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House of Lords

Joint Committee on Human
Rights

Youth detention: solitary confinement and restraint

Nineteenth Report of Session 2017–19

*Report, together with formal minutes
relating to the report*

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Joint Committee on Human Rights

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Summary

Around 2,500 children are detained by the state in England and Wales at any one time. Some are detained in hospitals for therapeutic care, and some are detained in custody due to criminal convictions. Although these institutions have different functions, they face many common issues. These children are detained for different reasons, but most are highly vulnerable and many have multiple challenges. They are under the care of the state, and yet they can be subject to practices of restraint and separation from normal human contact that can cause harm and undermine the therapeutic and rehabilitation aims of their detention. These situations engage rights under the European Convention on Human Rights (ECHR): Article 2, the right to life; Article 3, the prohibition of inhuman or degrading treatment; Article 5, the right to liberty and security; Article 8, respect for private and family life.

We heard evidence from young people who had been restrained and separated from normal human contact whilst detained in hospital and custody, and from parents of children who have been detained. Their testimony powerfully illustrated to us the damaging impacts upon children when they are restrained or separated, including long-term impacts. We received unanimous evidence from medics, inspectors, lawyers, and staff who work in detention, that restraint and separation are harmful to children and should be avoided if at all possible.

Some practices are particularly extreme or controversial. We urge greater monitoring of the use of the controversial ‘prone restraint’, which is currently being reviewed, and urge its use only in exceptional circumstances when absolutely necessary. The deliberate infliction of pain in Young Offenders’ Institutions (YOIs) is unacceptable under any circumstances under rights legislation. The use of restraint for maintaining ‘good order and discipline’ must be prohibited in all but the most exceptional of circumstances.

Separation from normal human contact can take different forms, and several different terms are in use; all of these practices can have negative impacts. They range from segregation into small groups, to isolation from other children but with constant observation by staff, to being totally alone in a child’s own cell or in a designated unit. We use the term ‘separation from normal human contact’ or ‘separation’ to refer to all of these practices. Where isolation from normal human contact exceeds 22 hours per day, we use the term ‘solitary confinement’, as defined in international law; where this lasts for over 15 days, it is defined as “prolonged solitary confinement”. This is contrary to human rights law in all circumstances. The Government must immediately take steps to ensure that separation of children from human contact never becomes solitary confinement. Decisions, and reviews of decisions, by YOIs and hospitals to extend periods of separation should be reported to the responsible Ministers on a monthly basis. The information must be certified by the Ministers and laid before each House for publication.

For all forms of restraint and separation (whether acceptable or not), data collection is incomplete in hospitals and custody, and there is good reason to believe that these practices are under-reported. Data is presented in ways that make it harder to interpret,

and the use of different definitions makes it harder to compare between different types of institutions. Data collection must be improved, and we recommend that institutions collect and publish data about all types of restraint and separation.

Data from hospitals and custody shows that children are restrained too often, with potentially thousands of unjustified restraints each year, and that separation is also used too often. Rates of restraint and separation are even higher for BAME children. We believe that the high rates of restraint and separation are incompatible with the threshold of 'last resort', and are therefore in breach of the rights of children. The issue is that staff sometimes do not attempt de-escalation methods, and too quickly move to restraint or separation. We recognise that staff face difficult situations, and they must be supported to use better alternatives whenever possible.

The excessive use of restraint and separation are partly due to insufficient staffing levels, insufficient staff training and experience, and inappropriate facilities. We recommend increased staffing levels, improved training, and a better mix of staffing and skills, all of which will increase the range of options that can be used instead of restraint and separation. We also conclude that some children are fundamentally in the wrong institutions (although some should not be in institutions at all), due to lack of spaces in more appropriate units. We recommend that the secure estate is reconfigured to ensure that there are sufficient spaces in the correct types of units (for example to provide mental health care to child offenders) and to ensure that all children can be placed close enough to home to allow regular family visits.

The rights of children in detention are often not enforced. The systems in hospitals and custody do not do enough to ensure that children are sufficiently aware of their rights and of how to appeal if their rights have been breached. Children and families (and other representatives) often do not have full access to evidence that would help in appeals.

Children lack confidence in the appeals systems: they feel that any recompense is not comparable with the impact of restraint or separation; and they are often not made aware of the outcomes of successful appeals by other children. We recommend more involvement for families in decisions about the children; more proactive roles for independent advocates; more effective debriefs after incidents, and clear communication of disciplinary action against staff. We also recommend the annual publication for each institution of data about appeals and their outcomes.

1 Introduction

Purpose of this report

1. Many institutions that detain children (i.e. people aged under 18 years) are permitted to physically restrain children and to separate children from normal human contact. Restraint can include controversial methods (as discussed in Chapter 2), and separation includes a range of practices including total isolation (as discussed in Chapter 3).¹ The practices of restraint and separation engage the rights of children under the European Convention on Human Rights (ECHR): Article 2, the right to life; Article 3, the prohibition of inhuman or degrading treatment; Article 5, the right to liberty and security; Article 8, respect for private and family life. These practices also engage further protections under international law, including the UN Convention on the Rights of the Child. We undertook this inquiry to assess whether the practices of restraint and separation of children in detention in the UK are subject to appropriate limits and effective safeguards. This report seeks to answer three questions that were set out in the inquiry's terms of reference:²

- Does the use of restraint and segregation in youth detention lead to children's rights being commonly breached?
- Is the guidance on restraint and segregation compliant with human rights standards?
- Is the Government doing enough to ensure rights compliant standards are applied across the estate, including in privately run institutions?

Scope of our inquiry

2. We considered several different types of institution, as set out below. These institutions detain around 2,500 children at any one time:³ some for care, treatment or welfare reasons, and some because of criminal offences.⁴ Each type of institution has its own terminology and rules governing the use of restraint and the use of separation from human contact.

- Around 1,200 children with mental health issues are detained in Child and Adolescent Mental Health Services (CAMHS) Tier 4 units, under the mental health legislation.⁵
- Around 250 autistic children and children with learning disabilities are detained in Assessment and Treatment Units (ATUs), CAMHS units or other inpatient units, under the mental capacity legislation or mental health legislation.⁶

1 We use the term 'separation from normal human contact' or 'separation' to refer to a range of practices and terms used in different institutions; these are discussed in Chapter 3. Where appropriate, we use the term 'solitary confinement', as defined in international law.

2 Youth Detention: Restraint and Solitary Confinement: [Terms of Reference](#)

3 In this report, we use the term to refer to under 18 year-olds but some of our comments and recommendations refer to young people over 18, and we make clear where this is the case.

4 This figure does not include children held in police custody.

5 Source of data for England: NHS England, [2017–18 NHS Benchmarking CAMHS Data](#), 2018. Different Acts pertaining to mental health apply in England and Wales, Scotland and Northern Ireland.

6 Source of data for England: NHS Digital [Learning Disability Services Monthly Statistics - AT: October 2018, MHSDS: August 2018](#), November 2018. Different Acts pertaining to mental health and mental capacity apply in England and Wales, Scotland and Northern Ireland.

- Around 900 children are detained in the Youth Secure Estate under custodial sentences for criminal convictions: 650 children aged 15–17 years in Youth Offenders’ Institutes (YOIs); 130 children aged 15–17 years in Secure Training Centres (STCs); and 120 children aged 10–14 years in Secure Children’s Homes (SCHs).⁷
- Around 100 children aged 10–14 years are detained in Secure Children’s Homes (SCHs) for welfare reasons.⁸

3. The original scope of this inquiry included children who are serving custodial sentences in Young Offenders’ Institutes and Secure Training Centres, and children who are detained for reasons of mental health in CAHMS units. During the inquiry, we received evidence about Secure Children’s Homes, which we have considered as part of this inquiry, but in insufficient detail to reach firm conclusions. We additionally sought evidence about autistic children and children with learning disabilities who are detained in Assessment and Treatment Units (ATUs) and other inpatient units, some of which we have considered in this inquiry, and some of which we are considering as part of a further inquiry into the appropriateness of placements for these children.⁹

4. The Committee was greatly assisted by the many individuals and organisations that submitted evidence, most of which (excluding that which we were asked to keep confidential) is available on the Committee’s website.¹⁰ These included staff who work with the children and who helped us to appreciate the challenging situations; representatives and advocates who act on behalf of the children; inspectors and monitoring bodies; and Government Ministers and officials. We are particularly grateful to “Rosie” and “William”, who spoke of their experiences in detention, “Jay”, who wanted to speak with the Committee but was unable to do so due to personal circumstances, and the parents who gave accounts of their children’s experiences in detention. They showed great courage in conveying difficult experiences to help us to understand the impacts on children and their families.¹¹

5. The evidence that we received mostly referred to the situations in England. Health matters are devolved to Wales, Northern Ireland and Scotland; justice matters are devolved to Northern Ireland and Scotland. The exact definitions and functions of institutions differ in some cases across the UK. However, our recommendations to the UK Government and its agencies may also be of relevance to the Devolved Administrations.

Human rights framework for detention of children

6. The UK has signed up to international agreements that protect people’s rights, and as the Joint Committee of Human Rights we consider whether the UK abides by those commitments. The decision to detain anyone is in itself a significant matter, constituting a restriction of the right to liberty (ECHR Article 5), which can only be done with sufficient justification, for example as punishment for a crime or for certain medical reasons. The

7 Source of data for England and Wales: Ministry of Justice, [Youth Justice Statistics 2017–18](#), Table 7.1, January 2019

8 Department for Education, [Children accommodated in secure children’s homes: 31 March 2018](#), 2018

9 Detention of children and young people with learning disabilities and/or autism: [Terms of reference](#)

10 Evidence for inquiry on [Youth Detention: Restraint and Solitary Confinement](#). This report also cites evidence taken at an evidence session on [Conditions in learning disability inpatient units](#), and the subsequent inquiry into [Detention of children and young people with learning disabilities and/or autism](#).

11 The young people gave evidence anonymously and are hereinafter referred to by their pseudonyms, Rosie and William. In the transcript of her evidence session, Rosie is referred to as “Witness B”.

UN Convention on the Rights of the Child (UNCRC) states that the imprisonment of a child shall be used “only as a measure of last resort and for the shortest appropriate period of time”.¹²

7. The European Convention on Human Rights, which applies to adults and children alike, states in Article 3 that: “No one shall be subjected to torture or to inhuman or degrading treatment or punishment.” The UN Convention on the Rights of the Child, which the UK has ratified, states in Article 37 that: “No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment” and that “every child deprived of liberty shall be treated ... in a manner which takes into account the needs of persons of his or her age”.¹³ The Committee on the Rights of the Child (which monitors compliance with the UNCRC) has stated that: “Any disciplinary measure must be consistent with upholding the inherent dignity of the juvenile and the fundamental objectives of institutional care; disciplinary measures in violation of article 37 of CRC must be strictly forbidden, including corporal punishment, placement in a dark cell, closed or solitary confinement, or any other punishment that may compromise the physical or mental health or well-being of the child concerned.”¹⁴

8. The UK has accepted international obligations, and incorporated certain obligations into domestic law, to ensure that children are not be subject to cruel, inhuman or degrading treatment. The Government must comply with its international and domestic obligations and ensure that children in detention are treated with appropriate care.

