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INTRODUCTION

Human rights treaties to which the United Kingdom (UK) is a party guarantee the right to life; the right not to be subjected to torture and cruel, inhuman or degrading treatment or punishment; and the right to be treated with respect for the inherent dignity of the human person. Amnesty International is concerned that the authorities responsible for the welfare of children and young persons in young offenders institutions in England and Wales have failed to ensure respect for these basic human rights.

Reports of abuses of the internationally guaranteed rights of children and young people have persisted in recent years despite numerous and thorough reports by the Chief Inspector of Prisons for England and Wales[1], the Prisons Ombudsman[2] and various non-governmental organizations documenting serious human rights violations in several young offenders institutions. This report draws on information emerging from Amnesty International's research and provided by non-governmental organizations including Inquest, Women in Prison, the Howard League for Penal Reform and the Prison Reform Trust; prisoners' lawyers; the news media and published reports by the Chief Inspector of Prisons and the Prisons Ombudsman.

Young offenders institutions are designed to house both children aged between 15 and 18, and young people aged between 18 and 21.

1. THE RIGHT TO LIFE

Amnesty International is concerned that the failure of the authorities to prevent violence between children and young people detained or imprisoned and to adequately care for and

[1]The Chief Inspector of Prisons has the duty to inspect and report to the Home Secretary on prison service establishments in England and Wales, and in particular on conditions in those establishments; the treatment of prisoners and other inmates and the facilities available to them; and other matters as the Home Secretary may direct.

[2]The Prisons Ombudsman is appointed by the Home Secretary and is mandated to investigate complaints by individual prisoners, provided that the prisoner has previously sought redress through the prison service complaint service. The mandate extends to reviewing decisions made by prison service staff and agents as well as others working in a prison, with the exclusion of decisions involving the clinical judgment of doctors. The Ombudsman may visit establishments only after making arrangements with the Prison Governor or staff. His recommendations are made to the Director General of the prison service or the Home Secretary and the prison service is to reply to recommendations within six weeks.

monitor those who may be at risk of self-harm or suicide has resulted in violations of the right to life.

Article 2 of the European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR) enshrines the right to life. Judgement of the European Court of Human Rights and of the European Commission of Human Rights has made clear that the right to life under Article 2 requires the state not only to refrain from the unlawful taking of life but also to take measures to protect life.

The authorities are required to do all that can reasonably be expected of them to avoid a real and immediate risk to the life of an identified person which they know about or ought to have known about from the criminal acts of a third party.[3]

With regard to persons deprived of their liberty and in the custody of the state, there may be circumstances in which the death of a prisoner by suicide can also give rise to a violation of the right to life. The European Court of Human Rights has found that: "There are general measures and precautions which will be viable to diminish the opportunities for self-harm, without infringing personal autonomy. Whether any more stringent measures are necessary in respect of a prisoner and whether it is reasonable to apply them will depend on the circumstances of the case".[4]

1.1. INTER-PRISONER VIOLENCE: THE CASE OF ZAHID MUBAREK

Nineteen-year-old Zahid Mubarek was killed by his cell mate, Robert Stewart, in Feltham Young Offenders Institution and Remand Centre, Middlesex, in March 2000. Robert Stewart was convicted of murder later in the year. The death of Zahid Mubarek, which attracted considerable public attention, highlighted the potentially fatal consequences of flawed policy and systems, coupled with human errors of varied nature and gravity. It also demonstrated the need to address in a holistic manner many intertwined and overlapping issues -- such as racism, the treatment of mentally-ill detainees, the protection of vulnerable inmates and the monitoring of dangerous ones -- if the fundamental rights of children and young people deprived of their liberty are to be adequately protected.

Amnesty International is concerned both about this particular case and about the wider context in which this killing took place, aspects of which were highlighted by the findings of an internal prison service investigation into the murder. The investigation identified a number of management failures and other major problems affecting Feltham. Media reports, based on information contained in the report of the internal investigation by the prison service, pointed to evidence of poor management, a break-down in screening procedures, and a failure to monitor adequately letters written by Robert Stewart. The second part of the report of the prison service

[3] *Osman v UK*, 1999, para.116.

