



The Carlile Inquiry 10 years on

The use of restraint, solitary confinement and strip-searching on children

the Howard League for Penal Reform

Key points

- In 2006 the Howard League published the findings of an independent inquiry, chaired by Lord Carlile, into the use of restraint, solitary confinement and strip-searching in penal institutions for children
- In child prisons, adults can use physical force on children. The majority of children are detained in institutions where restraint is routinely used to get children to do as they are told. This is unlawful
- Despite a decrease in the number of children in custody, the rate of restraint has more than doubled in the last five years
- Force that causes the deliberate infliction of pain on children account for over a third of all approved 'techniques' that can be used on children. Pain is being used illegally to secure children's compliance
- 4,350 injuries have been sustained by children while being subject to restraint between 2011 and 2015
- The current crisis in children's prisons has given rise to the widespread practice of holding children in conditions of solitary confinement on main prison wings, locked in their cells for 23 hours a day
- Conditions in segregation units have not improved since 2006, when the Carlile Inquiry described them as "little more than bare, dark and dank cells that exacerbate underlying risks and vulnerabilities". Segregation units should be immediately closed
- Routine strip-searching has ended and been replaced by a risk-led approach. In 2015, however, there were 367 strip-searches of boys in prison

Introduction

In 2006 the Howard League published the findings of an independent inquiry, led by Lord Carlile of Berriew QC, into the use of restraint, solitary confinement and strip-searching in penal institutions holding children. The Carlile Inquiry was launched in the wake of the deaths of 15-year-old Gareth Myatt, who died whilst being restrained by officers, and 14-year-old Adam Rickwood, who was found hanging in his cell after he had been restrained by staff.

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

Any reform effort which does not address the areas of concern the Carlile Inquiry identified, and which are still relevant in child custody today, will founder. In particular it is time for the Ministry of Justice to ban the unlawful use of restraint on children simply in order to get children to do as they are told. Otherwise the mistakes of the past will only be repeated.

Ten years on from the Carlile Inquiry

In the 10 years since the inquiry concluded, there has been much progress in youth justice, not least the reduction in the number of children in custody in England and Wales. At the time of the inquiry, there were nearly 3,000 children behind bars. This has reduced to fewer than 1,000 and is a considerable achievement (Ministry of Justice, 2016a). There is still much further to go to ensure that only the few children who require a period in a secure environment are in custody. In particular, the over-representation of BME children and those needlessly held on remand should be addressed.

The secure estate has rapidly shrunk over the last 10 years. Of the 11 institutions visited by the inquiry team in 2005, only six of which still hold children. As recommended by the inquiry, there have been particular successes in reducing the number of 'split-site' institutions, where adults and children are detained separately but within the same prison: there were nine split sites and now there are two. One of the privately-run secure training centres, where Adam Rickwood died, has been closed.

The reductions, however, have also given rise to challenges. Children are now held further away

from home and many of the small, local secure units, highlighted by the inquiry as providing the best care and support for children, have been closed in order to make financial savings. In 2005 there were 15 secure children's homes, which held up to 235 children. There are now eight units with a total of 117 places. There are no secure children's home beds in London, or in the wider South East and the East of England.

Since the publication of the Carlile Inquiry, five more boys have died in prison.

In relation to the three specific areas that the inquiry looked at – restraint, solitary confinement and strip-searching – there have been some improvements but fundamental concerns remain. The slow and piecemeal progress in implementing the recommendations of the 2006 inquiry means that, 10 years on, children continue to be placed in danger and, because of poor and erratic treatment, they continue to reoffend.

The privately-run secure training centres have been subject to serious allegations of abuse in the last year. At Rainsbrook secure training centre (STC), where Gareth Myatt was unlawfully restrained to death, inspectors found that: "Poor staff behaviour has led to some young people being subject to degrading treatment, racist comments and being cared for by staff who were under the influence of illegal drugs" (HMIP, 2015a). At least six members of staff were dismissed. In January 2016 an investigation by the Panorama programme, aired on the BBC, revealed serious incidents of child abuse, coercion and falsification of records at Medway secure training centre. At the time of writing, the police investigation into the allegations at Medway was ongoing.

