



THE GOVERNMENT'S RESPONSE TO CORONERS' RECOMMENDATIONS FOLLOWING THE INQUESTS OF GARETH MYATT AND ADAM RICKWOOD

Introduction:

Gareth Myatt, aged 15, died in hospital on 19 April 2004, following a restraint incident at Rainsbrook secure training centre. Gareth's death revealed a number of shortcomings in relation to Physical Control in Care (PCC), the approved method of restraint in secure training centres and wider safeguarding issues were highlighted at the inquest into his death. Several months afterwards, on 9 August 2004, Adam Rickwood, aged 14, committed suicide at Hassockfield secure training centre. The jury at the inquest into Adam's death found that a restraint incident some hours before Adam's death had not contributed to it and that staff at Hassockfield had behaved appropriately throughout the time he was at the centre - but it was a clearly a distressing incident for Adam. A number of safeguarding issues arose from the inquest and the coroner made a number of recommendations.

The Government takes the welfare of young people in custody very seriously. We promised a full response setting out how we have addressed or are addressing the issues raised. We have also listened to the views of stakeholders who have contributed to the subsequent debate on restraint. This Action Plan represents the Government's response to those recommendations and shows the progress that has been made against each of them. It is a live document that demonstrates the volume of work being done to enhance safeguarding and child protection in the under-18 estate. We still have further to go before we achieve all that we have set out to do, but we believe good progress has been made in a number of areas to ensure that similar tragedies in custody are prevented wherever possible.

Inquest into the Death of Adam Rickwood: Recommendations Made by Coroner and Government Response:

Source	Coroner's Recommendation:	Work Completed	Work Outstanding	Timescale for Meeting Recommendation
Coroner Rule 43 Letter Action 1	With regard to trainees transfer request forms from one establishment to another there needs to be a clearly defined protocol to identify whose responsibility it is to send what information and when to the transfer team at the Youth Justice Board.	The Youth Justice Board has always had a protocol and guidance in place setting out the process that should be followed in making a transfer request. The protocol and supporting forms have been reviewed and updated. Transfer requests can be completed by the YOT and/or the establishment but in either case the applicant must provide supporting evidence. The revised form places greater emphasis on risk. Information is required on the urgency of the transfer request; whether there is a risk to the young person or others; and what the nature of that risk is.	Guidance supporting the revised form is currently being developed.	Revised protocol, forms and guidance will be issued by March 2008
Coroner Rule 43 Letter Action 2	I would encourage a regular audit of information sent by Youth Offending Teams to the Youth Justice Board to ensure that sufficient and adequate information is being provided to ensure that young people are allocated to the most suitable institution.		The Youth Justice Board's Wiring Up Youth Justice programme has developed an Electronic Yellow Envelope (EYE) system whereby documentation can be transferred between YOTs and the secure estate via the Youth Justice Board placements team. The system is	100% rollout of EYE by end March 2008

			<p>currently being rolled out region by region. A key feature of “EYE” is the ability to identify where information received from YOTs is incomplete.</p> <p>It is the responsibility of local authorities to ensure the information produced by the YOT is of a sufficient quality. Therefore any audit of the quality of the information rests with the local authority.</p>	
Coroner Rule 43 Letter Action 3	There needs to be clear training to ensure adherence to procedures and protocols affecting young people who may be subject to a Court Ordered Secure Remand (COSR)	Since before the time of Adam’s death the Youth Justice Board has had a protocol in place with local authorities in relation to COSRs. Lancashire is a signatory of this protocol. By signing the protocol local authorities are committed to ensuring that their staff are trained in procedures and protocols in relation to COSRs. The Youth Justice Board is working with DCSF regarding issuing guidance to local authorities in this area.	The COSR protocol is currently being revised by the Youth Justice Board. There is a specific requirement contained within the new protocol requiring local authorities to ensure staff are properly trained.	Youth Justice Board plan to issue revised COSR protocol by April 2008
Coroner Rule 43 Letter Action 4	I would hope that a review could be undertaken to enable consideration to be given as to whether there should be more than one level of response – perhaps a two tier response- to what is presently known as first response as there has been evidence provided at the inquest that a first	The Youth Justice Board issued a Behaviour Management Code of Practice to all secure establishments in February 2006 which emphasises the need for de-escalation and to avoid practice that may result in the use of restraint being seen as	The Youth Justice Board is regularly monitoring establishments’ compliance with the Code of Practice. The Youth Justice Board is funding an evaluation of the TCI pilot. On completion of this	Audit ongoing TCI Evaluation: September 2008

