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ADAM RICKWOOD BRIEFING

1. INTRODUCTION

1.1 14 year old Adam Rickwood is the youngest child to die in penal custody in the last 25 years. He was found hanging in his room in Hassockfield Secure Training Centre (STC) in County Durham on 9 August 2004 whilst on remand.

1.2 Adam's case reignites concerns over the treatment of children by the criminal justice system. His case has attracted substantial parliamentary and public disquiet and led for calls for a radical overhaul of the way the state treats child offenders.

1.3 The inquest into Adam's death will scrutinise:

- his placement in a secure training centre over 150 miles from his family;
- implementation of suicide prevention policies in Hassockfield and what action what action was taken to protect Adam given his age and known vulnerability to self harm;
- the use of restraint on Adam and its impact on his mental state;
- the monitoring of the use of restraint in Hassockfield;
- staff training in working with vulnerable children;
- the quality of the monitoring and inspection regime for STCs.

1.4 This briefing covers:

- a case summary;
- child deaths in custody and the use of restraint;
- what will happen at the inquest;
- details about INQUEST's call for a public inquiry into child deaths in custody.

2. CASE SUMMARY

2.1 14 year old Adam Rickwood was from Burnley, Lancashire. He was on remand and experiencing his first time in custody when he was placed at Hassockfield, 150 miles away from his family home. Adam had expressed his concerns about being in Hassockfield and how upset he was being so far away from his family in letters and phone calls to his mother Carole Pounder.

2.2 Adam's vulnerable state of mind was well known prior to his placement in Hassockfield and during his one month on remand before he died. Several hours prior to his death Adam was restrained by a custody officer using a 'nose distraction' technique. This is part of the pain compliance techniques which form part of Physical

Control in Care (PCC), the method of restraint used in STCs. Adam thought his nose had been broken and contacted his lawyer immediately.

2.3 Adam's death was investigated by the Prisons and Probation Ombudsman after a delay of over a year. The delay was due to the lack of agreed protocols within the Youth Justice Board (YJB) over responsibility for the investigation of deaths of children in STCs. This delay exacerbated the grief of the family as they received little information about how Adam had died.

2.5 STCs are privately-run children's prisons. They are contracted and monitored by the YJB on behalf of the Home Office to supply secure accommodation for children. Hassockfield STC opened in September 1999 and is in Medomsley, County Durham. It is run by Premier Training Services Ltd (SERCO).

2.6 The inquest into Adam's death will be presided over by HM Coroner Andrew Tweddle sitting with a jury. The inquest is scheduled to last for three weeks and will be the first time Adam's death will be subjected to public scrutiny. Evidence will be heard from amongst others: Adam's mother; the officers involved in the restraint; those responsible for the introduction of PCC; senior management of the YJB and of Hassockfield; medical experts; and other children held at Hassockfield when Adam died.

3. CHILD DEATHS IN CUSTODY AND THE USE OF RESTRAINT

3.1 Adam's death followed the restraint-related death of Gareth Myatt in April 2004 whose inquest will be reconvened on 25 June 2007 following an adjournment.[1]

3.2 It is well-documented that there are shockingly high levels of restraint used against children in STCs and Young Offender Institutions and pain compliance techniques are routinely used against children in the care of the state[2]. Lord Carlile, who conducted an inquiry into the use of restraint in Young Offender Instituions and STCs said:

> *My inquiry has considered 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…. 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.*[3]

3.3 At Adam Rickwood's inquest we hope that the following issues about the restraint of children will be scrutinised:

- the type and prevalence of physical restraint used against children in custody;

[1] For details see www.inquest.org.uk

[2] i) The Carlile Inquiry, Howard League for Penal Reform , 2006 ii) House of Lords debate on the treatment of children in custody since the Carlile report, Hansard, 29.01.07 iii) Annual report of HM Inspectorate of Prisons2005-2006 published on 30 January 2007.

[3] Carlile Inquiry op cit

- the appropriateness of the force used on Adam;
- how the type of the pain inflicting "nose distraction" technique used was originally approved and medically assessed;
- the monitoring, auditing and reviewing of PCC and if potential risks and injuries were identified;
- how the staff were trained in the use of restraint.

4. THE CALL FOR A PUBLIC INQUIRY

4.1 There have been 29 deaths of children in penal custody in England and Wales since 1990. There has never been a public inquiry following any of these deaths. Collectively they raise thematic issues that need to be addressed in a joined-up manner through a properly resourced inquiry so that appropriate recommendations are made to ensure that lessons are learned and safeguards put in place to protect the lives of children in the future. In 2005 INQUEST published the first detailed analysis of child deaths as *In The Care Of The State? Child Deaths in Penal Custody in England and Wales* by Barry Goldson and Deborah Coles.

4.2 INQUEST has been campaigning for a public inquiry into child deaths in custody since the death of 16 year old Joseph Scholes, a deeply disturbed young boy who hanged himself in his cell at Stoke Heath Young Offender Institution in Shropshire in 2002. Joseph's death raises serious questions about the ability of the state agencies to provide a safe environment to care for society's most vulnerable young offenders. His death also raises issues about the procedures for holding these agencies to account when they fail. In Joseph's case, the coroner who presided over the inquest into his death recommended a public inquiry, but this has been repeatedly turned down.

4.3 INQUEST's casework has highlighted that child deaths are too often linked to failings in the community, the inappropriate use of penal custody for vulnerable children, and inadequate treatment whilst in custody whereby the institutions are unable to care for the vulnerabilities of those that they detain.[4]

4.4 Since the launch of the campaign in November 2003, backing for the public inquiry into Joseph's death has snowballed, with key children's charities, penal reform groups, leading members of the legal establishment, peers and MPs supporting the call. More than 100 MPs signed an EDM (1423) in support of the call, and a second EDM (2410) tabled by the Scholes family MP Chris Ruane has received renewed support. Child deaths in custody have been debated extensively in parliament, most recently during the debate on the Corporate Manslaughter Bill 2006-07 in the House of Lords.

5. About INQUEST

5.1 INQUEST has worked with the family of Adam Rickwood since his tragic death in August 2004. We are working with the family lawyers Mark Scott from Bhatt Murphy solicitors and Richard Hermer from Doughty Street Chambers. Both are

[4] 'Why are Children dying In Custody' – available from www.inquest.org.uk

members the INQUEST Lawyers Group and have extensive experience in representing families of those who have died in custody.

5.2 INQUEST is the only charity in England and Wales that provides an in depth casework service directly to the families and friends of those who die in custody. This includes deaths at the hands of state agents and in all forms of custody; police, prison, young offender institutions, secure training centres and immigration detention centres. It also provides a free, confidential advice service to all families who go through the inquest process including those families whose relatives have died at work or following major disasters.

5.3 Through its casework over the last 25 years, INQUEST has a unique overview of how the inquest system operates from the perspective of bereaved families and their advisors. The casework service informs research, parliamentary and policy work and the organisation is widely consulted by government ministers and departments, MPs, lawyers, academics, policy makers, the media and the general public.

INQUEST
April 2007