[4] *Keenan v UK*, 2001, para. 91; see also the European Commission of Human Rights' decision in *Rebai v France*, 1995.

investigation into the murder of Zahid Mubarek focussed on racism at Feltham and concluded that the establishment was institutionally racist. Management was reportedly aware of racist abuse against both staff and inmates belonging to ethnic minorities and of the measures which it should take to address the problem, but failed to take action.[5]

Zahid Mubarek was placed in the same cell as Robert Stewart, even though prison officers were, or should have been, aware of Robert Stewart's racial prejudices and violent behaviour. Robert Stewart was on remand charged under the Harassment Act with sending racially-motivated malicious communications. He had allegedly written hundreds of letters containing racist statements. In addition, a month before killing Zahid Mubarek, Robert Stewart had written a letter in which he stated that he would consider killing his cell mate in order to get "shipped out" if he did not get bail when he appeared in court on 7 February. He had also allegedly scrawled "KKK" (Klu Klux Klan) on a board in his cell.

As a general rule, prison officers at Feltham read 10 per cent of all letters written by inmates for censorship purposes. Once something disturbing is found, all mail written by the inmate should be monitored. However, only one of the hundreds of letters written by Robert Stewart was intercepted and returned to him. As an inmate charged with an offence under the Harassment Act, all Robert Stewart's telephone calls and correspondence should have been monitored and details of his offence should have been written on the front page of his prisoner escort record. However, these safeguards were reportedly not in place.

Zahid Mubarek was beaten to death with a table leg. Robert Stewart had prepared the weapon some time prior to the killing and hidden it in his cell. However, it was not found during daily searches of the cells.

Feltham prison officers took the decision to put Robert Stewart and Zahid Mubarek in the same cell despite Robert Stewart's personal history -- his criminal record includes convictions for bodily harm and common assault -- and his prison file, which lists many violent episodes and numerous and recurrent comments by senior officers relating to his fragile mental health and to the risk he posed to others' safety. In addition, in 1997 Robert Stewart had been diagnosed with a personality disorder in connection, among other things, with acts of self-harm. Four months before he killed Zahid Mubarek, he was seen by a mental health nurse who reportedly confirmed the personality disorder and a lack of remorse, feeling, insight, foresight or emotion. It is not known what, if any, measures were taken as a result of the nurse's report.

Following the murder of Zahid Mubarek, the Commission for Racial Equality (CRE)[6],

[5] Some of the findings of this second part of the internal prison service report were quoted in the domestic press, and are reported in the section of this report on racial abuse.

[6] The Commission for Racial Equality is a publicly funded, non-governmental body set up under the Race Relations Act 1976 to tackle racial discrimination and promote racial equality. It works in both the public and private sectors to encourage fair treatment and to promote equal opportunities for everyone, regardless of their race, colour, nationality, or national or ethnic origin. It provides information and advice to people who think they have suffered racial discrimination or harassment; it

extended its inquiry into racism at Brixton and Parc prisons to include Feltham. However, the CRE decided to hold its session in private, thus excluding representatives of the Mubarek family. Zahid Mubarek's family applied for judicial review of the CRE decision, on the grounds that if the inquiry were to be held in private, there would be no public scrutiny of how Zahid Mubarek had been placed in the same cell as Robert Stewart. An inquest was initially opened into Zahid Mubarek's death -- as is routine with all suspicious deaths. However, the coroner decided not to reconvene the inquest on the grounds that a verdict of unlawful killing was obvious.

On 5 October 2001 the High Court ruled that the Home Office should initiate a public and independent investigation into the failures -- described in the ruling as "systemic" -- which led to the death of Zahid Mubarek. The judge is reported to have stated that, as there would not be an inquest into the death of Zahid Mubarek, the obligation to hold an effective and thorough investigation -- as required according to the jurisprudence of the European Court of Human Rights under Article 2 of the ECHR -- could only be met by holding a public and independent investigation with the family legally represented, with disclosure to the family's representatives of relevant documents and with the right to cross-examine the principal witnesses. The Home Office decided to appeal against the ruling, maintaining that there were sufficient investigations into the killing in connection with the trial of Robert Stewart and through the internal prison service investigation mentioned above.