	response can be seen as an almost inevitable step towards PCC which may hamper the proper deployment of de-escalation techniques with the young person in question.	inevitable. In addition the Youth Justice Board is currently piloting a set of de-escalation techniques called Therapeutic Crisis Intervention (TCI) at Hassockfield STC.	evaluation the Youth Justice Board will disseminate findings and promote emerging practice in this area.	
Coroner Rule 43 Letter Action 5	The evidence clearly indicated that there was confusion between PCC instructors, PCC trainers and Care Officers with regard to PCC its application and the reasons therefore and when if ever guidance in the appropriate manuals could be disregarded.	There was evidence of confusion at the inquest. Consequently, Ellie Roy wrote to STCs in July 2007 to clarify the circumstances in which PCC could be used. The Ministry of Justice took action to align the STC Rules with the duties imposed in the Act, in order to clarify the legal position, through laying a statutory instrument in Parliament. Following the STC rule change a further letter was sent by Ellie Roy to all STCs.	The Prison Service continually updates the PCC manual. The PCC Management Board discussed revision of the manual at its February meeting. It was agreed that complete revision needed to await the findings of the Joint Review of Restraint. As the manual is for the use of instructors, it would not be suitable for distribution to all staff; but custody officers should have written guidance, particularly on the medical risks associated with restraint. The Board is advising Ministers on action to prepare suitable guidance.	Advice to Ministers March: 2008
Coroner Rule 43 Letter Action 6	The Youth Justice Board monitor should be fully aware of all documents and statistics produced from an establishment with the detailed reporting procedures in place to ensure that all relevant information from all STCs is centrally monitored and assessed so the whole STC system and similar institutions may benefit.	The Youth Justice Board currently monitors the performance of STCs and as appropriate uses available levers to improve the performance and practice of STC contractors. Monitors seek to have a good understanding of the performance and practice in a STC in order that they are aware of all relevant information. In part this is achieved by reviewing	The Youth Justice Board is further developing its monitoring and contract / SLA management function. The development recognises that: "the role of monitoring will be to provide assurance that the provider has effective systems in place to achieve the Youth Justice Board's requirements and to provide	Project is being implemented incrementally with a planned completion date of June 2009. This is the earliest practicable date that this could be achieved by.

		documents and statistics produced by the establishment as well as meeting staff and young people, visiting house units, etc. The STC's management has a statutory and contractual responsibility to properly manage its centre and the monitoring processes are designed to provide assurance that this is being achieved.	<p>feedback to the Youth Justice Board when those are not operating properly".</p> <p>As a result of this development the Youth Justice Board will:</p> <ul style="list-style-type: none"> • revise what information providers are required to provide to the YJB • in relation to STCs, document the processes the monitors should follow to satisfy their obligations under the Criminal Justice and Public Order Act 1994 and the STC Rules • enhance its management of issues so that issues identified (including those from monitors) are adequately recorded and managed with a view to securing improvement in the performance of providers <p>operate its contract management and monitoring function within an ISO9000 accredited environment to give assurance that it is being appropriately managed.</p>	
Coroner	Some staff members could not remember	Providers must regularly review all	Hassockfield is currently in	STC and SCH site

<p>Rule 43 Letter Action 7</p>	<p>being trained in matters of self harm/suicide awareness and if they could not remember being trained it is doubtful that they could remember what their training did or ought to have included. Accordingly, it may well be of benefit to all staff employed in STCs for a review to be carried out of training within centres particularly in matters of suicide prevention/self harm.</p>	<p>aspects of the training delivered to staff working with children and young people. The training programme, which includes training on self harm and suicide awareness, was reviewed and updated at Hassockfield in 2005.</p>	<p>negotiation with external agencies and trainers to deliver the refresher training during 2008 and they are working with Newcastle College to get their Initial Training Course (ITC), which all staff working with young people in the centre must pass, externally accredited via the Open College Network.</p> <p>The Youth Justice Board is currently carrying out a review of safeguarding with a team of experts from the National Children's Bureau. The Youth Justice Board will be submitting recommendations arising from the review to Ministers during the Spring.</p>	<p>visits completed in December 2007</p> <p>Safeguarding Review to submit recommendations to Ministers: Spring 2008</p>
<p>Coroner Rule 43 Letter Action 8</p>	<p>The evidence at the hearing showed deficiencies in the CCTV system, the morse watchman system and the handheld videos of restraints and therefore there should be clear management responsibility for ensuring the correct use of such technology, that it is funded adequately thus providing a significant benefit from protection for trainees and staff alike.</p>	<p>In 2005 the analogue video recording system at Hassockfield was replaced with a digital system. There is an effective monitoring system in place which allows managers to access high quality, live footage from a range of sites across the Centre. There is also a system in place to ensure that all necessary equipment is in good working order. In addition, Ofsted carry out two inspections per year on each STC and the physical environment is considered during such inspections.</p>		<p>Achieved</p>

Coroner Rule 43 Letter Action 9	The evidence indicated certain system deficiencies with regard to handover procedures and therefore I believe that it would be of benefit for there to be clearly defined handover procedures to ensure that important and relevant information about trainees was handed over from one shift to another.	Since Adam's death, Hassockfield has introduced a new Director's Rule for staff briefings and handover meetings. All staff are briefed when they come on shift. The attendance at meetings is logged in order to ensure relevant information has been communicated to everyone. The briefings cover information on admissions, discharges, mobility and movements as well as an update on young people who are subject to High Risk Assessment Team (HRAT) procedures and information around the initiation or review of Individual Crisis Management Plans (ICMP). Operational information, particularly around behaviour management, is passed on and reinforced. Following the briefing, operational staff are required to review any new ICMPs or Behaviour Management Plans in detail.	The Youth Justice Board will use the STC Directors Forum, and also encourage the use of the Directory of Emerging Practice, to disseminate emerging practice in this area.	Achieved
Coroner Rule 43 Letter Action 10	An urgent review should be undertaken to clarify the interrelationship between the Criminal Justice and Public Order Act 1994 (s9), the STC Rules issued thereunder and the Directors Rules to avoid any confusion whatsoever. It must be seen as essential that there must be no ambiguity in anyone's mind, young person, staff, management or those in the Youth Justice	The STC Rules were amended by Parliament in response to this recommendation in July 2007.		Achieved