In May 2016, the government published a damning report on Medway, which concluded that "the lack of clarity on the purpose of a STC and the leadership within the STC has driven a culture that appears to be based on control and contract compliance rather than rehabilitation and safeguarding vulnerable young people" (Ministry of Justice, 2016b).

The Medway report, although long overdue, is welcome. The majority of children in prison, however, should not be behind bars.

Reform in youth justice must focus efforts on continuing to reduce the number of those incarcerated. At the same time, the treatment of those children still in custody must be addressed if the mistakes of the past are not to be repeated.

No matter what happens in the future, however, children are being harmed in prisons today and steps to ensure their safety must be taken immediately.

Restraint

In prisons adults use physical force on children. The majority of children are detained in institutions where restraint is routinely used to get children to do as they are told. This is unlawful.

Following on from the deaths of Gareth Myatt and Adam Rickwood, and the publication of the Carlile Inquiry, the use of force on children in custody has been the most controversial and examined issue in youth justice over the last decade. Thousands of pages of official reviews, parliamentary inquiries, court cases and guidance have been reviewed for this report.

Despite this wealth of work, restraint is being used too readily on children in custody. Although the number of incidents of use of force have reduced in children's prisons, the rate per 100 children in custody has more than doubled in the last five years. Monitors at Cookham Wood prison reported that children had been restrained 841 times in a year (Cookham Wood IMB, 2015). At Feltham prison inspectors found "very high" levels of use of force, with 427 cases in the previous six months (HMIP, 2015b). At Cookham Wood there had been 400 use of force incidents in the six months before the inspection compared with 282 before the previous inspection (HMIP, 2015c).

The Carlile Inquiry recommended that one safe and certified technique be used on children across the secure estate and that this be developed as a matter of urgency. It was not until July 2012 that the government announced a new system of restraint for use in children's prisons: 'Minimising and Managing Physical Restraint' (MMPR), which has brought about minor improvements. The Carlile Inquiry recommended that improvements should be made to the recording and monitoring of the use of restraint on children. This has been implemented. The MMPR data provides a detailed breakdown of the use of recorded restraint on children, and further improvements to monitoring and oversight have been included in the system.

Pain

Force that causes the deliberate infliction of short bursts of pain on children account for over a third of all approved MMPR techniques. This is despite the recommendation in the Carlile Inquiry that they are unacceptable and

may be unlawful. It is particularly concerning that the Restraint Advisory Board (RAB), who advised the government on the new system of restraint, reported that they were not able to consider a system of restraint that involved no pain-inducing techniques and that this "had a number of practical limitations for and placed limitations upon RAB's work" (RAB, 2011).

Pain continues to be used on children and at an increasing rate. At Werrington prison inspectors said "it was concerning that the use of pain-inflicting techniques had increased from one during the six months before the previous inspection to 10 in the same period before this inspection" (HMIP, 2016).

It is also alarming that inspectors have found that: "Pain compliance techniques were used but not all were recorded. Incidents involving the mandibular angle technique (pressure applied to a point below the ear) were recorded, but pain applied through the wrists or calf was not" (HMIP, 2015c).

There have also been examples of pain being applied to bring restraint to an end quickly "to defuse particularly difficult situations". As the review of the implementation of MMPR concluded: "This is an extremely concerning misinterpretation of the guidance, which potentially leaves children open to ready infliction of pain, without the prescribed criteria being met" (HMIP, 2015d).

The courts have held that deliberately inflicting pain on a child to get them to do as they are told is unlawful (*R (C) v Secretary of State for Justice*, 2008). The prison inspectorate has, however, highlighted examples where this has occurred.

In an incident at Cookham Wood, one boy was restrained for refusing to leave a room after a review into whether he was at risk of harming himself. Inspectors found that "force was instigated quickly and escalated to the infliction of pain by an officer kicking a boy in the calf with his heel" (HMIP, 2015c).

Inspectors also found that the use of pain compliance has almost doubled at Wetherby prison and none of the incidents had been referred to the safeguarding team for investigation (HMIP, 2015e). In another prison the reason for use of pain was recorded as "refusal to move back to cell. Needed to move [child] to continue with the regime" (HMIP, 2015d).

Restraint is inherently painful and distressing, even when pain is not the primary purpose:

“One member of staff grabbed my neck and then others pushed me to the ground and held me there telling me to calm down. While I was on the floor a male member of staff was holding my head almost between his knees. I have been sexually abused in the past so you can imagine how that made me feel. I was terrified.”