12 United Nations, The United Nations Convention on the rights of the child, [Article 37, UNCRC](#), November 1989

13 United Nations, The United Nations Convention on the rights of the child, [Article 37, UNCRC](#), November 1989

14 UN Committee on the Rights of the Child (UNCRC), [General Comment No. 10 on Children's rights in juvenile justice](#), April 2007, paragraph 89

2 Restraint of children

Human rights framework for restraint of children

9. This inquiry has focused on manual restraint of children (i.e. using hands). The UN Committee on the Rights of the Child recognised in 2007 that there are “exceptional circumstances” in which dangerous behaviour by children may justify the use of “reasonable restraint to control it”: “Restraint or force can be used only when the child poses an imminent threat of injury to him or herself or others, and only when all other means of control have been exhausted.”¹⁵ It continued: “The principle of the minimum necessary use of force for the shortest necessary period of time must always apply. Detailed guidance and training is also required, both to minimize the necessity to use restraint and to ensure that any methods used are safe and proportionate to the situation and do not involve the deliberate infliction of pain as a form of control.”¹⁶ It has stated: “Staff of the facility should receive training on the applicable standards and members of the staff who use restraint or force in violation of the rules and standards should be punished appropriately.”¹⁷

Experiences and impacts of restraint

10. We heard evidence from a range of witnesses, some of whom spoke about several different types of restraint (we focused on manual restraint of children i.e. using hands), and some of whom spoke about either hospitals or custody (we found that many of the points apply to both settings). The Ministry of Justice provided us with anonymised case files from YOIs and STCs that illustrate some of the reasons for using restraint and the processes that should be followed.¹⁸ Other witnesses relayed examples of when the processes had not worked properly.¹⁹ It was not possible for the Committee to see anonymised case files for hospital settings, but witnesses did relay examples to us.²⁰ The main points from the evidence are summarised as follows.

11. **Restraint can be painful.** Rosie told us of her experience of being restrained in a CAMHS unit: “I remember it being painful, but for me personally never for an extended period of time, because for me the idea of further restraint was just so uncomfortable and distressing that I would just stop and comply with whatever from there.”²¹ William told us of his experience of being restrained in a YOI: “I do not have scars or bruises to show for it, but I was in pain.”²² Staff in YOIs (but in no other children’s institutions) are permitted to deliberately inflict pain on children, but the Standing Committee for Youth Justice told

15 UN Committee on the Rights of the Child (UNCRC), [General Comment No. 10 on Children’s rights in juvenile justice](#), April 2007, paragraph 89

16 UN Committee on the Rights of the Child (UNCRC), [General Comment No. 8 on Children’s rights in juvenile justice](#), April 2007, paragraph 15

17 UN Committee on the Rights of the Child (UNCRC), [General Comment No. 10 on Children’s rights in juvenile justice](#), April 2007, paragraph 89

18 These case files were provided to the Committee in confidence and have not been published.

19 The Howard League ([YDS0030](#))

20 Conditions in learning disability inpatient units, [Q18](#) [Julie Newcombe]

21 [Q11](#) [Witness B: Rosie]

22 [Q39](#) [William]

us that: “Whether inducing pain is officially sanctioned or not, children will experience restraint as painful, so it is important to avoid a proposition that ‘pain free’ restraint is possible.”²³

12. Restraint can cause injuries.²⁴ Julie Newcombe described the result of a restraint on her son, Jamie, who is autistic, when he was kept in a hospital unit as a child: “He had his arm broken in a restraint, the right humerus bone. His arm was wrenched up behind his back until the bone snapped.”²⁵ Academics from the University of Essex told us: “Children often report getting physical injuries from restraints, from carpet burn to bruising to broken bones, and there is ample evidence to support these claims.”²⁶ As the Howard League for Penal Reform told us, restraint can also exacerbate existing physical conditions such as breathing difficulties;²⁷ to account for this, staff are supposed to follow handling plans specific to the child.²⁸ Smallridge and Williamson, in their 2008 report on the use of restraint in youth custodial settings, wrote that “there is no such thing as ‘entirely safe’ restraint”.²⁹

13. Restraint can be distressing and psychologically harmful, both at the time and afterwards. Rosie said that the “idea of further restraint” was itself “uncomfortable and distressing”;³⁰ William spoke of being “in shock” after the event;³¹ and Julie Newcombe relayed a parent’s account of their child being “hyper-alert ... to the staff who have used restraint on him”.³² The report by Smallridge and Williamson stated that restraint was “intrinsically unsafe”, as even where it did not end in physical injury it could be “profoundly damaging psychologically”.³³ The impacts serve to reinforce mental health issues and behavioural issues, underlining the importance of taking such issues into account in handling plans.³⁴ According to the British Medical Association:

“Lord Carlile’s review found that children and young people felt ‘violated and abused’ following restraint, while patients with a history of mental disorder linked to abuse often associated restraint with earlier traumatic experiences ... evidence which emerged during the inquests of the deaths of some of those in custody points to the severe distress caused by the use of force against vulnerable children, particularly those who have suffered physical or sexual abuse.”³⁵

14. Restraint can make a child’s time in detention counterproductive. It adds to the pressures felt by people with autism, learning disabilities or communication issues.³⁶ Julie

23 Standing Committee for Youth Justice (YDS0012)

24 In extremis, some forms of restraint previously permitted for use on children have resulted in death; Gareth Myatt died in 2004 when restrained at an STC in a manner that is no longer permitted.

25 Conditions in learning disability inpatient units, Q14 [Julie Newcombe]

26 Munira Ali, Dr. Alexandra Cox, and Julie Hannah, University of Essex (YDS0019)

27 The Howard League (YDS0030)

28 Her Majesty’s Inspectorate of Prisons (YDS0020)

29 P. Smallridge and A. Williamson, [Independent review of restraint in juvenile secure settings](#), 2008

30 Q11 [Witness B: Rosie]

31 Q39 [William]

32 Conditions in learning disability inpatient units, Q18 [Julie Newcombe]

33 P. Smallridge and A. Williamson, [Independent review of restraint in juvenile secure settings](#), 2008

34 Royal College of Psychiatrists Royal College of Psychiatrists (YDS0004)

35 British Medical Association British Medical Association (BMA) (YDS0018); the reference is to Lord Carlile of Berriew QC (2006) An independent inquiry into the use of physical restraint, solitary confinement, and forcible strip searching of children in prisons, secure training centres and local authority secure children’s homes. London: The Howard League for Penal Reform, p. 62

36 Royal College of Speech and Language Therapists RCSLT (YDS0009)

Newcombe shared with us an account from a parent of an autistic child who wrote: “He has started banging his head in frustration and I can see how hyper-alert he is to the staff who have used restraint on him.”³⁷ Referring to accounts by children in custody, the Howard League for Penal Reform wrote: “Calls to the Howard League suggest that children are both harmed by the use of force and it can have a counter-therapeutic and brutalising effect.”³⁸

15. Restraint harms relationships between children and staff, inhibiting the provision of care and the modelling of normal relationships.³⁹ Restraint can also be distressing and psychologically harmful for staff, as explained by Glyn Travis of the Prison Officers’ Association: “It is very traumatic for staff, because a lot of them are young mums and young fathers who have to deal with young children of their own. ... Whenever you use control and restraint, whether it is required as a hold or a physical restraint, it is never a pleasant experience.”⁴⁰ We are concerned that the use of force can suggest to children that violence is an acceptable means of solving problems.

16. Professor Raymond Arthur summarised studies that found that restraint of young people caused “... perceptions of unfairness, a broken spirit and re-traumatisation” and that “[m]any of the girls ... felt that the procedure impacted on them negatively in terms of their mental health and well-being, and they disliked it intensely; boys in contrast reported feelings of anger.”⁴¹ Academics from the University of Essex summarised the issue as follows: “... physical and mechanical restraints not only compound and reproduce the harms associated with early childhood exposure to abuse, neglect and violence, but they also intervene in children’s lives in a way that treats their challenging behaviour as something to be managed rather than dealt with through care, empathy and respect.”⁴²

17. There is substantial medical evidence of the physical and psychological impacts of restraint, particularly when used upon children. This evidence was brought into stark relief by the evidence of young people who had experienced these impacts, and parents who relayed the impacts upon their children. While restraint might seem to solve an immediate problem in custody or hospital, it causes harm in the short term and the longer term: it harms children, it harms staff, it undermines the objectives of detention, and contributes to a vicious circle of problems that can continue into the future including inhibiting life chances into adulthood. The use of restraint upon children can amount to inhuman or degrading treatment which is a breach of children’s rights.

Rates of restraint of children

18. NHS England regularly publishes datasets about restraint of people in hospitals as part of its Mental Health Bulletin for in-patient units that provide mental health, learning disability and autism services. The data for 2017–18 states that there were 3,338 child (under-18) inpatients (6% rise from 2016–17); that 818 patients under-20 were subject to 17,476 physical restraints excluding prone (21.4 per patient affected on average); and

37 Conditions in learning disability inpatient units, [Q18](#) [Julie Newcombe]

38 Howard League for Penal Reform The Howard League ([YDS0013](#))

39 [Q35](#) [Dr Heidi Hales]

40 [Q29](#) [Glyn Travis]

41 Professor Raymond Arthur, Northumbria University ([YDS0002](#))

42 Munira Ali, Dr. Alexandra Cox, and Julie Hannah, University of Essex ([YDS0019](#))

that 399 patients under-20 were subject to 2,994 prone restraints (7.5 per patient affected on average).⁴³ NHS England also published data in 2018 in response to a Freedom of Information request about people with learning disabilities in hospital in-patient units, showing that there were 22,000 restraints on people with learning disabilities in 2017 (up 50% from 2016). Of these, 3,100 (14% of the total) were prone restraints (up 50% from 2016).⁴⁴

19. For the Youth Custody Estate, the Ministry of Justice and the Youth Justice Board jointly publish annual reports about YOIs, STCs and SCHs, most recently for the year ending March 2018.^{45,46} This states that there were nearly 6,600 ‘use of force incidents’ in YOIs and STCs on around 300 children, i.e. about one third of children experienced use of force almost twice a month on average; and that MMPR techniques were applied in almost 4,200 incidents.⁴⁷ There were 100 injuries to children in 2017.⁴⁸ We note that the total number of Restrictive Physical Interventions (including restraints) was 20% higher than in the previous year, but the population increased by only 3%. The report notes that this is “the largest year-on-year increase seen over the last five years. While the number of RPIs in the latest year is still lower than five years ago, the number of these incidents has been increasing over the last couple of years.” These datasets also show that the rates of restraint are higher for BAME children. Where we have presented averages per child, it follows that some of these children experience even higher numbers of restraints and separations.

20. **The data published about restraint in custodial settings and hospitals is not complete, and is hard to interpret. Each sector (health and custody) has datasets about restraint that are at once incomplete and also overlapping, making it difficult to obtain a clear picture of the issues. Furthermore, the different terminology used by each sector to describe essentially the same practices simply serves to complicate the making of comparisons.**

21. **Despite the shortcomings in data collection, it is clear that in YOIs, STCs and hospitals a large minority of children experience restraints and separations; the average number of restraints and separations that these children experience is high. BAME children are particularly affected. From the evidence that we have heard, it is clear that some restraints are not justified on the grounds of ‘last resort’ to prevent**

43 NHS Digital, [Mental Health Bulletin: 2017–18 Annual Report](#) Reference Tables, Table 7.1. All of these figures were around 5–10% higher than in 2016–17.

44 Table 2 of [NHS Digital, LDA Monthly Statistics from AT - October 2018: Reference Tables](#), November 2018. This dataset covers ATUs and mental health units, so there is overlap with the figures above; it does not include autistic people; and it is not split into adults and children. The number of people with autism or learning disabilities held in inpatient units in England was around 2,350 in October 2018, of whom around 250 were children (compared to 110 in March 2015).

45 Youth Custody Board and Ministry of Justice, [Youth Justice Statistics 2017/18](#), January 2019

46 We note that the data are incomplete and can be difficult to interpret thanks to issues including differences between regimes in YOIs, STCs and SCHs, and the phased introduction of the Minimising and Managing Physical Restraint (MMPR) regime for restraint in YOIs and STCs. As a result, historical data include two overlapping regimes, and even now some YOIs are not reporting data consistently (see [Q59](#) [Edward Argar MP]).

47 The Youth Justice Statistics seeks to explain the definitions: “Within MMPR, any physical intervention is counted as a ‘use of force’, unlike the RPI system which only counts those physical interventions deemed restrictive.” “Owing to the different definitions of Use of force, MMPR and RPI a particular use of force may be classed as MMPR, RPI, both MMPR and RPI, or neither”. “All uses of MMPR or RPI must be counted as a use of force: It is not possible for either a use of MMPR or an RPI to be not classed as a use of force, although it is possible for a use of force to be neither MMPR or RPI.” In addition, the data only records the highest level of MMPR technique used in an incident, so some uses of MMPR techniques are not recorded.