	Board or indeed Government as to when the use of restraint or force to maintain good order and discipline or for compliance reasons is authorised.			
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Inquest into the Death of Gareth Myatt: Recommendations Made by Coroner and Government Response:

Source	Coroner's Recommendation:	Work Completed	Work Outstanding	Timescale for Meeting Recommendation
<p>Coroner Rule 43 Action 1</p>	<p>A system should be established to inform the staff coming on duty as fully as possible about the newly arrived trainees whom they will be dealing with. It is unsatisfactory that staff pick up the information piecemeal, for example by what they might be told by other staff handing over to them, or by using such information as might be available in their unit within files.</p>	<p>There is a robust system in place at Rainsbrook that ensures staff coming on duty have as much information as possible about the newly arrived trainees. The management of Rainsbrook operate a regular compliance audit of the system. There is a handover period where shifts change which ensures that staff leaving the centre have time to brief staff beginning their shift.</p>	<p>The Youth Justice Board will use the STC Directors Forum, and also encourage the use of the Directory of Emerging Practice, to disseminate emerging practice in this area.</p>	<p>Achieved</p>
<p>Coroner Rule 43 Action 2</p>	<p>Every Statutory Incident Report involving the use of PCC should contain full details of what happened, statements by those involved, any injury to a trainee or to staff, reasons for the use of PCC and reasons why other means of dealing with the situation were not used or had proved unsuccessful. Such Reports must also include a statement by the trainee, in their own hand where possible, and the form should provide the opportunity for a trainee to report any injury. Up to the time of Gareth's death there was no input from the child into this</p>	<p>A significant number of young people that are placed in any secure establishment have low literacy and numeracy skills. Many cannot read or write on admission. In addition, for a number of young people English is not their first language. On that basis, a system which relies heavily on the young person writing on a form may not be the best way to ensure that the experience of a young person is recorded. Rainsbrook has adopted Restorative Justice Interventions (RJI) which are undertaken following every</p>	<p>The Youth Justice Board will disseminate this as an example of emerging practice in the secure estate.</p>	<p>March 2008</p>

	<p>Reporting system. The new Reports should include a facility for both staff and trainees to conclude what lessons they had learned from the incident and how PCC might be avoided on a future occasion. The need for the trainees account, allied to the matters as to “complaints” under Action 3... came to be referred to during the inquest as “listening to the voice of the child”, The phrase is a telling one, and one that ought to be borne in mind by everyone at all times.</p>	<p>physical intervention with the young person. This process enables staff to review the incident with the young person to consider what happened and why, what can be learnt from this incident and then an action plan is devised to prevent further incidents occurring. This action plan is then reviewed by a Residential Service Manager with the young person to consider its effectiveness and future coping strategies for dealing with conflict. This process ensures the young person’s voice and view of what happened is taken into account.</p>		
<p>Coroner Rule 43 Action 3</p>	<p>Where any complaint by a trainee is being investigated it is essential to talk to the trainee. It is not adequate simply to proceed only on the basis of what the trainee has put in writing and then interview only the staff. The practice should be adopted, whoever is investigating the complaint that the trainee is spoken to, not only in the initial stages, but during the course of the investigation and after the investigation as well.</p>	<p>The Rainsbrook complaint system has been updated since 2004. A database compiled by their Information Officers documents the process. The Complaints database is audited not only by the Youth Justice Board monitor and the Independent Advocacy Service (Voice) but also by OFSTED who examine these on each inspection. All complaints are recorded and dated in the Complaints Register (electronically and hard copy), by the Information Officer. Young people can consult with Voice advocates (who visit on a weekly basis) regarding Rainsbrook’s complaint procedure. The procedures allow for an appeal to the monitor if the complaint cannot be resolved.</p>	<p>The Youth Justice Board will carry out a review of the complaints system in STCs during 2008-09. The coroner’s recommendations will be included in this review. The review will also consider the future role of the Prisons and Probation Ombudsman in dealing with STC complaints.</p>	<p>Review of Complaints, 2008-09</p>