Children have also reported that some holds in the new restraint system, which are not intended to cause pain, caused them significant discomfort and pain. This was supported by staff who had undergone MMPR training and had holds applied to them (HMIP, 2015d).

Compliance

A central recommendation of the Carlile Inquiry was that restraint should never be used to secure compliance and that the resort to restraint was a failure to de-escalate conflict.

In the case of ‘C’ in 2008, the Court of Appeal found that the use of force in privately-run secure training centres for discipline fell within the legal prohibition on the use of “cruel, inhuman or degrading treatment”. It has been banned in the secure training centres as a consequence of this judgment. Secure children’s homes do not use force to get children to do as they are told.

The Howard League, alongside numerous experts, avers that rules which allow the use of force to get children to do as they are told in young offender institutions are equally unlawful. This means there is illegal, systemic physical abuse of children in prison, sanctioned by the state. As stated by the Joint Committee on Human Rights:

“The law is clear that the use of force on children can only ever be justified in order to protect the child or others from harm, and can never be justified for the purposes of good order and discipline” (JCHR, 2014).

Data published on MMPR showed that the use of force to get children to do as they were told accounted for between 22-34 per cent of total incidents of use of force in young offender institutions (YJB, 2015).

At Cookham Wood prison: “In one incident, staff fully restrained a boy whom they knew well, who refused to give his name and prison number when he returned from court to reception” (HMIP, 2014).

Head hold

In 2011 the RAB raised significant concerns regarding the ‘head hold’ technique, which is part of the MMPR system: “This form of restraint was considered by RAB to have some inherent potentially serious risks even when applied with complete accuracy and to be too easily misapplied by staff... with relatively small, inadvertent errors nonetheless carrying further risk of serious harm. The margin of safety was considered too small” (RAB, 2011).

The Independent Restraint Advisory Board reported in 2014 that children had suffered from petechial rashes (haemorrhages) after being subjected to the head hold. Further concerns were raised “about the potential to misapply the head hold, and, in particular, about how easy it is to pull a young person’s head forward rather than merely guide it while he or she is being restrained. This could result in the restrained person’s head being held too low and that might, in turn, risk compressing his or her chest area and/or raise the risk of staff misapplying the trigger hold to the neck rather than to the chin” (IRAP, 2014).

The MMPR guidance states the head hold should only be used when the child is ‘so violent that not controlling the young person’s head would place them, or staff at risk.’ Yet the YJB’s own data shows that when force was used on children, the head hold was used in 22 per cent of all incidents (YJB, 2016).

The circumstances that led to the death of Gareth Myatt demonstrate the clear link between reported breathing difficulties and the fatal consequences that can occur if these warnings are not heeded. It is therefore concerning that the review of the implementation of the new system of restraint raised frequent reports that children struggled to breathe during a restraint, particularly in relation to the ‘head hold’, often described by children as a ‘choke hold’. These fundamental concerns were compounded by the attitude of a minority of staff:

“I told the staff I couldn’t breathe when I was being walked and he said ‘I’m not asking you to breathe, not even talk’.”

“Kids sometimes just say stuff so that you let them go, like they can’t breathe, but you know that they are having you on” (HMIP, 2015d).

Timeline

April 2004 – 15-year-old Gareth Myatt is restrained at Rainsbrook secure training centre in a ‘double-seated embrace’, which results in him becoming breathless before choking to death on his own vomit (Inquest, 2007)

August 2004 – 14-year-old Adam Rickwood is found hanging in his cell at Hassockfield secure training centre after having pain deliberately inflicted on him for ‘good order and discipline’ (Branigan, 2004)

2005 – The Howard League establishes an independent inquiry into the use of physical restraint, solitary confinement and forcible strip-searching in penal institutions for children, led by Lord Carlile of Berriew QC

2006 – The Howard League publishes the findings of the Carlile Inquiry. It recommends that restraint should not be used to secure compliance and that the deliberate infliction of pain is not acceptable and may be unlawful (Howard League, 2006)

2007 – The inquest into the death of Gareth Myatt returns a verdict of accidental death. The jury, however, makes sweeping criticisms of the YJB for the failure to test the safety of the restraint technique used on him, and find that this had been a contributing factor to what happened to him (Smith, 2007)