48 Youth Justice Board and Ministry of Justice, [Youth Justice annual statistics: 2016–2017](#), January 2018

harm. The available data about numbers of reported restraints suggest that potentially thousands of unjustified restraints are conducted each year. We conclude that rates of restraint of children in the custody estate and in hospitals are unacceptably high, and children's rights are being commonly breached.

22. There also appear to have been increases in the use of restraint over recent years. The Youth Custody Service and the Department for Health and Social Care considered that these increases were in part due to improved reporting and the different categorisations in new regimes in custody settings and in hospitals. Even so, they acknowledged that this was not the only factor.⁴⁹ In particular, it is notable that the increased use of restraint in YOIs has occurred alongside a fall (by two thirds since 2010) in the number of children detained. Peter Gormley of the Youth Custody Estate, suggested that this reduction in the custody population was in fact one cause of the increased rates of restraint and separation.⁵⁰ This “concentration of need” argument essentially states that new sentencing policies result in custodial sentences for only the most violent or persistent child offenders, who are likely to have more difficulties,⁵¹ and there are fewer “moderate” children in custody, hence affecting the statistics. Other witnesses, including the Standing Committee for Youth Justice, were cautious about this argument, on the grounds that it had not yet been evidenced.⁵² Similar arguments have been made about a changing population of children in hospital.⁵³ Whatever the truth of the matter, institutions need to ensure that they use approaches to care that are suited to the children and that reduce the need for restraint and separation.

23. We believe that the reported increases in the use of restraint in custody and hospitals are a combination of better reporting (showing that the problems are worse than previously thought) and actual increases (illustrating that the problems are becoming worse still). The issue must be tackled from both angles, with continued improvements in reporting in order to see the true scale of the issues, and action to reduce the need for restraint and separation, in all secure settings.

Pain-inducing restraints in YOIs

24. The MMPR guidance for YOIs permits the use of restraint techniques that deliberately inflict pain on children.⁵⁴ These techniques are supposed to be a last resort, in order to protect the child or other people from “an immediate risk of serious physical harm”.⁵⁵ They are sometimes called “pain distraction techniques”, the theory being that a momentary sharp pain will be sufficiently unpleasant to cause the child to desist from physical resistance and comply with instructions. The Youth Justice Statistics report that

49 [Q70](#) [Peter Gormley] and [Q71](#) [Teresa Fenech]

50 [Q70](#) [Peter Gormley]

51 Bateman, National Association for Youth Justice, [The State of Youth Justice 2017](#), 2017; Royal College of Psychiatrists ([YDS0004](#)) and [Q28](#) [Glyn Travis]

52 Standing Committee on Youth Justice ([YDS0012](#))

53 Detention of children and young people with learning disabilities and/or autism inquiry, [Q14](#) [Dame Christine Lenehan]

54 Ministry of Justice, Youth Justice Board, National Offender Management Service and Young People's Estate, [Minimising and managing physical restraint: safeguarding processes, governance arrangements, and roles and responsibilities](#) 2015

55 Ministry of Justice, Youth Justice Board, National Offender Management Service and Young People's Estate, [Minimising and managing physical restraint: safeguarding processes, governance arrangements, and roles and responsibilities](#), 2015

pain was deliberately inflicted around 260 times in the year ending March 2018,⁵⁶ up from around 110 in the year ending March 2017.⁵⁷ HMIP reported that pain-inducing techniques were used “frequently”,⁵⁸ which seems contrary to the threshold of ‘last resort’.

25. The Howard League for Penal Reform relayed a child’s experience of a wrist hold designed to induce pain: “... he was then escorted back to his room by several members of staff and while they were walking this member of staff ‘bent my wrists all the way back’ ... he said to them, ‘what are you doing to my wrists, it’s hurting, stop that’ ... the staff members said nothing but pushed his wrists back harder ... his wrists ‘hurt a lot’, and ‘still hurt’ at the time of the call.”⁵⁹ The Standing Committee for Youth Justice wrote that the mandibular angle technique (applying pressure to a point at the base of the jaw) “delivers a sharp and very unpleasant pain, recallable at several years distance”.⁶⁰ These methods are more than a distraction, having the potential for significant distress at the time, in subsequent hours and even in the longer-term.

26. The deliberate infliction of pain on a child is incompatible with international human rights law. Article 37(a) of the UNCRC states unconditionally that: “No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment.” The Committee on the Rights of the Child has interpreted this as meaning that restraints must be conducted such that they “do not involve the deliberate infliction of pain as a form of control”.⁶¹ After calls from numerous organisations, including this Committee in a report in 2008,⁶² the Government banned the use of pain-inducing techniques in STCs. The Government developed the MMPR regime which, while introducing some welcome distinctions between the adult and child regimes, specifically allowed the continued use of pain-inducing techniques on children in YOIs. Calls have been ongoing to bring YOIs into line with other children’s institutions, including by the EHRC in 2011,⁶³ the UN Committee against Torture (UNCAT) in 2013,⁶⁴ and most recently by the Independent Inquiry into Child Sexual Abuse in February 2019.⁶⁵ The Government published in 2012 a version of the MMPR training manual, but with 182 redactions,⁶⁶ and has resisted ongoing calls (notably by the charity Article 39) to publish the full details of the manual, making it impossible to fully evaluate the practices. We note that, during our inquiry, the Ministry of Justice launched a review of pain-inducing techniques in YOIs, which is expected to report in summer 2019.

56 Youth Justice Board and Ministry of Justice, [Youth Justice Statistics 2017/18, England and Wales](#), 31 January 2019, Table 8.28

57 Youth Justice Board and Ministry of Justice, [Youth Justice Statistics 2016/17, England and Wales](#) 25 January 2018

58 HMIP, [Behaviour management and restraint of children in custody](#), 2015

59 The Howard League (YDS0030)

60 Standing Committee for Youth Justice (YDS0012)

61 UN Committee on the Rights of the Child (UNCRC), [General comment No. 8 \(2006\): The Right of the Child to Protection from Corporal Punishment and Other Cruel or Degrading Forms of Punishment \(Arts. 19; 28, Para. 2; and 37, inter alia\)](#), March 2007

62 Joint Committee on Human Rights, 11th Report of Session 2007–08, [The Use of Restraint in Secure Training Centres](#), HC 378 HL 65

63 Submission by Equality and Human Rights Commission to Lord Carlile of Berriew QC’s Public Hearing on 11 May 2011 into Use of Force on Children in Custody

64 UN Committee Against Torture, [Concluding observations on the fifth periodic report of the United Kingdom, adopted by the Committee at its fiftieth session](#), May 2013

65 Independent Inquiry into Child Sexual Abuse, [Sexual Abuse of Children in Custodial Institutions: 2009–2017](#), February 2019

66 [Ministry of Justice, Minimising and Managing Physical Restraint—2012—Volume 5—Physical Restraint, 2012](#)

27. There is clear evidence that the use of pain-inducing techniques (which are designed to cause pain and work by deliberately inflicting pain) on children inflicts physical distress and psychological harm in both the short and longer term, and it is clearly not compliant with human rights standards. *We recommend that the use of specific pain-inducing techniques in Youth Offenders' Institutes should be prohibited. We also recognise the right of prison officers to act in self-defence and we are aware that these issues are currently subject to review.*

Restraint for “good order and discipline” in YOIs

28. In YOIs, restraint is permitted for the purposes of “good order and discipline”.⁶⁷ In the year ending March 2018, this was the reason for 233 restraints in YOIs in England and Wales (4% of the total).⁶⁸ We heard compelling evidence that the use of restraint was a blunt instrument, giving a poor example to the child about how to resolve disputes. As the BMA told us, it serves to inhibit children’s trust in the staff who are supposed to care for them: “Even witnessing the use of restraint led to a divisive ‘us and them’ attitude between staff and children.”⁶⁹ Furthermore, we believe that there can be a blurred line between the use of restraint for “good order or discipline” and the use of restraint for punishment (which is not allowed in YOIs, or in any other settings), particularly in the perception of the children who are restrained, hence adding to mistrust of the processes and staff.

29. The use of restraint for “good order and discipline” has been addressed by the Committee on the Rights of the Child, which has stated: “Any disciplinary measure must be consistent with upholding the inherent dignity of the juvenile and the fundamental objectives of institutional care; disciplinary measures in violation of article 37 of CRC must be strictly forbidden, including corporal punishment, placement in a dark cell, closed or solitary confinement, or any other punishment that may compromise the physical or mental health or well-being of the child concerned.”⁷⁰ In its latest report about the UK, the CRC repeated that it was concerned about “the use of physical restraint on children to maintain good order and discipline in young offenders’ institutions”.⁷¹

30. In its 2008 report on *The Use of Restraint in Secure Training Centres*, this Committee stated that the criterion of “good order or discipline” would “pose the very real danger of entrenching in legislation ambiguity for staff and detained young people ... The phrase ‘good order and discipline’ is imprecise, overbroad and inherently subjective.”⁷² It is our view that this ambiguity is an issue not just in STCs, but in any setting, including YOIs. The ‘good order and discipline’ criterion was removed from the guidelines for STCs after a successful legal challenge, as Professor Raymond Arthur outlined: “The government had failed to show that such a dangerous practice is necessary purely for the purpose of enforcing good behaviour.”⁷³ Professor Arthur gave the example of another case, of

67 The Young Offender Institution Rules 2000 (SI 2000/3371)

68 Youth Custody Board and Ministry of Justice, [Youth Justice Statistics 2017/18](#), January 2019, Table 8.24

69 British Medical Association (BMA) (YDS0018)

70 UN Committee on the Rights of the Child (UNCRC), [General Comment No. 10 on Children’s rights in juvenile justice](#), April 2007, paragraph 89

71 Committee on the Rights of the Child, [Concluding observations on the fifth periodic report of the United Kingdom of Great Britain and Northern Ireland](#), 2016

72 Joint Committee on Human Rights, Eleventh Report of Session 2007–2008, [The Use of Restraint in Secure Training Centres](#), HC 378 / HL Paper 65

73 Professor Raymond Arthur, Northumbria University (YDS0002) referencing *R(C) v Secretary of State for Justice* (2009)

potentially wider application, in which the judge said that the power to use force “is not a free-standing right to use force whenever a staff member thinks it necessary or appropriate ... the limits on the use of force on children in custody was driven by the core principles set out in the UN Convention on the Rights of the Child”.⁷⁴

31. The use of restraint in YOIs for the purposes of ‘discipline and good order’ is not compliant with human rights standards, and is counterproductive for children’s rehabilitation and the development of beneficial relationships with staff. We recommend that the use of restraint for the purposes of ‘discipline and good order’ in Young Offenders’ Institutes be prohibited in all but the most exceptional circumstances, and that the guidelines produced by the Ministry of Justice and its agencies be updated accordingly.

Prone (face-down) restraint

32. Staff in ATUs, CAMHS, YOIs and STCs are permitted to put children “to the floor” in restraint, either supine (face-up) or prone (face-down).⁷⁵ There are particular concerns about the dangers and distress of prone restraint,⁷⁶ although The Royal College of Psychiatrists noted that “there is mixed evidence about the use of prone (face down) over supine (face up) restraint”, and that the “duration of any restraint appears to be a more significant factor than prone v supine with regards to safety”.⁷⁷ There is a general consensus that prone restraint should be used only in “very exceptional circumstances”,⁷⁸ but The Royal College of Psychiatrists was concerned that “banning prone restraint would mean that some patients and staff are put at increased risk and emotional distress if options for appropriate restraint positions are limited.”⁷⁹ Witnesses explained that examples where prone restraint could be justified in preference to supine restraint include people who have “a problem with their back or some other physical ailment that means holding them on the ground on their back is either more uncomfortable or more dangerous”,⁸⁰ and people who have “suffered physical and/or sexual abuse associated with a particular restraint position (e.g. rape)”.⁸¹ The Royal College of Psychiatrists highlighted the need for a “comprehensive review of the evidence for supine over prone restraint”,⁸² and its Professional Practice and Ethics Committee has merged its review with work by NHS England to produce official guidelines that are expected to be published in late 2019.⁸³

74 Professor Raymond Arthur, Northumbria University (YDS0002) referencing R (on the application of Pounder) v HM Coroner for the North and South Districts of Durham and Darlington (2010)

75 Prone restraint is often referred to as “face-down”, whereas the clearest feature is “chest-down” and the face can be pointing downwards or sideways.