<p>Coroner Rule 43 Action 4</p>	<p>There must be a clear policy developed by the relevant Ministries, the Youth Justice Board, in fact all those involved, as to the circumstances in which matters such as complaints by a trainee and/or injuries to a trainee are referred to the Local Safeguarding Children Board, and/or to other local Children's Services and/or to the police or any other outside body.</p>	<p>The Youth Justice Board has addressed this as part of its contribution to the development of "Working Together to Safeguard Children" (HM Government 2006) which sets out a framework for how concerns about children's welfare, and allegations of abuse against those who work with children, should be handled. STC Directors are now statutory members of Local Safeguarding Children Boards, which are required to develop local policies and procedures, compatible with national legislation and guidance, covering matters such as thresholds for referral and the handling of allegations.</p>	<p>Where child protection issues are concerned, either through a complaint or some other route, Youth Justice Board will develop guidance for Youth Justice Board monitors on child protection procedures in the context of Working Together (WT) (2006). The Youth Justice Board will also remind STCs of the relevant provisions of WT and section 11 of the Children Act 2004. Finally Youth Justice Board will participate in DCSF's planned research into section 11 compliance by ensuring relevant questions are included for response by STC directors. Complaints not relating to child protection do not in general require referral to children's social care although referrals may be needed for other reasons.</p>	<p>Youth Justice Board Guidance for Monitors: June 2008</p>
<p>Coroner Rule 43 Action 5</p>	<p>In addition, there must be a clear protocol as to what action should be taken and by whom when a complaint is made by a trainee, or after a decision has been taken to refer injuries or any other matter to an outside body. In particular there should be a clear protocol as to the circumstances, if any, in which it might be appropriate to ask</p>	<p>Rainsbrook refer to the Local Authority Designated Officer (LADO) any child protection allegation, as do other STCs. The referral includes all documentation relating to the allegation including: the relevant incident report, secured videotape, if applicable, and the body map completed by healthcare following any physical intervention. It is the role</p>	<p>The Youth Justice Board will carry out a review of the complaints system in STCs during 2008/09. The coroner's recommendations will be included in this review. The review will also consider the future role of the Prisons and Probation Ombudsman in dealing with STC complaints.</p>	

	<p>the STC itself to investigate any matter. The reasons for a withdrawal of a complaint need careful investigation by outside bodies.</p>	<p>of local authorities to investigate any child protection concerns arising in their area.</p> <p>Since 2004 the Youth Justice Board has funded advocacy services in all STCs. One of the roles of the advocate is to help support the young person in pursuing any complaint he or she may have.</p>		
<p>Coroner Rule 43 Action 6</p>	<p>The Children’s Commissioner, the National Children’s Bureau and child advocacy services should be asked to assist with the formulation of appropriate protocols and actions as to the matters raised in Actions 3, 4 and 5.</p>	<p>It is the Youth Justice Board 's practice to seek the views and contributions of stakeholders, and the Youth Justice Board would wish to consult with these and other relevant organisations in relation to the formulation of appropriate protocols.</p> <p>The investigation of child protection concerns is a matter for local authorities, based upon the guidelines contained within “Working Together to Safeguard Children” (DfES 2006). The guidance was issued by DfES following an extensive consultation process involving key stakeholders.</p>		<p>Achieved</p>
<p>Coroner Rule 43 Action 7</p>	<p>The Ministry of Justice and the Youth Justice Board must publicly clarify where responsibility for the system of PCC and its permitted use lies.</p>	<p>The responsibility for PCC in STCs lies with the Secretary of State. The newly formed PCC Management Board advises Ministers on these matters. The Board met on 5 November and 25 February. Its terms of reference are:</p>		

		<ul style="list-style-type: none"> • to oversee and assure the process for the application of PCC techniques, including ensuring that regular reviews of PCC are undertaken and recommendations implemented. • to ensure that training is conducted to appropriate standards. • to ensure that the PCC manual is regularly reviewed and that it reflects up-to-date medical information and is made available to all custody officers. • to receive data on current use of PCC, its trends and exceptions and share knowledge with all relevant partners, drawing attention to areas of concern where necessary. • to ensure that information on restraint methods is shared with other organisations that use PCC restraint. • to consider submissions from medical panels on latest developments/research into restraint methods and their impact on PCC guidance and 		
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		<p>training</p> <ul style="list-style-type: none"> to advise Ministers on any other PCC issues <p>The role of the Youth Justice Board is primarily to commission services. In undertaking its contract management and monitoring role it supports the Secretary of State in achieving compliance with the regulatory framework.</p>		
Coroner Rule 43 Action 8	<p>All those responsible for PCC must clearly state publicly the range of circumstances in which PCC can be used, whether there are immediate amendments to the STC rules or not. Those responsible must also constantly consider whether or not PCC is being used too frequently, or is being used inappropriately, for example as a “default” system in the way I have already outlined.</p>	<p>Parliament has amended the STC Rules to ensure there is clarity as to when restraint can and cannot be used in STCs. It is the responsibility of the STC operators to ensure that the use of PCC is within the law. The Youth Justice Board has a responsibility to ensure STCs have appropriate and effective systems in place. To that end Ellie Roy wrote to STC Directors in July and September 2007. Operators must ensure that staff are fully trained and equipped with the skills required to assess situations and make informed decisions on the appropriate use of restraint.</p>	<p>The Youth Justice Board’s aim is to reduce the use of restraint in the secure estate for children and young people. The Code of Practice on Behaviour Management outlines the principles establishments should work towards in order to develop systems of managing behaviour which minimise the use of restraint. Full implementation of the Code of Practice aims to achieve this across the secure estate.</p>	
Coroner Rule 43 Action 9	<p>Whatever decision is made by Parliament as to the circumstances in which PCC can be used, there must be full and careful teaching given to staff as to the meaning and full implications of</p>	<p>The STC contracts and legislation require staff to be properly trained. Staff must undergo annual refresher training in PCC. At Rainsbrook they operate an enhanced training</p>	<p>There will be ongoing monitoring of the delivery of PCC training at STCs. The PCC Management Board discussed methods of training staff in the use of PCC at</p>	