In December 2001 Amnesty International urged the government to withdraw its decision to appeal against the High Court ruling as well as its decision to oppose the initiation of a public and independent inquiry into the death of Zahid Mubarek, to no avail. In March 2002 the Court of Appeal ruled that a public inquiry was not necessary and that there had been no violation of Article 2 of the ECHR.[7] The Court of Appeal judges said that it had already been established that the prison service was at fault, an inquiry into this had been held and the family invited to be involved; that the cause of death had been established by Robert Stewart's conviction for murder; and that there was no basis for prosecuting any member of the prison service. They also added that there were no "factual unknowns" which would impede the family from bringing a claim in the civil courts for damages. The family of Zahid Mubarek were planning to appeal to the House of Lords.

1.2. SELF-HARM AND SUICIDE

Between 1990 and 26 February 2002, 152 children and young people in custody died as a result of self-inflicted injuries. There is concern among penal reform organizations about the figures

runs campaigns to raise awareness of race issues; and it makes sure that all new laws take full account of the Race Relations Act.

[7] Amnesty International sent a representative to observe the appeal proceedings.

for such deaths in recent years -- there were 15 in 1998, 19 in 1999, 18 in 2000, 15 in 2001, and three in the first two months of 2002.[8]

In 1999 the Chief Inspector of Prisons recommended that government ministers and the prison service should declare a commitment to reduce suicides in prisons in England and Wales. He called, among other things, for the introduction of a prevention strategy for female prisoners and young prisoners, based on the different needs of these groups.[9] In 2001 the prison service embarked on a three-year prevention strategy to reduce suicide and self-harm in prisons which included improvements to reception and induction, first-night support centres, safer cells and staff training.

While noting the attention and resources the government is devoting to tackling suicide and self-harm in prisons, including young offenders institutions, Amnesty International remains concerned that recommendations regarding safety have not been fully and promptly implemented, thus allowing further suicides to occur in almost identical circumstances.

Amnesty International is concerned about the circumstances of the following cases of death in prison custody.

On Saturday 29 September 2001 16-year-old Kevin Jacobs was found dead in Feltham. He had reportedly hanged himself. Kevin Jacobs had been on suicide watch, but was reportedly -- and unusually -- occupying a single cell. It was unclear whether the hourly checks required for all inmates on suicide watch had been carried out on the night he died. On 28 September 2001 another young person, 19-year-old Luke Cortezo-Malone was found dead at Brinsford. He had reportedly hanged himself. Internal prison inquiries were opened to ascertain the circumstances of both deaths, but their outcome was not known at the time of writing.

Eighteen-year-old Colin Williamson committed suicide at Portland on 3 June 2001. Prior to his death he had written to his mother and girlfriend telling them that he felt he was going mad. Colin Williamson had been sentenced to five years' imprisonment for robbery and related offences, carried out to finance his drug addiction. His family background was problematic and he had learning difficulties. At Portland Colin Williamson was deemed a suicide risk and put under special scheme to prevent self-harm -- suicide watch. He was also diagnosed as suffering from chronic depression and prescribed medication. However, instead of being put in shared accommodation, he was placed in a double cell but on his own. Three days before he died a prison officer -- without reference to any medical staff -- decided to take him off suicide watch. According to reports, a prison service internal inquiry concluded that even if he had stayed on suicide watch, it was unlikely that his death could have been prevented. However, his consultant psychiatrist maintained that he would have been much more likely to have survived, had he been in a shared cell. Colin Williamson's mother was planning to launch an action against the prison

[8] *Statistical information, Deaths in prison (England and Wales)*, Inquest. See Inquest's website at www.inquest.org.uk

[9] *Suicide is everyone's concern: a thematic review*, Her Majesty's Chief Inspector of Prisons, 1999.

service under the Human Rights Act, which incorporates most of the European Convention on Human Rights, including Article 2 guaranteeing the right to life, which requires the state to safeguard the lives of those in its custody.[10]