76 Detention of children and young people with learning disabilities and/or autism inquiry, Q13 [Caoilfhionn Gallaher QC]

77 Royal College of Psychiatrists (YDS0004)

78 Q7 [Ray James, NHS England]

79 Royal College of Psychiatrists (YDS0004)

80 Q7 [Dr Paul Lelliot, Care Quality Commission]

81 Royal College of Psychiatrists (YDS0004)

82 Royal College of Psychiatrists (YDS0004)

83 Correspondence with Royal College of Psychiatrists (unpublished) stated that: “The Royal College of Psychiatrists was asked by NHS England to work with them on the official guidelines on restraint in mental health. These guidelines will review the evidence of the safety of different types of restraint and provide a new set of standards, along with standards on reducing restrictive practices in clinical settings. The College Professional Practice and Ethics Committee decided to focus on supporting NHS England with their official guidelines rather than duplicate their work with their own position statement. We expect the NHS England guidelines to be published in late 2019.”

33. Without wishing to pre-empt the details of the upcoming guidelines, we note the scale of the issue. The data presented earlier show that prone restraint accounted for around 15% of all incidents of restraint (for under-20s in mental health units, and for inpatients of all ages with autism or learning disabilities). NHS England told us that it “would be very keen to see significantly reduced usage”.⁸⁴ We do not know how many patients have personal needs that make supine restraint inappropriate, but 15% of cases does not appear congruent with the threshold of “very exceptional circumstances”.

34. The use of prone (face-down) restraint is distressing and can be dangerous, and its use as anything but a last resort is not compliant with human rights standards for children. We believe that prone restraint is used too often. *While we acknowledge that there may be exceptional circumstances in which prone restraint is preferable to alternatives, it must be more rigorously regulated by governing health bodies and regulators, including by annual publication of statistics for each institution (broken down by patients’ diagnoses, age and justification for not using an alternative method).*

84 Detention of children and young people with learning disabilities and/or autism inquiry, [Q7](#) (Ray James)

3 Separation from human contact

Human rights framework

35. The UN Convention on the Rights of the Child includes a prohibition on “placement in a dark cell, closed or solitary confinement, or any other punishment that may compromise the physical or mental health or well-being of the child concerned”.⁸⁵ The ECtHR has drawn a distinction between “complete sensory isolation” and partial or relative isolation (for example through restrictions on contact with other prisoners or family members).⁸⁶ We considered various forms of separation from human contact to determine whether they can harm a child’s physical or mental well-being. In most of these practices, the children lack any human contact for a period of time, including the specific issue of solitary confinement. In some practices, children are constantly observed by a member of staff, but are isolated from ‘normal’ human contact.

Experiences and impacts of separation

36. All types of institution allow staff to separate children temporarily (for a few hours) after an incident, to allow tensions to diminish before a swift return to the child’s usual place in the unit. Beyond that, there are significant differences between settings. Hospital staff (in CAMHS and ATUs) are allowed to segregate children into small groups or put an individual child into seclusion for the containment of severe behavioural disturbances which are likely to cause harm to others.⁸⁷ YOI staff are allowed to segregate children into small groups and to isolate a child from their peers.⁸⁸ Another scenario in YOIs is a child being isolated in their own cell on some form of reduced privileges regime: this is not regulated by the guidelines.

37. The evidence highlighted common issues that affect children whenever they are separated from normal human contact. Rosie told us about being put on “ward restriction” for six months while in a hospital’s CAMHS unit. She was segregated with a small number of patients, and sometimes isolated with no other patients, and was always in the presence of staff:

“I ended up on 24-hour observations for six and a half months straight. There was someone with me in my room at all times ... I was not allowed off the ward to the dinner hall or anything like that ... It was very dehumanising. It felt like I was in a cage, especially with the ward restriction ... It was so difficult to find a reason to carry on and even recover, and as I said it felt so dehumanising because I could not do anything without someone there with me. I could not go to the bathroom without someone coming with me, and I was not even allowed outside.”⁸⁹

38. Julie Newcombe conveyed accounts from parents whose children had been separated from other patients in hospital: “My son was kept in seclusion for up to nine hours at a time. The rule was that he could not leave until he was quiet. With his anxiety and sensory

85 UNCRC, [General Comment No 10 \(2007\) on Children’s rights in juvenile justice](#), April 2007, paragraph 89

86 *Sotiropoulou v Greece*, No. 40225/02, 2007

87 Mental Health Act Code of Practice, 26.103

88 Rule 49 and Rule 51 of YOI Rules and Prison Service order (PSO)

89 [Q4](#), [Q5](#), [Q6](#) and [Q7](#) [Witness B: Rosie]

presentation, there was no way this was possible. He started to bang his head against the wall and would bite the wood in the doorframe out of desperation.”⁹⁰ The Howard League for Penal Reform conveyed the experiences of children who were kept in the own cells in custodial settings: “A 16 year old [in a YOI] ... had been locked in his cell on the wing for over 23 hours a day for days on end ... He said he was now ‘fed up with it’ and that he felt ‘caged like a dog’ ... he felt sad and angry. His sleep was ‘all over the place’—he would struggle to get out of bed and felt he had no energy.”⁹¹ Jeremy told us about his daughter Bethany, who is autistic and who has been isolated in a single room for almost two years at an ATU:

“Their answer to that was to lock Bethany away. When I visited Beth I knelt down at a hatch in the door six inches square and talked to my daughter through that hatch, the hatch they feed her through ... In that room Beth has no privacy. They watch Bethany showering and going to the toilet ... A child with my daughter’s sensory issues is placed in a seclusion cell, which is a horrific environment anyway ... Not only is she shut in an unsuitable environment, but her activities are restricted. What can you do with a child through a little square hole in the door?”⁹²

39. William told us about being kept in isolation (on ‘block’) for 13 days while detained in a YOI:⁹³

“It is not for the weak-minded, and it also depends what block you’re on. There were a lot of young boisterous guys. Some are happy to be there. There could be two guys from rival gangs who have a fight and they are put on block, but I could be on block for something completely different. All night those two guys are arguing out the window and I am trying to sleep. They shout, ‘You X, you this, you that’. There are people with mental health problems. It is not nice ... it is literally 23 and a half hours with a toilet and sink. I used to get 25 minutes to walk around the exercise yard and five minutes to make a phone call or shower, and then I would be back in my cell. I would get my dinner, then come out and I would get a book to read and I would be back in there.”⁹⁴

40. William also told us about being confined to his cell on ‘lock down’ when other children caused disruption:

“Some people in cells would smash up TVs, go on dirty protests, do whatever and just be a total pain. When they are a total pain, that distracts attention from everyone else, so we would be banged up because of somebody else’s nonsense. There are a lot of difficult prisoners so I was kind of empathetic to the fact that the staff had to deal with them, but we suffered a lot because of those difficult prisoners. One guy could take away 10 officers because they had to calm him down ... I am quite a calm person, so I took it in my stride,

90 Conditions in learning disability inpatient units, [Q18](#), [Julie Newcombe]

91 The Howard League for Penal Reform ([YD50030](#))

92 Conditions in learning disability inpatient units, [Q11](#) [Jeremy]

93 This particular event occurred when William was aged 19, in the 18–21 wing of a YOI, but the insights he offered are directly relevant to the impact of restraint in children’s YOIs.

94 [Q40](#) [William]

really, but then there would be people shouting out abuse and banging their doors all day and screaming. There is nothing you can do except just listen and hope for the best.”⁹⁵

41. There are ongoing arguments about definitions of separation. We have focused on whether practices of separation, whatever their duration or definition, cause harm to children, noting the view of Dr Sharon Shalev of the University of Oxford that segregation has three features that can cause harm: social isolation; reduced sensory input; and increased control of the person.⁹⁶

42. **Separation causes psychological harm**, and can be particularly profound for children, as the British Medical Association wrote: “Negative health effects can occur after only a few days in isolation, but the severity of symptoms increases with the length of confinement ... For children and young people, who are still in the crucial stages of developing socially, psychologically, and neurologically, the health effects of isolation and solitary confinement can be particularly damaging.”⁹⁷ The BMA cited studies into the harmful effects, which include “anxiety; depression; hostility, rage and aggression; cognitive disturbances; hypersensitivity to environmental stimulation; paranoia; and in the most extreme cases, hallucinations and psychosis”. They also noted that children who are isolated even for short durations can experience “paranoia, anxiety and depression”, and that children who are isolated for extended durations “are more likely to attempt or commit suicide”.⁹⁸

43. **Separation can also reinforce existing mental health problems**, particularly if the isolation is of long duration. A mother whose son was isolated for four weeks while in a custodial setting wrote that isolation was sometimes “used for those who are suffering from mental health problems who have, in their emotional state, become uncontrollable”.⁹⁹ The Royal College of Psychiatrists explained regarding CAHMS and custody: “When a young person with mental health and/or emotional difficulties is denied two hours of meaningful contact and so enters a state of solitary confinement, their mental health problems and/or emotional difficulties are likely to be significantly exacerbated.”¹⁰⁰ The Royal College of Psychiatrists also explained that this risk of reinforcing problems is particularly acute because of the high prevalence of pre-existing issues:

“There are higher rates of ADHD, autism, and learning difficulties in secure establishments than in the community; these are specific risk factors for the exacerbation of mental and behavioural distress for those in solitary confinement. Whilst some with autism may find separation helpful at times, those with ADHD and learning difficulties often find it more difficult than other young people. For those with ADHD, it may trigger more impulsive risk behaviour that warrants further consequences and therefore trigger a downward spiral of behaviour that the young person cannot get themselves out of without support.”¹⁰¹

95 [Q38](#) and [Q39](#) [William]

96 Shalev, S. and Edgar, K. for the Prison Reform Trust, *Deep Custody: Segregation units and Close Supervision Centres in England and Wales*, 2016

97 British Medical Association (BMA) ([YDS0018](#))

98 British Medical Association (BMA) ([YDS0018](#))

99 Mother of son in isolation ([YDS0021](#))

100 Royal College of Psychiatrists ([YDS0004](#))

101 Royal College of Psychiatrists ([YDS0004](#))

44. **Separation can undermine the aims of detention**, for example Rosie said of her ward isolation (when she was observed by a member of staff, but lacked ‘normal’ human contact) that “I would not have been able to come off the 24-hour observations even if I had wanted to, because I was so unused to being on my own”.¹⁰² Children who are separated from others will miss out on the usual routine of an institution, for example children in YOIs can miss some or all of the requisite weekly routine of 15 hours of education and two hours of physical exercise.¹⁰³ In the case of custodial settings, a report by the Children’s Commissioner noted that isolation can actually contribute to reoffending:

“Children often come to the secure estate establishments from very complex backgrounds, which means that they have previously lacked structure and guidance in their lives and that emotional regulation is difficult for them to grasp. Prolonged or frequent isolation can often serve to worsen these problems as the children fail to learn the important lessons of social order and interaction which they will need when they leave the establishment. In that sense, isolation can have a long-term negative impact on a vulnerable child and can contribute to the perpetual vicious cycle of release and re-offending. This would also explain an earlier finding of this study, that the children who were isolated once are likely to be isolated again.”¹⁰⁴

45. **We acknowledge that short-term separation has a role to play in allowing ‘cooling off’ after difficult incidents, and longer-term separation is sometimes necessary for medical observations and treatment, although it poses risks. Separation is not appropriate for other purposes. We conclude that the use of separation from human contact is harmful to children if used for more than a few hours at a time and, beyond that, it can amount to inhuman or degrading treatment that is a breach of children’s rights.**

Prevalence of separation

46. For hospitals, NHS England’s Mental Health Bulletin¹⁰⁵ for 2017–18 shows that 14 people aged under-20 were subject to 23 segregations (1.6 per person on average), and 366 people aged under-20 were subject to 1544 seclusions (4.2 per person on average). NHS England published data in 2018 in response to an FoI request about people with learning disabilities in hospital in-patient units, showing that seclusion was used 2,000 times in 2017, (up 40% from 2016).¹⁰⁶

47. HMIP’s annual survey of children in custody heard that a quarter of boys in YOIs said they had spent a night in the segregation unit in 2015–16, rising to 38% in 2016–17,

102 [Q6](#) [Witness B: Rosie]

103 The Howard League ([YDS0013](#))

104 Associate Development Solutions and the Children’s Commissioner for England, [Isolation and Solitary Confinement of Children in the English Youth Justice Secure Estate](#), 2015

105 NHS England, [Mental Health Bulletin: 2017–18 Annual Report](#), 2018, Reference Table 7.1. All of these figures were around 5–10% higher than in 2016–17, but it is not clear whether these is a genuine change, given the uncertainty in the data. Data was not available for inclusion in NHS England’s reports for earlier years.