	<p>the STC Rules. Staff and trainees need very clear guidelines as to the day-to-day interpretation of the STC rules and the circumstances in which physical restraint is and is not allowed.</p>	<p>programme where staff are refreshed in all aspects of PCC on a six-monthly basis.</p>	<p>its February meeting and the Youth Justice Board, the Prison Service, the Northern Ireland Office and the Borders and Immigration Agency are currently working together to take forward matters considered by the Board. Further strategic consideration of training issues will be needed when the independent review of restraint has reported. The delivery of training and monitoring will be linked to the agreed arrangements.</p>	
<p>Coroner Rule 43 Action 10</p>	<p>Quite separate from any “joint review” on restraints there should be an immediate, urgent and complete Review by both the Ministry of Justice and the Youth Justice Board of all techniques of physical restraint and control within PCC, such review to include a review of the medical safety of each and every one of those techniques. It became apparent during the inquest that some holds authorised within PCC, for example the double basket hold, continue in use notwithstanding the conclusions of Dr Bleetman and Mr Boatman that they are dangerous. I understand that the use of such holds has been reviewed and that their use is subject to extra advice given by Mr Bleetman. The continued use of</p>	<p>The Youth Justice Board has secured the ongoing services of a medical expert to review the exception incident reports it receives from all secure establishments. As a result of this the Youth Justice Board communicated updated medical advice to STCs in September 2007. Separately from the independent review on restraint, an expert PCC medical review panel met on 2 November 2007 to review the safety of all PCC holds and make recommendations. In response to some concerns expressed by the panel, Ministers decided to suspend the use of the double basket hold and the nose distraction technique, pending final recommendations from</p>	<p>Medical Panel’s recommendations to Ministers: March 2008.</p>	

	<p>such holds needs immediate review. The review should also consider other possible means of restraint. Before any such review is acted on, or authorisation is sought from Parliament for amendments to the STC Rules, the views of the Children's commissioner, the National Children's Bureau and Local Safeguarding Children Boards should be sought. The most up to date information available from the Forum for Preventing Deaths In custody on restraint should also be obtained.</p>	<p>the panel. A member of the Forum for Prevention of Deaths in Custody and advisor to the Prison Service has been invited to sit on the PCC Medical Panel.</p>		
<p>Coroner Rule 43 Action 11</p>	<p>The panel conducting that review suggested at Action 10 should include experts not only in the fields represented on earlier Panels but also in the relevant medical disciplines, for example a Pathologist or other consultant with specific expertise in respiratory matters. In addition there needs to be an expert on restraint asphyxia.</p>	<p>Dr Nat Carey, a pathologist, is a member of the PCC Medical Panel. The Youth Justice Board has also invited a member of the Forum for the Prevention of Deaths in Custody and advisor to the Prison Service to join the PCC Medical Review Panel.</p>		<p>Achieved</p>
<p>Coroner Rule 43 Action 12</p>	<p>Further consideration should be given by the Ministry of Justice and the Youth Justice Board to implementing the teaching of PCC at national level by national instructors. This would be the best possible system.</p>	<p>We accept the need for consistency in the training delivered. There are different ways in which this can be achieved.</p>	<p>The PCC Management Board discussed methods of training staff in the use of PCC at its February meeting and the Youth Justice Board, the Prison Service, the Northern Ireland Office and the Borders and Immigration Agency are currently working together to take forward matters considered by the Board. Further strategic consideration of training</p>	

			issues will be needed when the independent review of restraint has reported.	
Coroner Rule 43 Action 13	The resources at the Prison Service Training Centre at Kidlington (and elsewhere if relevant) should be reviewed, along with the system of training the National Instructors themselves, so as to ensure that all those at the highest level are familiar with developments in techniques and in medical knowledge of Positional Asphyxia at the relevant time.	The Youth Justice Board has asked the Prison Service Training Centre at Kidlington to review their training resources to support their role in the delivery of PCC training.	The required resource level at Kidlington can only be finally determined when all issues relating to the training model have been resolved. The PCC Management Board discussed methods of training staff in the use of PCC at its February meeting and the Youth Justice Board, the Prison Service, the Northern Ireland Office and the Borders and Immigration Agency are currently working together to take forward matters considered by the Board. Further strategic consideration of training issues will be needed when the independent review of restraint has reported.	Ongoing
Coroner Rule 43 Action 14	In the event that teaching continues to be “cascaded down”, so that teaching continues to be carried out by STC staff at STC level, then as a bare minimum there needs to be nationally based supervision and inspection of such teaching, by the Ministry of Justice.	The Youth Justice Board is currently discussing with the prison service the monitoring and evaluation of training to ensure consistency.	See action 13, above	
Coroner Rule 43 Action 15	Particular attention should be paid, during training, to the theory and practice as to “medical aspects” arising from the use of PCC, with full discussion of those aspects. There should be distinct	The Youth Justice Board wrote to all STCs in October 2004 detailing the medical advice received by Dr Bleetman. A further letter was written in March 2007 reminding STCs of Dr	See action 13, above. It was agreed that custody officers should have written guidance on the medical risks associated with restraint. The Board is advising	