On 6 September 2000, 17-year-old Kevin Henson, was found hanging from an electric cable in his cell at Feltham. He had been held there on remand for a week. Kevin Henson had developed emotional problems following the death of his mother when he was 14 years old and had become seriously dependent on alcohol. In April 2001, at the inquest into his death it reportedly emerged that medical records, including an assessment by a police doctor who diagnosed Kevin Henson as suffering from alcoholism and severe anxiety, had not been passed to reception staff at Feltham. Senior staff at Feltham were allegedly unable to explain how this had happened. It also reportedly emerged that Kevin Henson was seen by three healthcare workers, but no concerns were raised about the risk of self-harm. As a result he was not regarded as "at risk" and was not placed on suicide watch. Kevin Henson committed suicide after a court hearing at which he was denied bail. After the court hearing he was returned to his cell, where he was being held on his own. According to the transcript of a BBC television program, *Panorama -- Boys behind bars*, broadcast on 11 March 2001, the wing where Kevin Henson died was staffed at night by one support officer who had received only a few days' training. Kevin Henson hanged himself using as a ligature point some electric cables which had not been boxed off. According to the BBC *Panorama* program, there had been concerns about the risk caused by these electric cables and the cells should not have been certified as habitable. The BBC program showed that in some cells the electricity cables from which Kevin Henson had hanged himself were still not boxed off; the BBC crew pointed this out to the governor. Following the inquest into the death of Kevin Henson, the coroner stated that she would be reporting her concerns about Feltham, including failures in communication and in the identification of at-risk prisoners, to the Home Office. According to the information available to Amnesty International, no prosecutions have been brought and no disciplinary proceedings have been initiated in connection with this case.

Cheryl Simone Hartman, a 20-year-old woman with a history of mental health problems, was found hanging in her cell in the young offenders wing of Holloway Prison on 18 June 2000. In March 2000 -- while she was on bail awaiting trial on a charge of assault brought following an incident which occurred while she was reportedly under the influence of alcohol and medication -- she had asked to go to prison to get some medical help. In May 2000 Cheryl Hartman was sentenced to nine months' imprisonment. In passing the sentence the judge expressed his hope that the authorities could find her appropriate help. Cheryl Hartman was initially placed in the psychiatric wing in Holloway prison and received treatment from a psychiatrist. In June 2000 the psychiatrist marked her for transfer to the young offenders wing, hoping to prepare her for release on parole the following August. The psychiatrist, however, reportedly wrote in her notes that if she was unable to cope, the psychiatric wing was willing to take her back. Within days Cheryl Hartman had become the victim of violent bullying. On 12

[10] *Private Eye*, 16 November 2001.

June she saw the prison medical officer, who noted that she was "depressed and trembling". The medical officer did not contact the psychiatrist who had treated her at the psychiatric wing, and wrote in her notes that Cheryl Hartman should have an appointment with another visiting psychiatrist. It was reported that prison staff never arranged the appointment. A few days later Cheryl Hartman was clearly ill and prison staff met to consider whether she should be put on an official suicide watch. This was not considered necessary, as she was in a shared dormitory and it was assumed that the other inmates would keep an eye on her. After a few days, however, she was placed in a single cell, because it was feared that she was being bullied. On 18 June Cheryl Hartman asked a prison officer if she could see the prison doctor in order to be transferred back to the psychiatric wing. When the prison officer returned, some 20 minutes later, she had hung herself using her dressing-gown belt slung over a curtain rail.

Although standard practice reportedly requires the prison authorities to go in person to inform the family of the death of an inmate, Cheryl Hartman's mother was informed by telephone of her daughter's death. She was alone when she received the call.