2007 – At the first inquest into the death of Adam Rickwood, the coroner refuses to allow the jury to consider whether the restraint used on him prior to his death was lawful. The jury returns a verdict saying that he intended to take his own life (Allison and Hattenstone, 2007)

2007 – The government amends the secure training centre rules to extend the circumstances in which restraint can be used to include ‘good order and discipline’ (JCHR, 2008)

2008 – The then Chief Inspector of Prisons, Anne Owers, calls for Oakhill STC, run by G4S, to be temporarily closed after ‘staggering’ levels of force against children are uncovered

2008 – The Court of Appeal quashes the secure training centre amendment rules, which allow force to be used on children for good order and discipline. Lord Justice Buxton says the restraint methods amounted to ‘inhuman and degrading treatment’ (R (C) v Secretary of State for Justice, 2008)

2008 – Report of the Independent Review of Restraint in Juvenile Secure Settings makes 58 recommendations (Smallbridge and Williamson, 2008)

2009 – Following a judicial review, the High Court rules that the coroner overseeing the death of Adam

Rickwood acted unlawfully, and that the physical restraint on Adam was a breach of STC rules and an assault on him. The verdict is quashed and a new inquest ordered (R v HM Coroner, (2009)

2010 – After a five year Freedom of Information battle, the government releases the restraint manual for use in secure training centres. It reveals that staff are authorised to, among other ‘techniques’, “use an inverted knuckle into the trainee’s sternum and drive inward and upward”; “continue to carry alternate elbow strikes to the young person’s ribs until a release is achieved”; and “drive straight fingers into the young person’s face, and then quickly drive the straightened fingers of the same hand downwards into the young person’s groin area” (Townsend, 2010)

2011 – The second inquest into the death of Adam Rickwood concludes that the unlawful use of force contributed to his decision to take his own life and that there had been widespread, unlawful use of restraint against children (BBC, 2011)

2012 – The High Court rules that the unlawful use of restraint was widespread in secure training centres for at least a decade (CRAE v Secretary of State for Justice, 2012)

2012 – The government announces a new system of restraint for use in children’s prisons: ‘Minimising and Managing Physical Restraint’ (MMPR)

2013 – The roll-out of MMPR commences

2015 – The inspection of Rainsbrook reveals that children were subjected to degrading treatment and racist comments and had been cared for by staff who were under the influence of illegal drugs. The inspection report reveals that staff had smuggled in ‘inappropriate’ DVDs. Children were restrained 166 times in six months – 72 of these restraint incidents were in response to children harming themselves. Despite this, the Youth Justice Board announces the next day that G4S has been granted an extension for its contract at Medway (HMIP, 2015a)

2016 – An investigation by the Panorama programme airs on the BBC, displaying serious allegations of child abuse, coercion and falsification of records at Medway secure training centre. At the time of writing, the police investigation into the allegations at Medway was ongoing.

2016 – New figures show that 4,350 injuries have been sustained by children while being subject to restraint in the last five years (Hansard, 2016)

2016 – The Medway Improvement Board report is published. The prison service announces that it will take over the running of the centre on an interim basis.

Injuries

A total of 4,350 injuries have been sustained by children while being subject to restraint in the last five years (Hansard, 2016). Until February 2016 the Youth Justice Board did not disclose the full extent of injuries suffered by children as a result of the use of force.

Under the new restraint system children should be offered support from an advocate and healthcare following force being used on them. Too often, however, this is not happening. The prison inspectorate found one example where “a child had attempted to hang himself with a ligature following a restraint. He had not been offered appropriate support, despite staff awareness that he had a tendency to self-harm following restraint. Had the child not been discovered when another boy looked through the observation panel, this could have led to another tragic incident.”

Healthcare staff do not medically assess all children after restraint. Instead they will ‘check on’ children through the hatch in their door. As one member of healthcare staff told the inspectorate:

“We will examine the young person depending on their mood. We are guided by officers about this and we may just speak to them through their door. If they are pacing around their room we will assess them through their door. Well at least we know they are still breathing” (HMIP, 2015d)

Solitary confinement

In 2006 the Carlile Inquiry reported on the largely hidden world of prison segregation. It found that most segregation units, which were known by a range of euphemisms, were little more than bare, dark and dank cells that in effect were inducements to suicide.