	<p>“lesson plans” within the teaching to minimise any tendency for the teaching to be diluted by the “cascading down” process.</p>	<p>Bleetman’s medical advice and their responsibility to ensure that their staff are aware of this advice. Additional medical advice in relation to PCC was communicated to STCs in September 2007.</p> <p>All the medical advice the Youth Justice Board received in relation to PCC was communicated to PCC trainers at the Prison Service in Kidlington to ensure that the training they delivered reflected the latest medical advice.</p>	<p>Ministers on action to prepare suitable guidance.</p>	
<p>Coroner Rule 43 Action 16</p>	<p>The present PCC manual should be reviewed immediately and regularly thereafter, so as to ensure that it contains the most up to date medical information.</p>	<p>The PCC manual was reviewed and re-issued by the Prison Service following the 2005 review of PCC. This was followed by staff training based on the new manual.</p> <p>The review of the manual is part of a cycle which involves: the recommendations of the PCC panel being approved by the Secretary of State; the revision of the manual to take into account all amendments; the delivery of new training to all staff; the effect of the training being implemented in day to day practice; a sustained period of implementation of the new procedures in order to gather information to enable a future panel to evaluate the effectiveness of the new system.</p>	<p>The Prison Service continually updates the PCC manual. The Manual will be further revised in the light of the findings of the review of restraint.</p>	
<p>Coroner</p>	<p>The PCC manual (or a simplified but</p>	<p>The PCC Management Board</p>	<p>The Board is advising Ministers on</p>	<p>Advice to Ministers:</p>

Rule 43 Action 17	adequate version of it, particularly with regard to medical safety) should be provided to all those staff in STCs who are empowered to use PCC. Such a document should also be provided to all those with monitoring responsibilities.	discussed revision of the PCC manual at its February meeting. It was agreed that revision needed to await the findings of the Joint Review of Restraint. As the manual was for the use of instructors, it would not be suitable for distribution to all staff but custody officers should have written guidance, particularly on the medical risks associated with restraint.	action to prepare suitable guidance.	March 2008
Coroner Rule 43 Action 18	There should be an immediate and thorough review by the Ministry of Justice of its own system of monitoring the Youth Justice Board. The Ministry must satisfy itself that the Youth Justice Board adequately fulfils its duty to provide a safe environment at STCs. The Ministry of Justice will need to devise systems whereby it can say that its own monitoring of the Youth Justice Board is satisfactory. Only by such means can the Ministry properly say whether or not the Youth Justice Board is in fact providing the safest possible environment for trainees and therefore whether or not the Youth Justice Board is, with regard to the safety of trainees, "fit for purpose".	The Ministry of Justice and Department for Children, Schools and Families, which are jointly responsible for the YJB, are due to conduct a periodic review of the Youth Justice Board in 2008. There are regular meetings between Ministers and the Youth Justice Board and day-to-day contact between the YJB and officials in the Joint Youth Justice Unit. The PCC Management Board, which is chaired by DCSF and MoJ Ministers, oversees the actions of Youth Justice Board and other stakeholders in monitoring the use of PCC in STCs and ensures that safeguarding procedures with regard to restraint are in place. Any safeguarding issues in STCs are considered by the Board, which can institute any necessary further action.		
Coroner Rule 43 Action	There should also be an immediate and thorough review by the Ministry of Justice and the Youth Justice Board of	Since 2004 the Youth Justice Board has significantly changed its monitoring of secure establishments. It has	The Youth Justice Board will seek ISO 9000 accreditation for its monitoring activity to ensure there	December 2008

19	<p>the Youth Justice Board's monitoring systems. Such a review should also establish systems to ensure that there is "qualitative analysis" of information gathered by monitoring. It is essential to assess not only the accuracy of information gathered but also the implications arising from that information. The issues arising from the monitoring go way beyond the simple issue of testing whether or not the "contract" between the Youth Justice Board and Rebound is being complied with. The review of monitoring systems should be geared to answer these questions: Is the information obtained through the monitoring system full and accurate? Is that information obtained through the monitoring system full and accurate? Is the monitoring system actually helping us to provide the safest possible environment for trainees and thereby making us, with regard to the safety of trainees "fit for purpose"?</p>	<p>developed a framework for monitoring known as the Effective Regimes Monitoring Framework (ERMF) which ensures consistent qualitative analysis of performance in the secure estate.</p> <p>This was followed in 2006 by a fundamental review of all of the Youth Justice Board's monitoring activities. This resulted in a major re-organisation of the Youth Justice Board's contract management and monitoring function. Where monitors raise concerns there are now clear processes and accountability for the identification, escalation and resolution of issues.</p>	<p>is independent validation of its monitoring systems</p>	
Coroner Rule 43 Action 20	<p>I repeat the matters set out at Actions 3, 4 and 5 above as to complaints by trainees and the referral of matters to outside bodies as being relevant items which there is a need for review once monitoring systems have been set up.</p>	<p>See responses to Action 3, 4 and 5 above.</p>		
Coroner Rule 43 Action	<p>In conjunction with the reviews already suggested, the Youth Justice Board's system of monitoring based mainly on a</p>	<p>The review of monitoring has resulted in the development of a risk-led monitoring approach which allows the Youth</p>	<p>The Youth Justice Board will evaluate the effectiveness of the new monitoring regime and</p>	