106 NHS Digital, [Learning Disability Services Monthly Statistics](#), August 2018. This dataset covers ATUs and mental health units, so there is overlap with the figures above; it does not include autistic people; and it is not split into adults and children. The number of people with autism or learning disabilities held in inpatient units in England was around 2,350 in October 2018, of whom around 250 were children (compared to 110 in March 2015)

although falling again to 30% in 2017–18.¹⁰⁷ Rates are higher for BAME children.¹⁰⁸ In late 2018 the Children’s Commissioner for England published new data about separation in YOIs and STCs (the issues with separation are mainly in YOIs),¹⁰⁹ which she presented to us in an evidence session.¹¹⁰ In a six-month period in 2018 (compared, where possible, to a similar period in 2014), separation occurred 437 times (up 43% from 2014), and 314 children were segregated at least once.¹¹¹ 70% of separations lasted over a week in 2018, the average length of separation episodes was 16 days in 2018 (doubled from 8 days in 2014), and the longest separation in 2018 was 100 days.

48. The Youth Custody Statistics reports also include data about “single separation” in STCs and SCHs, which is defined as “the confining of a child or young person in an area as a means of control, without the child or young person’s permission or agreement. A member of staff is not present and the door is locked to prevent exit. The data in this section refer only to Secure Children’s Homes (SCHs) and Secure Training Centres (STCs).”¹¹² In the year ending March 2018, there were 3,822 single separations, affecting around 100 children in SCHs and STCs;¹¹³ that is, about a third of children were separated at least once, and on average over three times each. Data are not held for YOIs, which may mask a problem of unreported separation. HMIP’s survey of children in custody found that 64% of children in STCs said that, in 2017–18, they had been made to stay in their room away from the other children because of something they had done¹¹⁴ (up from 48% in 2015–16).¹¹⁵ The Youth Justice Board (which monitors the work of the Youth Custody Service) is planning to undertake a wide inquiry into ‘time out of rooms’, which will offer an opportunity to regulate the use of confinement in children’s own cells.

49. **We are concerned that the data published about separation in custodial settings and hospitals is not complete, and is hard to interpret. Each sector (health and custody) has datasets about restraint that are at once incomplete and also overlapping, making it difficult to obtain a clear picture of the issues. Furthermore, the different terminology used by each sector to describe essentially the same practices simply serve to complicate the making of comparisons.**

50. **In hospitals and custodial settings, children are separated from human contact (whether in their own room or in a particular unit) too often and for too long, where other options would be less harmful and more effective. The problem is even worse than is reported, due to some data not being collected fully and some data not being**

107 HMIP, [Children in custody 2015–16: An analysis of 12–18 year olds’ perceptions of their experiences in STCs and YOIs](#), 2016; HMIP, [Children in custody 2016–17: An analysis of 12–18 year olds’ perceptions of their experiences in STCs and YOIs](#), 2017; and HMIP, [Children in custody 2017–18: An analysis of 12–18 year olds’ perceptions of their experiences in STCs and YOIs](#), 2019.

108 HMIP, [HM Chief Inspector of Prisons for England and Wales Annual Report 2016–17](#), 2017

109 In STCs (and indeed also in SCHs), separation is used as a ‘time-out’ after an incident; only two episodes in STCs exceeded a few hours.

110 Children’s Commissioner for England, [A report on the use of segregation in youth custody in England](#), 2018

111 The average YOI population is 650, but due to shorter sentences more than 650 children were in custody at some point in that six-month period, so the figure of 314 is not directly comparable with the 650.

112 Youth Justice Statistics 2017–18, section 8.5

113 The figure of 100 children is the average affected, based on numbers affected in each month.

114 [Children in custody 2017–18: An analysis of 12–18 year olds’ perceptions of their experiences in STCs and YOIs](#) (Her Majesty’s Inspectorate of Prisons, 2019)

115 [Children in custody 2015–16: An analysis of 12–18 year olds’ perceptions of their experiences in STCs and YOIs](#) (Her Majesty’s Inspectorate of Prisons, 2016)

collected at all in particular for the separation of children in their own cells in YOIs. We recommend that all use of separation in all institutions is regulated and monitored, with data published annually by institution.

Solitary confinement

51. The Istanbul Statement on the Use and Effects of Solitary Confinement provides the following definition: “Solitary confinement is the physical isolation of individuals who are confined to their cells for twenty-two to twenty-four hours a day. In many jurisdictions prisoners are allowed out of their cells for one hour of solitary exercise. Meaningful contact with other people is typically reduced to a minimum. The reduction in stimuli is not only quantitative but also qualitative. The available stimuli and the occasional social contacts are seldom freely chosen, are generally monotonous, and are often not empathetic.”¹¹⁶ This definition is adopted in the UN Standard Minimum Rules for the Treatment of Prisoners (‘Mandela Rules’),¹¹⁷ that also define “prolonged” solitary confinement as being “for a time period in excess of 15 consecutive days”.¹¹⁸ These parameters of 22 hours and 15 days are also used by a UN Special Rapporteur of the Human Rights Council,¹¹⁹ and the UK Supreme Court in the case of *Bourgass*.¹²⁰

52. The Committee on the Rights of the Child said in 2016 that Young Offenders’ Institutions in the UK use solitary confinement on children, and recommended an immediate end to the practice.¹²¹ Similarly, the UK’s National Preventive Mechanism (‘NPM’),¹²² reported on YOIs and “identified practices amounting to solitary confinement outside formal isolation facilities”.¹²³ The UK Government has repeatedly insisted that solitary confinement is not used for young people and children in the UK.¹²⁴ Written evidence from the Ministry of Justice to this inquiry stated:

“It is our legal position that the published policies around segregation are compliant with human rights as they contain multi-layered procedural safeguards that as a package are sufficient to ensure that the policy is compliant with article 8 of the European Convention on Human Rights (namely, right to respect for private life). The guidance on segregation include an in-built system of reviews to ensure that continuing segregation remains necessary and proportionate.”¹²⁵

116 Istanbul Statement on the Use and Effects of Solitary Confinement 9 December 2007 at p 1

117 UN Standard Minimum Rules for the Treatment of Prisoners (‘Mandela Rules’), General Assembly (Res 70/175, 17 December 2015), Rule 44

118 UN Standard Minimum Rules for the Treatment of Prisoners (‘Mandela Rules’), General Assembly (Res 70/175, 17 December 2015), Rule 44

119 Report submitted to the UN General Assembly in August 2011 by Juan E Méndez, the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment, 2011, paras 25 and 26

120 *R (on the application of Bourgass and another) (Appellants) v Secretary of State for Justice (Respondent)*, 2015, paras 1, 22, and 37

121 Committee on the Rights of the Child, [Concluding observations on the fifth periodic report of the United Kingdom of Great Britain and Northern Ireland](#), 2016

122 The NPM is made up of bodies that monitor detention facilities in the UK and is coordinated by HM Inspectorate of Prisons (England and Wales), and has a duty to ensure that independent, preventative monitoring takes place at all places of detention, in order to fulfil the UK’s obligation under Article 11 of the Optional Protocol to the UN Convention against Torture (OPCAT).

123 NPM, [Monitoring Places of Detention: Sixth Annual Report of the United Kingdom’s National Preventive Mechanism](#), 1 April 2014–31 March 2015, December 2015

124 HC Deb, 1 May 2018, [col 99WH](#) [Westminster Hall] and Edward Argar [[Q59](#)]

125 Ministry of Justice ([YD50010](#))

53. Many commentators disagree with the Government's assertion, including all of the witnesses who commented on this matter in evidence to this inquiry. The Howard League for Penal Reform wrote: "Calls to the Howard League legal team suggest that there are numerous instances where children are isolated for more than 22 hours a day, sometimes for days on end. The Howard League recorded over 40 such concerns on behalf of children in last 12 months leading up to March 2018."¹²⁶ The Children's Rights Alliance for England told us that: "[T]he European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) was extremely critical of children being on a 'separation list' where they're locked up alone in their cells for 23.5 hours a day."¹²⁷

54. We agree with the Government that the guidelines for separation in YOIs and STCs do not permit solitary confinement; and we do not suggest that any of the Ministers who have given these assurances would allow children to be intentionally placed into solitary confinement. There are supposed to be safeguards in place, and decisions to isolate a child in a YOI have to be reviewed after 72 hours, and then every 21 days.¹²⁸ However, formal isolation of children in YOIs and other forms of separation in YOIs and STCs can sometimes 'drift' into situations of severe isolation, which may be prolonged, and which bring the risks associated with solitary confinement. As Professor Barry Goldson stated: "It is clear that practices of segregation and de facto solitary confinement of children and young people comprise enduring features of penal policy and practice."¹²⁹

55. Evidence over several years shows that incidents of separation can 'drift', so that children end up in what amounts to solitary confinement (at least 22 hours per day without meaningful contact) which may be prolonged (at least 15 days' duration). This breach of children's rights is not a policy decision by the Government, but it is within the power of Government to prevent it.

56. We recommend that every decision, or review of a decision, by YOIs to extend a period of separation beyond 72 hours is reported to the responsible Minister, on a monthly basis, who will certify the information and lay it before each House for publication. The information provided to the Minister should specifically highlight any separations that extend beyond 21 days. These figures should be simultaneously copied to the Independent Monitoring Board.