In February 2001 an inquest was held into the circumstances of Cheryl Hartman's death. It emerged that suicide prevention policies at the establishment were a serious concern; prison officers reportedly revealed that they only received suicide awareness training five weeks before the inquest. It also emerged that prison authorities had failed to implement fully the recommendations of an internal prison service inquiry into the suicide in August 1999 of Sharon Peters. That inquiry had called for all curtain rails to be removed. Many of the curtain rails in the prison had in fact been removed in line with this recommendation; those in the young offenders wing had not. The jury returned an open verdict.[11]

Holloway Prison is widely regarded as housing some of the most seriously mentally ill women prisoners in the country. Yet in March 2001, shortly after the inquest into the death of Cheryl Hartman, the authorities at Holloway Prison dispensed with the services of the psychiatrist who had treated her in the psychiatric wing, without appointing an immediate replacement. For six weeks only emergency cover was available. Around this time, another inmate who had been treated by the psychiatrist who ceased working at the prison in March, hanged herself. Two other women in the psychiatric wing attempted to commit suicide but were resuscitated.

In March 2000 David Henderson, 18 years old, was found hanging in his cell at Brinsford. After a three-day inquest into the circumstances of his death, a jury returned a verdict of accidental death contributed to by neglect. David Henderson had arrived at Brinsford on 3 February 2000 for driving offences. Two days later he took an overdose of tablets; he had reportedly complained of bullying to prison officers. He was then transferred to a wing for "vulnerable" prisoners, but the bullying appears to have continued. On 14 February 2000 he received a letter telling him that his girlfriend had suffered a miscarriage. On the evening of 16 March 2000, prison officers discovered David Henderson hanging in his cell. He was transferred

[11] This account is based on information provided to Amnesty International by the non-governmental organization Women in Prison and a report in *The Observer*, 29 July 2001.

to a local hospital but never regained consciousness. He was pronounced dead on 22 March 2000. David Henderson's father said that his son had been relentlessly bullied by other inmates and that he had telephoned Brinsford to report the problem about a month before his son's death; the authorities at Brinsford had no record of the telephone call. David Henderson's father said that his son was routinely beaten, bullied every day, and that his possessions had been taken by other inmates. He stated that his son had approached a member of staff but that three days later he was attacked by a fellow inmate as a punishment for this. Prison officers told the inquest that Brinsford had a policy of "zero tolerance" of bullying, that David Henderson had been moved to a wing for vulnerable inmates, and that he was being monitored. However, the inquest jury found that the authorities at Brinsford had been negligent and were partly to blame for David Henderson's death.

These cases raise very grave concerns about the government's fulfilment of its obligation to protect the right to life and to physical and mental integrity of those in its custody.

The authorities' failures, emerging from these cases, include lack of implementation of previous recommendations regarding safety; lack of communications between all the agencies involved in a case and also between staff within the same young offenders institution; lack of training of staff to identify and treat adequately vulnerable inmates; and lack or disregard of procedures to deal with vulnerable inmates; and inability to address bullying.

1.3. INVESTIGATIONS INTO DEATHS IN PRISON

Amnesty International is concerned that the authorities are violating the right to life of children and young persons in detention and the right of the families of those who died in prison custody to an effective remedy by failing to ensure that there are effective, independent, transparent and thorough investigations into deaths in prison. Full implementation of the right to life as guaranteed by the ECHR and the 1998 Human Rights Act includes the obligation to provide an effective remedy in cases where the right to life has been violated.

The essential features of an investigation under Article 2 of the ECHR have been outlined by the European Court of Human Rights in a case decided in May 2001 regarding disputed killings in Northern Ireland[12]: the Court ruled that an investigation must be independent, effective, reasonably prompt, capable of public scrutiny, and capable of involving the next of kin of the deceased to the appropriate extent.

Under Article 13 of the ECHR, the state is under an obligation to respond diligently to any breaches of the convention's rights. With reference to the right to life the European Court has stated:"Given the fundamental importance of the right to protection of life, Article 13 requires, in addition to the payment of compensation where appropriate, a thorough and effective investigation capable of leading to the identification and punishment of those responsible for the

[12] *Jordan v UK*, 1999.

deprivation of life and including effective access for the complainant to the investigation procedure."[13]

Recent cases have shown that deaths in custody, whether they are the result of violence by other inmates or suicide, can involve systemic failures, flawed procedures, and errors or omissions by prison staff at various levels. Amnesty International considers that internal prison service investigations, in which the family of the victim cannot participate and the results of which are not made public, are neither independent nor transparent and cannot be regarded as adequate to allay concerns about how the government ensures, or fails to ensure, the protection of the right to life of those in its care and custody. The UK authorities have failed to put in place mechanisms to address violations of the right to life which appear to be the result of corporate failure.