21	single resident monitor should be looked at immediately. At the very least there should be more central oversight of monitoring and more on-site visits by the Youth Justice Board Regional Manager and, indeed, by those higher up the Youth Justice Board. The use of more than one monitor may be appropriate and further consideration should be given to the use of “teams of specialist monitors”. Similar considerations apply to Rebound.	Justice Board to allocate resources to areas where it has most concerns. A key element of the revised monitoring arrangements is focused thematic reviews of areas of concern in establishments. In addition, the Youth Justice Board continues to ensure that the statutory role of the STC monitor is complied with. There is a regular programme of visits by senior officials at the Youth Justice Board to STCs and these will continue in the future.	amend the system where necessary.	
Coroner Rule 43 Action 22	There should be an immediate review by the Ministry of Justice, the Youth Justice Board and Rebound of Rebound's monitoring systems. Again this review should be geared to ensuring that the monitoring system answers these questions: Is the information obtained full and accurate? Is that information telling us what is really going on? Is the monitoring system actually helping us to provide the safest possible environment for trainees, and thereby making us, with regard to the safety of trainees, “fit for purpose”?	The Youth Justice Board's new monitoring approach which focuses on monitoring the systems that are in place in secure establishments enables it to have assurance of Rebound's internal monitoring systems. Bi-annual inspections carried out by OFSTED also examine the management of the centre.	As the monitoring systems are refined following evaluation, assurance levels should increase.	
Coroner Rule 43 Action 23	The new monitoring system must include proper study and analysis of the Incident Reports, so that the actual techniques used during PCC can be monitored and so that the reason why PCC was used can be monitored. That will also give rise to finding out why alternative	STCs are the primary reviewer of incident reports as responsibility for the operation of the centre lies with the provider. The Youth Justice Board has identified an important example of emerging practice taking place at Hassockfield STC. Hassockfield hold a	The Youth Justice Board will disseminate this emerging practice to other STCs through the STC Directors Forum.	

	strategies had not been used or had not worked.	monthly Critical Incident Review Panel where Hassockfield management and representatives of the police service, social services and other local agencies review the incidents that have occurred in the establishment over the previous month. Multi-agency advice is also sought in the development of practice and policy in this area.		
Coroner Rule 43 Action 24	Reports of any injuries caused during PCC, or reports of any breathing difficulties or vomiting, need the most careful scrutiny and analysis by the Ministry of Justice, the Youth Justice Board and by Rebound. Any such Reports need consideration at the highest level and must be regularly included in Reports to Ministers and to Parliament.	The Youth Justice Board set up a system of exception reporting in February 2006 where any incidents resulting in difficulty breathing, vomiting etc are reported directly to the centre of the Youth Justice Board. The Youth Justice Board has established ongoing medical advice to assist in the review of exception reports arising from restraints as they are received. This information is included in quarterly reports to Ministers. In addition, it will be considered by the PCC Management Board and shared with STC Directors and Prison Service instructors at Kidlington. The information was also provided to the PCC Review Panel when it met on 2 November 2007.		
Coroner Rule 43 Action 25	The Youth Justice Board and the Forum of STC Directors should develop a clear system of "best practices" as to Behaviour Management. These "best practices" should relate particularly to the	The current review of compliance with the Code of Practice on Behaviour Management will identify examples of emerging practice.	The Youth Justice Board intends to disseminate emerging practice among establishments.	June 2008

	<p>need for and the avoidance of the need for the use of PCC. “Best Practices” and their teaching and adoption will avoid PCC becoming the easy “default” system for resolving difficult behaviour. Consideration should be given to extending information sharing as to such “good practice” across the juvenile “secure estate”.</p>			
<p>Coroner Rule 43 Action 26</p>	<p>Continuing urgent consideration needs to be given to strategies that avoid the need for segregation (also referred to as “single separation”) that avoid the need for the removal of “risk assessed items” from trainees rooms and that avoid, so far as is possible the use of any physical intervention against the trainee.</p>	<p>The Youth Justice Board has asked all centres to review their practice in relation to the use of segregation. The centres have a clear policy on the use of segregation with escalating levels of approval required depending on the time the young person is segregated. For example a segregation period of 15 minutes requires the authorisation of a Training Supervisor whereas a period in excess of 30 minutes requires authorisation of the Duty Director. In the STC Rules the use of removal from association has an upper limit of three hours in a twenty four hour period. This is a very stringent limit compared to other sectors of the secure estate for children and young people.</p>	<p>The Youth Justice Board is developing a project to review single separation and segregation across the secure estate. In particular work will look at definitions of segregation, since recording practice varies. This recommendation will be considered as part of the wider review.</p>	<p>June 2008</p>
<p>Coroner Rule 43 Action 27</p>	<p>“Best Practice” guidance and teaching should be given by the YJB and Rebound to staff at STCs on a regular basis.</p>	<p>The Youth Justice Board has a web-based directory of emerging practice where all youth justice practitioners are encouraged to submit examples of emerging practice.</p>	<p>The Youth Justice Board will consider the most appropriate way to disseminate emerging practice at a local, regional and national level.</p>	