57. Case files provided by the Ministry of Justice gave details of children who were in isolation units for up to 100 days, for reasons including containment of extremely violent behaviour, observation to prevent self-harm, and self-isolation due to fear of harm by other children.¹³⁰ In an October 2018 report, the Children's Commissioner for England commented on this issue:

"... The Youth Custody Service has explained that within these figures there are some children who choose to self-isolate. We have also been told by YOI staff that some children do not want to engage in the normal regime or interact with their peers for various reasons: some do not feel safe, and others are acutely mentally unwell. The Commissioner is concerned that if a child chooses to self-isolate for long periods then the reasons for this

126 The Howard League ([YDS0013](#))

127 Children's Rights Alliance for England ([YDS0007](#))

128 Rule 49, as amended in the The Prison and Young Offender Institution (Amendment) Rules 2015 ([SI 2015/1638](#))

129 Professor Barry Goldson, University of Liverpool ([YDS0017](#))

130 These case files were provided to the Committee on the basis that they would remain confidential.

should be investigated and appropriate support needs to be put in place. We hear from YOI staff of boys kept in isolation because they are too mentally unwell to associate with peers, yet are unable to access mental health beds.”¹³¹

58. We acknowledge that there are cases of children in custody who are so unwell, violent or afraid that it is difficult to know how to treat them. *They should be moved to an institution that is equipped to look after them, or the institutions in which they reside should be reconfigured to enable them to adopt responses other than solitary confinement.*

59. There are also examples of long-lasting separation in hospitals. The Royal College of Psychiatrists argued that these examples are different to those in YOIs, stating: “there are no circumstances when a young person in secure hospital will be detained in what could be described as solitary confinement”.¹³² We acknowledge that isolation for observation or treatment (for example, to prevent self-harm) is sometimes necessary, and that there are strict rules about isolation in hospitals. We are concerned, however, that children may have been kept in isolation for durations that are extreme and unjustifiable. For example, we heard about the case of Bethany, who had at that time been isolated for almost two years at a hospital. From the description provided by her father (summarised earlier in this report), her situation has all the characteristics of solitary confinement. The CQC has reported on an inspection of ATUs and CAMHS units at this hospital, concluding that the staff faced very challenging situations and that the hospital had “identified that they were not able to meet the care needs of three patients with very complex problems and behaviours”, and that it had not “facilitated independent reviews of patients in long term segregation in line with the Mental Health Act Code of Practice”.¹³³

60. The CQC is also conducting a thematic review into restrictive practices in ATUs, which will report in March 2020.¹³⁴ We asked the CQC for the reasons for this long timescale, and as part of our ongoing work on ATUs we will scrutinise the CQC’s interim report, due in May 2019, to see what actions can be taken at that stage. We received assurances from the CQC that “if we have concerns about [patients’] welfare we will escalate those concerns immediately”.¹³⁵

61. The use of separation from human contact for medical observation and treatment must be weighed against the risks of distress and harm to the child. Some cases in hospitals amount to solitary confinement, which is not compliant with human rights standards for children. *We recommend that the use of separation in hospitals be more rigorously regulated. Each institution in the health sector must report data on extension of separations to the responsible Minister on a monthly basis, who will certify the information and lay it before each House for publication.*

131 Children’s Commissioner for England, [A report on the use of segregation in youth custody in England](#), 2018

132 Royal College of Psychiatrists ([YDS0004](#))

133 Care Quality Commission, St Andrew’s Healthcare Adolescents Service Quality Report, February 2019

134 Care Quality Commission, [Thematic review of the use of restraint, prolonged seclusion and segregation for people with mental health problems, learning disabilities and/or autism: Terms of Reference](#), November 2018

135 The detention of young people with learning disabilities and autism, [Q8](#) [Dr Paul Lelliott]

4 Systemic issues contributing to restraint and separation

Availability and suitability of placements

62. The complexity of many children's situations is such that they cannot simply be pigeon-holed into a particular categorisation of need. This in turn has implications for where they are placed (if at all) in detention. Some children with learning disabilities or autism also have mental health issues, but they are not necessarily well-served by either ATUs or CAHMS, or indeed any sort of institution.¹³⁶ Other children have an uncommon diagnosis, such as a specific form of autism for which an ATU might be poorly suited. As Jeremy told us: "ATUs are full of very distressed people, so Beth witnessed self-harm, she heard screaming, she heard people distressed and shouting. With Bethany's condition, she has massive sensory issues. She cannot cope with that environment ... Their answer to that was to lock Bethany away."¹³⁷ He contrasted this with a potential placement that did not resort to separation: "If you have the right people doing the right thing—distracting, diverting, offering choices instead of placing demands—this will be negated. The potential placement does not have a seclusion room. It does not need one, because there are properly trained staff."¹³⁸

63. On the fundamental question of whether any form of detention is appropriate for some children, Julie Newcombe quoted from the Mental Health Act Code of Practice: "Compulsory treatment in a hospital setting is rarely likely to be helpful for a person with autism ... People with autism should be detained for as short a period as possible."¹³⁹ She added that, even though living in a community is often better for children with autism,¹⁴⁰ her son, Jamie, "spent 19 months in five different in-patient settings, one after the other. He kept being rocked on to the next one, because they did not know what to do to help him."¹⁴¹ The Transforming Care programme was supposed to end detention of people with autism or learning disabilities,¹⁴² but the number of children detained in ATUs has more than doubled since March 2015.¹⁴³ In our ongoing work on ATUs we are considering the reasons for this failure to allow more children with autism or learning disabilities to live in communities.

64. Most children who are in contact with the criminal justice system have multiple needs: they are among the most disadvantaged and vulnerable children in the country, with high rates of Adverse Childhood Experiences (ACEs), strong correlations with the

136 For a detailed study see: Dame Christine Lenehan, Council for Disabled Children, [These are our children, a review](#), January 2017, commissioned by the Department of Health

137 Conditions in learning disability inpatient units, [Q9](#) [Jeremy]

138 Conditions in learning disability inpatient units, [Q12](#) [Jeremy]

139 Department of Health, [Mental Health Act 1983: code of practice](#), (2015), chapter 20, paragraph 20

140 Conditions in learning disability inpatient units, [Q11](#) [Julie Newcombe]

141 Conditions in learning disability inpatient units, [Q12](#), [Julie Newcombe]

142 Department of Health, [Transforming care: A national response to Winterbourne View Hospital, Final Report](#), 2012

143 NHS Digital [Learning Disability Services Monthly Statistics - AT: October 2018, MHSDS: August 2018](#), November 2018

Indices of Multiple Deprivation,¹⁴⁴ and high incidences of mental health issues,¹⁴⁵ learning difficulties and autism,¹⁴⁶ as well as speech, and language and communication needs (SLCN).¹⁴⁷ As Francis Boylan of the British Association of Social Workers told us:

“The children held in secure settings are some of the most difficult, damaged children in the country ... the majority have been known to health, education and social services, if not throughout their lives, for a great proportion of that time. Crudely speaking, the majority of these children have been failed both by their families, and the state, which has been unable/unwilling to provide the necessary foundation to enable them to live happy, untroubled lives.”¹⁴⁸

65. It can be difficult to manage these complex issues in custodial settings as currently operated, and some of these children warrant care in healthcare institutions. Indeed, when sentencing children, courts have some latitude: YOIs are used for most offenders aged 15–17 years, and STCs for those aged 15–17 years whose offending is less serious or less persistent; but children aged 10–14 years will be placed in SCHs, and courts can request a hospital placement for a child of any age who has serious mental health issues. Some judges, however, have commented on lack of places in SCHs and hospital units. For example, in October 2018 Judge Lazarus noted:

“I am keenly aware of the notable frustration and outrage ... at the lack of appropriate placements for extremely troubled children ... I am grateful to the social workers for their repeated and persistent efforts spending significant time and energy attempting to contact dozens of units in their attempts to find a single available placement prepared to take O. In August there were 31 children waiting for a placement, and on 5.9.18 there were 35 children for whom a placement in secure accommodation was being sought. Today there were at least 25 children, and likely to rise to 26, needing a placement.”¹⁴⁹

66. Data provided by the Ministry of Justice for our inquiry¹⁵⁰ showed that there are just over 200 places available in 14 SCHs in England in 2018, down from almost 300 in 16 SCHs in 2010. Local authorities are responsible for providing the places, but the Government told us that the policy sits under the Department for Education, which is increasing funds to provide more places.¹⁵¹ Of these places, 114 were allocated to the Ministry of Justice in 2018 (down from 176 in 2010), and the rest were allocated for children referred under welfare orders. These figures illustrate the complex interplay between the responsibilities and resources of Government departments and agencies working with young offenders, which is even more complex when the resourcing of the health sector is factored in. The

144 Francis Boylan ([YDS0008](#))

145 Royal College of Psychiatrists Royal College of Psychiatrists ([YDS0004](#))

146 Royal College of Psychiatrists Royal College of Psychiatrists ([YDS0004](#))

147 RCLT ([YDS0009](#))

148 Francis Boylan ([YDS0008](#))

149 Between London Borough of Bromley and Mrs. O and O (Case Number: ZE18C00536)

150 Ministry of Justice ([YDS0032](#))

151 Ministry of Justice ([YDS0032](#))

Government drew our attention, however, to the establishment of a Critical Case Panel to co-ordinate across Government and across disciplines regarding the care of young people with complex needs.¹⁵²

67. We have also considered the spread of institutions around the country. In the case of hospitals, sometimes children are not placed in the unit nearest to their home because specialist care is only available at certain sites. Jeremy told us that the distance to Beth was “just short of 70 miles ... We have been far farther away in the past.”¹⁵³ Initiatives such as New Care Models seek to bring people in hospital closer to home.¹⁵⁴

68. In the case of custodial settings, Edward Argar MP noted that in almost all cases it is beneficial for children to be located near to their families.¹⁵⁵ However, this is not always easy for families, as William said: “When I was closer [to home], when I first went in I could get visits twice a week, then I would get two or three a month. When I went up [to another YOI], it was whenever they could, because it’s like a day trip for them—it’s the whole day.”¹⁵⁶ This problem has been exacerbated by the closure of several sites in recent years, leaving only five YOIs in England and Wales (plus one site in each of Scotland and Northern Ireland). Furthermore, sometimes children are not placed in the institution nearest to their homes, for example with the aim of separating gang members. We note that the Government’s plans for Secure Schools in the custodial sector could lead to smaller units, spread more widely across England and Wales.¹⁵⁷

69. The detention of children in institutions that are inappropriate to their needs contributes to the unacceptably high rates of restraint and separation. This includes children who have mental health issues but are detained in custody for criminal convictions, and children who are autistic or have learning difficulties who could be better cared for in community settings. *The Ministry of Justice, the Department of Health and Social Security, and the Department for Education all have responsibilities for children in detention, and must increase their efforts to coordinate and reconfigure resources, to ensure that there are enough specialised placements (including in SCHs and CAMHS), so that each child can be placed in the most appropriate setting and as near as possible to home.*

Staffing levels, training and specialisms

70. Evidence to this inquiry highlighted staff shortages in all settings, due both to deliberate reductions in staff-to-child ratios (as in YOIs) and to recruitment problems, factors that are exacerbated by absences and the need to use agency staff who are not familiar with the children. The following examples illustrate that staff shortages increase the number of incidents (for example, by inhibiting a good routine or therapeutic activities); increase the likelihood that an incident will be addressed by restraint or separation without recourse to better alternatives; and increase the likelihood that restraint or separation will be conducted improperly.

152 Ministry of Justice ([YDS0032](#))

153 Conditions in learning disability inpatient units, [Q16](#) [Jeremy]

154 Department of Health, [New Care Models](#)

155 There are some children in custody whose families are harmful influences, and hence being near to them is not necessarily a priority, but this is the exception. [Q67](#) [Edward Argar MP]

156 [Q42](#) [William]

157 Ministry of Justice, [Secure Schools](#)

71. Rosie told us that when she was on ward restriction, individual staff would be with her “for maybe six hours straight ... it became very mundane and routine”.¹⁵⁸ She continued: “I had not been out for four or five months straight. There was always a glimmer of hope that I would be let outside, but a lot of the time those plans would fail because they did not have enough staff.”¹⁵⁹ She also said that “because of the lack of staff ... that person would have to restrain me by themselves, which obviously was not allowed as it was never the safest restraint ... I witnessed situations where there were not enough staff to safely restrain someone and people would come out of their rooms eventually with bruises and things like that.”¹⁶⁰ Jeremy told us: “When Bethany was returned to the unit, they did not have sufficient trained staff available to enable her to stay out of being secluded, so they put her back in a room and they locked the door.”¹⁶¹

72. William told us about the impacts at YOIs: “There were two officers for 30 young people. If there is a big fight, there are two officers and all they can do is press the bell and wait for help. By the time that happened, though, it could be a bloodbath. I do not think that there are enough officers.”¹⁶² William also highlighted the issue of weekend routines in YOIs:

“Weekends are always like a restricted regime, so it would be like, if you’re lucky enough to get a gym, you might get a gym. If not, it’s an association for maybe one hour or two hours and then that’s it ... For two hours a day. Saturday might be from 10 to 12, then you’re banged up until 4.30, you get your dinner and then you’re banged up again. Then, on Sunday, you might have an association from 2 to 4, but it depends. Different jails have different regimes. The older I got, the more time I got out of my cell. As a juvenile, I spent a lot of time behind my door.”¹⁶³

73. The Children’s Commissioner agreed: “We know that weekends are a trigger to really bad levels of violence on Monday and Tuesday because the kids are locked up in their rooms from two or three in the afternoon. They literally wind each other up shouting at each other through the windows for 12 hours and that all spills out on a Monday or Tuesday.”¹⁶⁴ The Youth Custody Service told us that these issues were now being addressed by a drive to increase the number of staff in YOIs by 20%.¹⁶⁵

74. As well as having sufficient staff, there needs to be an appropriate range of skills. Julie Newcombe’s evidence suggested that some staff at ATUs lack the appropriate training to help autistic people;¹⁶⁶ and Dame Christine Lenehan, Director, Council for Disabled Children told us that some private providers have replaced experienced staff with inexperienced staff.¹⁶⁷ Rosie told us that: “Things were going well for maybe a month or two, but then they started to deteriorate because I was not getting the psychological help that I needed through therapy and things like that. ... So I ended up on 24-hour observations for six

158 [Q7](#) [Witness B: Rosie]

159 [Q10](#) [Witness B: Rosie]

160 [Q11](#) [Witness B: Rosie]

161 Conditions in learning disability inpatient units, [Q11](#), [Jeremy]

162 [Q40](#) [William]

163 [Q42](#) [William]

164 [Q49](#) [Anne Longfield]

165 [Q63](#) [Peter Gormley]

166 Conditions in learning disability inpatient units, [Q12](#) [Julie Newcombe]

167 Detention of children and young people with learning disabilities and/or autism inquiry, [Q14](#) [Dame Christine Lenehan]

and a half months straight.”¹⁶⁸ In YOIs and STCs there is a need for more staff in non-discipline roles such as medics, social workers, psychiatrists, communication therapists and peer supporters or role models, all of whom can help to relate to de-escalate situations and hence reduce the use of restraint and separation.

