	1	1

## Appendix E **Key extracts from the Statement of Principles developed by the Restorative Justice Consortium, 2004**

---

Restorative practices are underpinned by a set of values, these include: Empowerment, Honesty, Respect, Engagement, Voluntarism, Healing, Restoration, Personal Accountability, Inclusiveness, Collaboration, and Problem-solving.

### **Processes**

- 1 Primary aim to be the repair of harm
- 2 Agreement about essential facts of the incident and an acceptance of some involvement by the person who caused the harm.
- 3 Participation to be voluntary for all participants and based on informed choice. This also applies to what is included in any outcome agreement, and any consequence for non-participation/ compliance to be made clear.
- 4 Adequate time to be given to participants to decide whether to take part and to consult with others, if they wish.
- 5 Acknowledgement of the harm or loss experienced by the person harmed, respect for the feelings of participants, and an opportunity for the resulting needs to be considered and where possible met.
- 6 The person/s who have been harmed or suffered loss to be (if they wish) the primary beneficiary of any reparation agreed with the person who has caused the harm.
- 7 Where harm is repaired or amends made, this to be acknowledged and valued.
- 8 The person/s who has harmed and the person/s harmed are the primary participants of any restorative process.
- 9 Restorative practitioners to be seen as neutral by participants and to act impartially.

### **Equalities/ Diversity/Non-discrimination**

- 10 Participants not to be discriminated against for any reason.
- 11 Diversity to be respected.
- 12 Respectful behaviour to be maintained in restorative processes, whilst enabling emotions and needs to be expressed.
- 13 The rule of law to be up-held.
- 14 Respect for the dignity of all participants at all times.

### **Information, Choice and Safety**

- 15 Access to information and referral to other organisations who might offer assistance to participants, before, during, after or if they decline participation in a restorative process.

- 16 Opportunity to participate in a restorative process, except where there is a significant risk of further harm, there is disagreement about the critical facts, or parties do not wish to participate
- 17 Ensuring choice is available to the participants regarding restorative processes, including direct and indirect forms of communication and the nature of any reparation.
- 18 Safety of participants before, during and after participation in a restorative process.
- 19 Additional protection and support for the particularly vulnerable to enable full participation.
- 20 Restorative Practitioners to keep confidential the content of restorative communications and personal information, subject to the informed consent of participants, the requirements of the law, and their agencies` policies.
- 21 Restorative agreements to be fair, appropriate to the harm done and achievable.

### **Agreements/Outcomes**

- 22 Outcomes of a restorative process to be monitored and timely action taken should a problem occur. Any developments should be communicated to participants, unless they have asked not to be contacted.
- 23 Evaluation of processes and outcomes to be carried out wherever possible.
- 24 Learning from restorative processes to lead to a reduction in harm and the fear of crime; whilst encouraging cultural and behavioural change amongst individuals and communities. This in turn can lead to improved social harmony and safer communities. Therefore, where appropriate, practitioners and services are encouraged to find ways to safely promote this learning to others.

### **Organisation/policies**

- 25 Those agencies/individuals carrying out restorative practices to have a commitment to practice based on the needs of the participants.
- 26 Organisations to be encouraged to use restorative principles in other areas of conflict, such as internal grievance, disciplinary systems, and external procedures e.g., client complaints, wherever possible.
- 27 Organisations and practitioners to have a commitment to high quality restorative practice through appropriate training, services and support for practitioners, and complying with the best practice guidance available at the time.
- 28 To provide best outcomes for participants, organisations carrying out restorative processes to ensure co-ordinated multi-agency working is established.



the **Howard League** for **Penal Reform**

**1 Ardleigh Road**

**London**

**N1 4HS**

**Tel:** 020 7249 7373

**Fax:** 020 7249 7788

**Email:** [info@howardleague.org](mailto:info@howardleague.org)

**Website:** [www.howardleague.org](http://www.howardleague.org)

**Charity No.** 251926

**ISBN:** 0903683830

**Price:** £15

**2006**