		In addition the Youth Justice Board also runs frequent national, regional and local events to share emerging practice and research developments.		
Coroner Rule 43 Action 28	Consideration should be given to “separating” trainees into a room other than their own room, e.g. to a cooling down room. This would avoid the need for removing “risk assessed” items from a trainees own room. CCTV could be used in such rooms; this would protect both staff and trainees. It also avoids problems of having CCTV in trainees own rooms.	The Youth Justice Board has asked all centres to review their practice in relation to the use of segregation. This would include the use of ‘cool-down rooms’.	The Youth Justice Board is developing a project to review single separation and segregation across the secure estate. In particular work will be done to look at definitions of segregation since recording practice varies. For example the use of a ‘cool-down’ room would be classified as segregation in some establishments and is often considered as less desirable than allowing a young person to go to their room since the surroundings are unfamiliar to the young person and may viewed as a form of punishment.	June 2008
Coroner Rule 43 Action 29	The Children’s Commissioner and the Local Safeguarding Children’s Boards should be involved in the process of developing “good practice” so as to ensure that “outside” views of what is “good practice” is taken into account”.	The Youth Justice Board has an ongoing programme of developing regimes and practice across the secure estate. It is normal practice to seek the views and contributions of the appropriate experts. The Youth Justice Board is in ongoing discussion with the Children’s Commissioner and meets regularly with his office to discuss the formulation and implementation of its strategy. It also works closely with other		

		<p>stakeholders: for example the Safeguarding Review that is currently underway involves a team of experts from the National Children's Bureau. In addition the Youth Justice Board runs extensive consultation projects in relation to all major pieces of work, such as the Secure Estate Strategy for Children and Young People.</p>		
<p>Coroner Rule 43 Action 30</p>	<p>The Forum for Preventing Deaths in Custody should be used by the Youth Justice Board as a means of providing information to others about the circumstances of Gareth's death and the lessons to be learned from the death, as well as a source of information about deaths in custody.</p>	<p>The Youth Justice Board is an active participant in the Forum for the Prevention of Deaths in Custody. The purpose of the Forum is for all members to share lessons learned from all deaths in custody.</p> <p>The Youth Justice Board used the Forum's meeting in November 2007 to discuss the actions taken and planned by the Youth Justice Board to meet the recommendations from the inquests in into the deaths of Gareth Myatt and Adam Rickwood.</p>		<p>Achieved</p>
<p>Coroner Rule 43 Action 31</p>	<p>The Forum for Preventing Deaths in Custody should become the collecting point for, and the source of distribution of, information from Inquests arising out of deaths in custody (for example, verdicts returned and any Rule 43 matters). Such information should be made readily available to all Forum members and, so far as is possible to the</p>	<p>The Forum's annual report published in September 2007 acknowledged that it had not been able to conduct or commission research into any of the issues it believed were worthy of it. Furthermore, it had no capacity to monitor or report on the recommendations that might be made as a result of investigations, inspections</p>	<p>The Government is considering what action it should take in response to the review.</p>	<p>Response to review: June 2008</p>

	public through its website.	<p>or inquests or to monitor whether and how they were implemented.</p> <p>During the debates on the Corporate Manslaughter Bill on 16 May, the Government made a commitment to review the Forum's current arrangements. A full review took place and Maria Eagle updated the House on its progress in December 2007 in a written Ministerial statement (WMS). The review has now been completed and the Government reported to Parliament in a further WMS on 25 February.</p>		
Coroner Rule 43 Action 32	All those involved in the STC system need to consider very carefully and very regularly how they can learn lessons from what happened to Gareth Myatt, how they can build on good practice, and how they can prevent another trainee dying as a result of physical restraint.	The Youth Justice Board has set up a Forum for STC Directors in order that emerging practice and lessons learned can be shared. The STC Directors Forum meets on a quarterly basis. In addition, STC Directors meet outside of formal Youth Justice Board meetings on a regular basis. All STC Directors have been made aware of all of the recommendations arising from this case.		Achieved
Coroner Rule 43 Action	Procedures to ensure speedy access for emergency vehicles to STCs should be reviewed.	The centres have Incident Contingency Plans, strategies and checklists which provide policy and guidance relating to		

33		<p>emergency vehicle access.</p> <p>In the design and build of secure establishments, careful consideration is given to the ability of emergency vehicles to access establishments. In addition provision is made in the STC contracts to ensure that establishments have procedures in place to deal with emergency situations.</p> <p>The Youth Justice Board has written to STC Directors asking them to review their policies in this area.</p>		
Coroner Rule 43 Action 34	<p>All matters raised by the death of Gareth Myatt should be brought immediately to the attention of OFSTED. OFSTED will, of course, need to examine and review the actual use of PCC by STCs. They will also need to examine the effectiveness of the system for referrals to outside agencies.</p>	<p>A copy of the Coroner's Rule 43 letter has been sent to Ofsted.</p> <p>Ministry of Justice / DCSF, the Youth Justice Board and OFSTED agreed a new Service Level Agreement in March 2007 for inspections of STCs, which takes account of the lessons learned from Gareth Myatt's death.</p>		Achieved