75. Staffing levels are too low in YOIs, CAMHS and ATUs, and the mix of skills is insufficient, preventing the appropriate care of children and the optimal management of difficult situations, and contributing to the unacceptably high rates of restraint and separation. We urge the Government and agencies to take steps to increase the numbers of staff qualified to manage children across the Youth Custody Service, NHS England and their respective estates and contractors. The objective should be to ensure that there is an appropriate mix of skills, so that staff can manage difficult situations without recourse to restraint and separation.

Rights, appeals and redress

76. There are several factors that prevent children from exercising their rights. Firstly, while children are told of their rights when they first arrive in any type of detention,¹⁶⁹ these discussions do not necessarily register with children, thanks to combinations of trying to adjust to their new situations, mental health issues, communication issues, and (in some cases) a mistrust of authority. While advocates work in detention settings to raise children’s awareness of their rights, the Children’s Commissioner commented:

“I would like to see them have a much more proactive role ... being built in from the start ... talking about the trends ... getting youth councils set up ... that is about confidence in them being able to do that, and about the governors taking that aspect seriously, and making sure that it is not only happening but seen to be happening, and is seen as important.”¹⁷⁰

77. Secondly, there is unwillingness to report incidents. William told us that he did not see any point in complaining about separation: “By the time the complaint had come back, I had already served my time ... I was not going to get it back.”¹⁷¹ Similarly, he told us that he did not see the point of complaining about restraint: “I do not see how it was going to happen for me getting a restraint. What was going to happen? They were going to say, ‘We believe that reasonable force was used because of X, Y and Z’. Then, what next? Even if they uphold it, what am I going to get? A ‘sorry’. It is too late.”¹⁷² The Children’s Commissioner told us that this was a common attitude in custodial settings: “All the young people tell me that they would not bother complaining, because either it will get worse or no one will listen.”¹⁷³ Furthermore, witnesses told us that they had not told their parents about issues, William because he did not wish to worry his mother,¹⁷⁴ and Rosie because she was not in a good relationship with her parents at that time.¹⁷⁵ If children are reluctant to complain to staff or to tell their families, the onus is on staff (especially advocates) to build confidence in the complaints process. Glyn Travis, of the Prison Officers’ Association, said

168 Q4 [Witness B: Rosie]

169 Children are also reminded of their rights thereafter in some institutions.

170 Q57 [Anne Longfield]

171 Q39 [William]

172 Q39 [William]

173 Q57 [Anne Longfield]

174 Q39 [William]

175 Q13 [Witness B: Rosie]

that a return to the system of senior officers being visible on units in YOIs and STCs would give children someone to approach about their concerns.¹⁷⁶ The Howard League for Penal Reform also argued that children and their representatives needed access to better quality evidence to support complaints, describing paperwork that lacked sufficient detail.¹⁷⁷ The Children's Commission for England and UK National Preventive Mechanism called for comprehensive CCTV monitoring (including body-worn cameras) in hospitals,¹⁷⁸ the Howard League for Penal Reform sought the same monitoring in custodial settings.¹⁷⁹

78. Thirdly, where an institution does acknowledge that staff acted wrongfully, the 'restorative' remedies are often seen as inadequate. William commented that a child cannot regain time lost in segregation or undo the distress of a restraint;¹⁸⁰ so compensation must be of worth to the children. Fourthly, there is often a lack of 'resolution' for the child, such that they can lose confidence in the systems. In contrast, Dr Heidi Hales, of the Royal College of Psychiatrists, told us:

"A complaint could be a good opportunity to show good adult behaviour in how to resolve a situation and think it through. You could use that for the benefit of a treatment or rehabilitation package. The request would be to have a driver to make sure that we use such opportunities. Nobody will ever be perfect, but if you show that you can admit your imperfection, learn from it and change, and acknowledge faults in their procedures, or to take action against staff who have breached children's rights work with the young person to help them think it through, it will also help them to think about it when those situations arise."¹⁸¹

79. Fifthly, if children and their families are to have confidence in the complaints systems, there needs to be clear evidence of change in response to previous errors, including changes to processes and resources. Rosie told us that she was repeatedly restrained by single members of staff (in breach of the guidelines), but that the issue was not addressed:

"Depending on which member of staff had carried out the restraint, they would apologise if they had hurt me. But a lot of the time it was brushed over. The ward manager would come and speak to me and say, 'This is why that happened', and people had to do incident reports. I heard a couple of times that people did not know what to write on the incident reports. If they said that they had carried it out by themselves, they would be in trouble, but what else could they have done? Something even worse, even fatal, could happen to the patient they did not restrain."¹⁸²

80. Julie Newcombe told us that, after her son's arm was broken by hospital staff, disciplinary action was taken, but she encountered difficulties when making complaints about wider governance issues: "The person who did it was suspended immediately and later dismissed from his job. I do not recall ever getting an apology ... We have since

176 [Q35](#) [Glyn Travis]

177 The Howard League ([YDS0030](#))

178 UKNPM and Children's Commissioner for England ([YDS0026](#))

179 The Howard League ([YDS0030](#))

180 [Q39](#) [William]

181 [Q35](#) [Dr Heidi Hales]

182 [Q12](#) [Witness B: Rosie]

complained about the ineffectiveness of the safeguarding, because that was no accident ... It is you against the hospital, you against the local authority, you against the commissioners. It is just you, the parent, trying to fight for your child.”¹⁸³

81. We have heard compelling evidence that institutions are not doing enough to ensure that children in detention are made sufficiently aware of (and understand) their rights; or to ensure that children can have trust in the complaints system and the staff disciplinary system; or to ensure that parents and other representatives are made aware of the problems faced by children in detention. Even when children, their parents and representatives are made aware of their rights, they face obstacles when challenging decisions. *We recommend that parents or other representatives should be informed of incidents and consulted about the appropriateness of interventions; that independent advocates should be given responsibility for proactively helping children to understand their rights; that debriefs about restraints and separation should allow the child to discuss the incidents with the staff who were involved; and that staff who have acted in breach of the rules must face disciplinary action that must be communicated to the child. There must be annual publication of statistics for each institution about appeals and their outcomes, including about disciplinary action against staff.*

82. *This is an area in which the Independent Monitoring Boards are well placed to play a role. Any concerns they raise with respect to these issues should be seriously considered.*

183 Conditions in learning disability inpatient units, [Q18](#) [Julie Newcombe]

Conclusions and recommendations

International human rights obligations

1. The UK has accepted international obligations, and incorporated certain obligations into domestic law, to ensure that children are not be subject to cruel, inhuman or degrading treatment. The Government must comply with its international and domestic obligations and ensure that children in detention are treated with appropriate care. (Paragraph 8)

Experiences and impact of restraint

2. There is substantial medical evidence of the physical and psychological impacts of restraint, particularly when used upon children. This evidence was brought into stark relief by the evidence of young people who had experienced these impacts, and parents who relayed the impacts upon their children. While restraint might seem to solve an immediate problem in custody or hospital, it causes harm in the short term and the longer term: it harms children, it harms staff, it undermines the objectives of detention, and contributes to a vicious circle of problems that can continue into the future including inhibiting life chances into adulthood. The use of restraint upon children can amount to inhuman or degrading treatment which is a breach of children's rights. (Paragraph 17)

Rates of restraint of children

3. The data published about restraint in custodial settings and hospitals is not complete, and is hard to interpret. Each sector (health and custody) has datasets about restraint that are at once incomplete and also overlapping, making it difficult to obtain a clear picture of the issues. Furthermore, the different terminology used by each sector to describe essentially the same practices simply serves to complicate the making of comparisons. (Paragraph 20)
4. Despite the shortcomings in data collection, it is clear that in YOIs, STCs and hospitals a large minority of children experience restraints and separations; the average number of restraints and separations that these children experience is high. BAME children are particularly affected. From the evidence that we have heard, it is clear that some restraints are not justified on the grounds of 'last resort' to prevent harm. The available data about numbers of reported restraints suggest that potentially thousands of unjustified restraints are conducted each year. We conclude that rates of restraint of children in the custody estate and in hospitals are unacceptably high, and children's rights are being commonly breached. (Paragraph 21)
5. We believe that the reported increases in the use of restraint in custody and hospitals are a combination of better reporting (showing that the problems are worse than previously thought) and actual increases (illustrating that the problems are becoming worse still). (Paragraph 23)

6. *The issue must be tackled from both angles, with continued improvements in reporting in order to see the true scale of the issues, and action to reduce the need for restraint and separation, in all secure settings. (Paragraph 23)*

Pain-inducing restraints in YOIs

7. There is clear evidence that the use of pain-inducing techniques (which are designed to cause pain and work by deliberately inflicting pain) on children inflicts physical distress and psychological harm in both the short and longer term, and it is clearly not compliant with human rights standards. (Paragraph 27)
8. *We recommend that the use of specific pain-inducing techniques in Youth Offenders' Institutes should be prohibited. We also recognise the right of prison officers to act in self-defence and we are aware that these issues are currently subject to review. (Paragraph 27)*

Restraint for "good order and discipline" in YOIs

9. The use of restraint in YOIs for the purposes of 'discipline and good order' is not compliant with human rights standards, and is counterproductive for children's rehabilitation and the development of beneficial relationships with staff. (Paragraph 31)
10. *We recommend that the use of restraint for the purposes of 'discipline and good order' in Young Offenders' Institutes be prohibited in all but the most exceptional circumstances, and that the guidelines produced by the Ministry of Justice and its agencies be updated accordingly. (Paragraph 31)*

Prone (face-down) restraint

11. The use of prone (face-down) restraint is distressing and can be dangerous, and its use as anything but a last resort is not compliant with human rights standards for children. We believe that prone restraint is used too often. (Paragraph 34)
12. *While we acknowledge that there may be exceptional circumstances in which prone restraint is preferable to alternatives, it must be more rigorously regulated by governing health bodies and regulators, including by annual publication of statistics for each institution (broken down by patients' diagnoses, age and justification for not using an alternative method). (Paragraph 34)*

Experiences and impacts of separation

13. We acknowledge that short-term separation has a role to play in allowing 'cooling off' after difficult incidents, and longer-term separation is sometimes necessary for medical observations and treatment, although it poses risks. Separation is not appropriate for other purposes. We conclude that the use of separation from human contact is harmful to children if used for more than a few hours at a time and, beyond that, it can amount to inhuman or degrading treatment that is a breach of children's rights. (Paragraph 45)