In the intervening years, little has changed. There is no central data on the number of children placed in segregation units, the length of confinement or reasons for confinement. The latest survey of children in prison found that over a quarter of boys had been held in segregation units at some point (Redmond, 2015). Information provided to Parliament showed that children spent 7,970 days in prison segregation units in 2013/14 (Hansard, 2014).

At Werrington prison, although the number of boys held in the segregation unit had decreased inspectors “were particularly concerned about the increasing number of boys who were segregated for excessive periods: one boy had spent 89 days in the CSU (segregation unit)” (HMIP, 2016). At

Cookham Wood, three of the seven children on the segregation unit at the time of the latest inspection had been held for long periods, in one case for nearly four months (HMIP, 2015c).

Inspectors were also critical of the high use of a “bleak, unsuitable care and separation unit shared with young adults” at Feltham prison. There had been 295 incidents of children being segregated in the six months prior to the inspection, an increase of 37 per cent since the previous inspection.

“The use of segregation had increased markedly and boys were still being held in the segregation unit on the young adult site. Too many of these periods of separation were brief stays awaiting adjudication. The segregation environment remained grim and quite inappropriate for children, with no suitable facility for face-to-face interventions, such as education” (HMIP, 2015b).

At Wetherby prison, inspectors described the regime on the segregation unit as “inadequate”.

“All the boys we spoke to told us they spent most of their time locked in their cells. There was little evidence of any constructive activities, although staff sometimes allowed boys out of their cells to carry out cleaning work on the unit... Showers and telephone calls were only offered every other day” (HMIP, 2015e).

Monitors at Wetherby prison raised concerns that conditions in the segregation unit “remain generally poor. Communal areas are stark and cells are small, cramped and poorly ventilated. Ants return as regular summer visitors and render one or two cells out of action” (Wetherby IMB, 2016).

In recent years, due to a combination of staff shortages and an increase in violence, children’s prisons have increasingly imposed restricted regimes, either across entire institutions or to ‘manage’ individual children. This has given rise to a relatively new and widespread practice of holding children in conditions of solitary confinement on main prison wings, locked in their cells for 23 hours a day. This includes children isolating themselves because they are too frightened to be on main prison wings.

In its latest annual report, HM Inspectorate of Prisons raised concerns that:

“Current efforts to tackle violence included physically separating boys from one another, with the consequence that too many boys spent too long locked alone in their cells. At Cookham Wood,

28 per cent of the mainstream population were on some form of regime restriction. Last year we reported on boys at Feltham who were confined to their cells for up to 22 hours a day; this year 26 per cent of the population were being managed on units under a restricted regime that excluded them from activities and meant that they were unlocked for less than an hour a day – in effect, solitary confinement on their residential units” (HMIP, 2015f).

At Feltham prison, boys on the most restricted regime had to choose between a shower, telephone call or exercise within a 30-minute period. The Care and Quality Commission judged that “being deprived of time in the open air was seriously detrimental to the health, development and wellbeing of growing boys” (HMIP, 2015b).

The Howard League legal team represented a child with significant needs who was awaiting assessment by a psychologist. The Howard League complained to the Prison and Probation Ombudsman (PPO) that he remained in solitary confinement for 23 hours each day in his cell and had spent extended periods of time in the segregation unit. For months he could not buy anything from the canteen, associate with other children or have a TV. The PPO said that it had found it impossible to establish what regime he had access to when he was held in solitary confinement in his cell as a result of a complex mix of plans in an attempt to manage him. It concluded that “there could be a risk of him being effectively subject to segregation or removal from association on occasions without having gone through due process”. The PPO recommended that the prison apologise to the child and review the way it managed children subject to regime restrictions.

Effects of solitary confinement

The Howard League has worked with a number of children and young people who have been segregated for long period and its experience is that putting vulnerable and disturbed people in conditions of solitary confinement tends only to exacerbate their problems. It is clear that there is an increased risk to the personal integrity, mental health and even life of people in segregation.

The possible long-term effects of solitary confinement on children are not well studied and most of the research conducted to date relates to adults. The United Nations Special Rapporteur on Torture, however, concluded in 2011 that “15 days is the limit between ‘solitary confinement’ and ‘prolonged solitary confinement’ because at that point, some of the harmful psychological effects of isolation can become irreversible”. This related to adults.

The Istanbul Statement (2007) on the use and effects of solitary confinement summaries the effects of solitary confinement on adults:

“Between one-third and as many as 90 per cent of prisoners experience adverse symptoms in solitary confinement. A long list of symptoms ranging from insomnia and confusion to hallucinations and psychosis has been documented. Negative health effects can occur after only a few days... the central harmful feature of solitary confinement is that it reduces meaningful social contact to a level of social and psychological stimulus that many will experience as insufficient to maintain mental health and well-being.”

In 2015, the Office of the Children’s Commissioner for England published research on the use of isolation and solitary confinement in children’s prisons and concluded that a third of children in custody would experience isolation at some point. It found that:

“As children within the secure estate are among the most disadvantaged and vulnerable society, isolation is likely to exacerbate such difficulties.”

“Children interviewed for the purposes of our research described how the experience of isolation generated feelings of boredom, stress, apathy, anxiety, anger, depression and hopelessness. Staff confirmed that even short periods of isolation could trigger self-harm, exacerbate the impact of trauma experienced in the past and cause psychotic episodes.”

The research also found that BME children are three times more likely to experience isolation; children with a recorded disability are two-thirds more likely to experience isolation; and looked after children are almost two-thirds as likely to experience isolation.

Children assessed as a suicide risk (or having comparable markers of vulnerability) are nearly 50 per cent more likely to experience isolation.

Prison inspectors have “found examples of boys on ACCT [suicide and self-harm] documents who had been locked up for too long with nothing to do and a few cases where documents confirmed that isolation brought about by restricted regimes had contributed to their self-harm” (HMIP, 2015b).

Following the Supreme Court judgment on the use of segregation (*R v the Secretary of State for Justice*, 2015), the government introduced a new regime that requires external authorisation of all decisions to segregate people beyond 42 days.

The Ministry of Justice has decided to review decisions to segregate children beyond 21 days, but this only provides a review and can still mean continued solitary confinement.

The Howard League has objected to this policy, which cannot safeguard children from the potentially irreversible damage that international experts recognise can set in after 15 days. A review of segregation that was promised in early 2016 is yet to materialise. The Howard League legal team continues to assist children who are detained for extended periods in isolation.

Strip-searching

In 2006 the Carlile Inquiry reported on the practice of routine strip-searching of children and concluded that:

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

The inquiry recommended that the routine strip-searching of children should end and be replaced by a risk-led approach.

Progress over the last 10 years has been slow but, ultimately, successful in principle:

- Routine strip-searching in secure children's homes and secure training centres, including on reception, was banned and replaced by an entirely risk-based approach
- Following a review by the Youth Justice Board conducted against the background in 2007 of the Gender Equality Duty and the Corston Report, routine strip-searching of 17-year-old girls in prison service units was replaced by a risk-based approach. These units are now closed
- In 2012 the prison rules were amended to introduce a risk-based approach in all aspects

of strip-searching of boys in young offender institutions, except for on initial reception

- Following successful and continued lobbying by the Howard League, the Ministry of Justice agreed to introduce pilots using a risk-based approach on reception. They were successful and in 2014 the prison rules were changed so that children are not automatically strip-searched on arrival.

In practice, however, there are concerns that too many children are still being strip-searched. Figures obtained by the Howard League under the Freedom of Information Act, show that there were 367 strip-searches of boys in young offender institutions. As one boy told the inquiry team 10 years ago: “Policy and what is done are two different things.”

In addition, there are particular concerns, highlighted by the prison inspectorate of boys being strip-searched under restraint before less intrusive methods had been exhausted (HMIP, 2015c).

The Howard League legal team continues to come across cases where children have been strip-searched inappropriately.

Conclusion

At a time of change, there is the opportunity to do something different. Children are being harmed in prisons today and steps to ensure their safety must be taken immediately. We know what works – as the Carlile Inquiry found 10 years ago, small, local units that have a record of success in providing the best care and rehabilitation for the few children who require a period in a secure environment. Prisons and the privately-run secure training centres should be closed down forthwith. We do not need to reinvent the wheel or repeat the mistakes of the past. Reform must focus efforts on getting the number of children in custody to an irreducible minimum.

The report of the Carlile Inquiry can be found at www.howardleague.org/publications/

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