Prevalence of separation

14. We are concerned that the data published about separation in custodial settings and hospitals is not complete, and is hard to interpret. Each sector (health and custody) has datasets about restraint that are at once incomplete and also overlapping, making it difficult to obtain a clear picture of the issues. Furthermore, the different terminology used by each sector to describe essentially the same practices simply serve to complicate the making of comparisons. (Paragraph 49)
15. In hospitals and custodial settings, children are separated from human contact (whether in their own room or in a particular unit) too often and for too long, where other options would be less harmful and more effective. The problem is even worse than is reported, due to some data not being collected fully and some data not being collected at all in particular for the separation of children in their own cells in YOIs. (Paragraph 50)
16. *We recommend that all use of separation in all institutions is regulated and monitored, with data published annually by institution.* (Paragraph 50)

Solitary confinement

17. Evidence over several years shows that incidents of separation can ‘drift’, so that children end up in what amounts to solitary confinement (at least 22 hours per day without meaningful contact) which may be prolonged (at least 15 days’ duration). This breach of children’s rights is not a policy decision by the Government, but it is within the power of Government to prevent it. (Paragraph 55)
18. *We recommend that every decision, or review of a decision, by YOIs to extend a period of separation beyond 72 hours is reported to the responsible Minister on a monthly basis, who will certify the information and lay it before each House for publication. The information provided to the Minister should specifically highlight any separations that extend beyond 21 days. These figures should be simultaneously copied to the Independent Monitoring Board.* (Paragraph 56)
19. We acknowledge that there are cases of children in custody who are so unwell, violent or afraid that it is difficult to know how to treat them. (Paragraph 58)
20. *They should be moved to an institution that is equipped to look after them, or the institutions in which they reside should be reconfigured to enable them to adopt responses other than solitary confinement.* (Paragraph 58)
21. The use of separation from human contact for medical observation and treatment must be weighed against the risks of distress and harm to the child. Some cases in hospitals amount to solitary confinement, which is not compliant with human rights standards for children. (Paragraph 61)
22. *We recommend that the use of separation in hospitals be more rigorously regulated. Each institution in the health sector must report data on extension of separations to the responsible Minister on a monthly basis, who will certify the information and lay it before each House for publication.* (Paragraph 61)

Availability and suitability of placements

23. The detention of children in institutions that are inappropriate to their needs contributes to the unacceptably high rates of restraint and separation. This includes children who have mental health issues but are detained in custody for criminal convictions, and children who are autistic or have learning difficulties who could be better cared for in community settings. (Paragraph 69)
24. *The Ministry of Justice, the Department of Health and Social Security, and the Department for Education all have responsibilities for children in detention, and must increase their efforts to coordinate and reconfigure resources, to ensure that there are enough specialised placements (including in SCHs and CAMHS), so that each child can be placed in the most appropriate setting and as near as possible to home.*(Paragraph 69)

Staffing levels, training and specialisms

25. Staffing levels are too low in YOIs, CAMHS and ATUs, and the mix of skills is insufficient, preventing the appropriate care of children and the optimal management of difficult situations, and contributing to the unacceptably high rates of restraint and separation. (Paragraph 75)
26. *We urge the Government and agencies to take steps to increase the numbers of staff qualified to manage children across the Youth Custody Service, NHS England and their respective estates and contractors. The objective should be to ensure that there is an appropriate mix of skills, so that staff can manage difficult situations without recourse to restraint and separation.* (Paragraph 75)

Rights, appeals and redress

27. We have heard compelling evidence that institutions are not doing enough to ensure that children in detention are made sufficiently aware of (and understand) their rights; or to ensure that children can have trust in the complaints system and the staff disciplinary system; or to ensure that parents and other representatives are made aware of the problems faced by children in detention. Even when children, their parents and representatives are made aware of their rights, they face obstacles when challenging decisions. (Paragraph 81)
28. *We recommend that parents or other representatives should be informed of incidents and consulted about the appropriateness of interventions; that independent advocates should be given responsibility for proactively helping children to understand their rights; that debriefs about restraints and separation should allow the child to discuss the incidents with the staff who were involved; and that staff who have acted in breach of the rules must face disciplinary action that must be communicated to the child. There must be annual publication of statistics for each institution about appeals and their outcomes, including about disciplinary action against staff.* (Paragraph 81)
29. *This is an area in which the Independent Monitoring Boards are well placed to play a role. Any concerns they raise with respect to these issues should be seriously considered* (Paragraph 82)

Declaration of Lords' Interests¹

Interests declared:

Baroness Hamwee

- No relevant interests to declare

Baroness Lawrence of Clarendon

- No relevant interests to declare

Baroness Prosser

- No relevant interests to declare

Lord Woolf

- Formerly a Judge
- Member of Committees dealing with penal matters including Prison Reform Trust, Butler Trust
- I refer to my register of interests entry

Lord Trimble

- No interests declared

Baroness Nicholson of Winterbourne

- No interests declared

¹ A full list of Members' interests can be found in the Register of Lords' Interests: <https://www.parliament.uk/mps-lords-and-offices/standards-and-financial-interests/house-of-lords-commissioner-for-standards-/registeroflords-interests/>

Formal minutes

Wednesday 10 April 2019

Members present:

Ms Harriet Harman MP, in the Chair

Ms Karen Buck MP	Baroness Hamwee
Fiona Bruce MP	Baroness Lawrence of Clarendon
Scott Mann MP	Baroness Nicholson of Winterbourne
Jeremy Lefroy MP	Lord Trimble
	Lord Woolf

Jeremy Lefroy declared an interest as a former member of an Independent Monitoring Board.

Draft Report (*Youth detention: solitary confinement and restraint*), proposed by the Chair, brought up and read.

Ordered, That the Chair's draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 82 read and agreed to.

Summary read and agreed to.

Resolved, That the Report be the Nineteenth Report of the Committee.

Ordered, That the Chair make the Report to the House of Commons and that the Report be made to the House of Lords.

Ordered, That embargoed copies of the report be made available, in accordance with the provisions of House of Commons Standing Order no. 134.

[Adjourned till Wednesday 24 April 2019 at 3.00pm.]

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the [inquiry publications page](#) of the Committee's website.

Wednesday 4 July 2018

Witness B (accompanied by Alice Victor, Youth Engagement Co-ordinator, Young Minds)

[Q1–15](#)

Wednesday 11 July 2018

Dr John Chisholm, Chair, Medical Ethics Committee, British Medical Association, **Dr Laura Janes**, Legal Director, Solicitor, Howard League for Penal Reform, **Glyn Travis**, Assistant General Secretary, The Professional Trades Union for Prison, Correctional and Secure Psychiatric Workers, and **Dr Heidi Hales**, Forensic Psychiatrist, Royal College of Psychiatrists

[Q16–36](#)

Wednesday 12 September 2018

"William" (accompanied by a supporting witness)

[Q37–48](#)

Wednesday 10 October 2018

Anne Longfield OBE, Children's Commissioner for England and **Angus Mulready-Jones**, Lead Inspector - Children in Detention, HM Inspectorate of Prisons

[Q49–58](#)

Wednesday 17 October 2018

Edward Argar MP, Parliamentary Under-Secretary of State, Ministry of Justice, **Peter Gormley**, Deputy Director for Casework, Partnerships Business and Change, Youth Custody Service, **Jonathan Marron**, Director General, Community and Social Care, Department of Health and Social Care, and **Teresa Fenech**, Director of Nursing and Quality Assurance, Specialised Commissioning, NHS England

[Q59–72](#)

Published written evidence

The following written evidence was received and can be viewed on the [inquiry publications page](#) of the Committee's website.

YDS numbers are generated by the evidence processing system and so may not be complete.

- 1 Article 39 ([YDS0011](#))
- 2 Boylan, Francis ([YDS0008](#))
- 3 The British Association of Social Workers (BASW) ([YDS0027](#))
- 4 British Medical Association (BMA) ([YDS0018](#))
- 5 Care Quality Commission ([YDS0016](#))
- 6 Children's Rights Alliance for England ([YDS0007](#))
- 7 Equality and Human Rights Commission ([YDS0015](#))
- 8 Goldson, Professor Barry ([YDS0017](#))
- 9 Her Majesty's Inspectorate of Prisons ([YDS0020](#))
- 10 HM Inspectorate of Prisons ([YDS0031](#))
- 11 The Howard League ([YDS0013](#))
- 12 The Howard League ([YDS0030](#))
- 13 Ministry of Justice ([YDS0010](#))
- 14 Ministry of Justice ([YDS0032](#))
- 15 mother of son in isolation ([YDS0021](#))
- 16 Munira Ali, Dr. Alexandra Cox, and Julie Hannah ([YDS0019](#))
- 17 NHS England ([YDS0033](#))
- 18 Northumbria University ([YDS0002](#))
- 19 Office of the Children's Commissioner ([YDS0028](#))
- 20 POA ([YDS0014](#))
- 21 Prison Reform Trust ([YDS0005](#))
- 22 RCLT ([YDS0009](#))
- 23 Royal College of Psychiatrists ([YDS0004](#))
- 24 Shalev, Dr Sharon ([YDS0001](#))
- 25 Standing Committee for Youth Justice ([YDS0012](#))
- 26 UKNPM and Children's Commissioner for England ([YDS0026](#))

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the [publications page](#) of the Committee's website. The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2017–19

First Report	Legislative Scrutiny: The EU (Withdrawal) Bill: A Right by Right Analysis	HC 774 HL 70
Second Report	Proposal for a Draft Human Fertilisation and Embryology Act 2008 (Remedial) Order 2018	HC 645 HL 86
Third Report	Legislative Scrutiny: The Sanctions and Anti-Money Laundering Bill	HC 568 HL 87
Fourth Report	Freedom of Speech in Universities	HC 589 HL 111
Fifth Report	Proposal for a draft British Nationality Act 1981 (Remedial) Order 2018	HC 926 HL 146
Sixth Report	Windrush generation detention	HC 1034 HL 160
Seventh Report	The Right to Freedom and Safety: Reform of the Deprivation of Liberty Safeguards	HC 890 HL 161
Eighth Report	Freedom of Speech in Universities: Responses	HC 1279 HL 162
Ninth Report	Legislative Scrutiny: Counter-Terrorism and Border Security Bill	HC 1208 HL 167 (HC 1827)
Tenth Report	Enforcing Human Rights	HC 669 HL 171
Eleventh Report	Second Legislative Scrutiny Report: Counter-Terrorism and Border Security Bill	HC 1616 HL 195
Twelfth Report	Legislative Scrutiny: Mental Capacity (Amendment) Bill	HC 1662 HL 208
Thirteenth Report	Proposal for a draft Jobseekers (Back to Work Schemes) Act 2013 (Remedial) Order 2018	HC 1451 HL 209
Fourteenth Report	Draft Human Fertilisation and Embryology Act 2008 (Remedial) Order 2018	HC 1547 HL 227
Fifteenth Report	Proposal for a draft Human Rights Act 1998 (Remedial) Order 2019	HC 1457 HL 228
Sixteenth Report	Immigration Detention	HC 1484 HL 279
Seventeenth Report	Human Rights Protections in International Agreements	HC 1883 HL 310
Eighteenth Report	Legislative Scrutiny: Immigration and Social Security Co-ordination (EU Withdrawal) Bill	HC 569 HL 324

First Special Report	Human Rights and Business 2017: Promoting responsibility and ensuring accountability: Government Response to the Committee's Sixth Report of Session 2016–17	HC 686
Second Special Report	Mental Health and Deaths in Prison: Interim Report: Government Response to the Committee's Seventh Report of Session 2016–17	HC 753
Third Special Report	Legislative Scrutiny: Counter-Terrorism and Border Security Bill: Government Response to the Committee's Ninth Report of Session 2017–19	HC 1578
Fourth Special Report	Windrush generation detention: Government Response to the Committee's Sixth Report of Session 2017–19	HC 1633
Fifth Special Report	Second Legislative Scrutiny Report: Counter-Terrorism and Border Security Bill: Government Response to the Committee's Eleventh Report of Session 2017–19	HC 1827