Inquests may also not be sufficient to guarantee a wide-ranging investigation into systemic failures and flawed procedures. At an inquest the jury and the coroner have to rely on the outcome of the investigation that -- in cases of deaths that appear to have been self-inflicted -- has been conducted by the prison service. In addition, very little, if any, information about the investigation may have been disclosed to the victim's family prior to the inquest.[14] In a ruling in connection with the suicide in May 1993 at Exeter Prison of Mark Keenan, the European Court of Human Rights stated that "...it is common ground that the inquest, however useful a forum for establishing the facts surrounding Mark Keenan's death, did not provide a remedy for determining the liability of the authorities for any alleged mistreatment, or for providing compensation". The Court went on to say that "no effective remedy was available to the applicant in the circumstances of the present case which would have established where responsibility lay for the death of Mark Keenan. In the Court's view, this is an essential element of a remedy under Article 13 [of the European Convention on Human Rights] for a bereaved parent."[15]

The Chief Inspector of Prisons expressed concerns regarding the lack of independence of prison service investigations and the limited role that the family of the victim is allowed to play before and during the inquest in his 1999 report *Suicide is everyone's concern: a thematic review*. Among other things, he recommended that independent monitoring of investigations should take place and that the results should be published, and that the remits of either the Prisons Ombudsman or the Chief Inspector of Prisons should be re-examined to take account of this. According to Amnesty International's information these recommendations have not been addressed.

[13] *Salman v Turkey, 1993.* See also *Kaya v Turkey*,1998, and *Aydin v Turkey,* 1998.

[14] On Amnesty International's concerns about inquests into controversial deaths in custody see also *United Kingdom - Deaths in custody: lack of police accountability*, May 2000, AI Index: EUR 45/42/00.

[15] *Keenan v UK*, 2001, paras. 127 and 131.

Amnesty International is concerned that the seriousness, variety and scope of the failures which appear to have contributed to the deaths of several people in prison in recent years are not adequately addressed by *ad hoc* internal prison inquiries and individual inquests, which may not examine the full circumstances surrounding deaths in custody or establish individual and/or corporate responsibility for such deaths.

2. THE RIGHT NOT TO BE TORTURED OR ILL-TREATED

In recent years Amnesty International has received allegations of cruel, inhuman or degrading treatment of children and young people held in several young offenders institutions. Allegations have included physical assaults and bullying, and verbal abuse, including racial abuse, by both prison staff and other detainees or prisoners. There have been reports that people who have suffered ill-treatment fear victimization if they make a complaint, and that they believe their complaint will not be taken seriously.

Amnesty International is concerned that the authorities have failed to prevent such abuses and that allegations of ill-treatment and other forms of misconduct are not investigated promptly, thoroughly, independently and impartially.

In Amnesty International's experience the availability of effective complaint mechanisms and of systems for investigating allegations of misconduct by prison staff promptly, thoroughly, impartially and independently are key in ensuring the safety of inmates. Several inmates whose cases are described in this report consider that lodging a complaint is futile at best or can lead to further abuse. The fact that complaints must be lodged via prison staff -- sometimes the very staff members against whom the complaint is being made -- means that many inmates are too frightened to complain. In some young offenders institutions there seems to be a widespread perception that prison staff can act with impunity.

In its 2000-2001 Annual Report the Prisons Ombudsman noted that young prisoners -- together with remand prisoners, prisoners sentenced to a short term of imprisonment and female prisoners -- have consistently been under-represented in the Prisons Ombudsman caseload. A survey was commissioned to investigate this matter and the Prisons Ombudsman is currently looking to develop more youth-friendly procedures.[16] The Prisons Ombudsman noted also that young prisoners and female prisoners are significantly more likely to be charged under the prison disciplinary system than adult men; but that, despite this, they both are under-represented in the Prisons Ombudsman caseload as appellants against adjudications.[17] In one young offenders institution visited by the Prisons Ombudsman in 2001 there had been 1,530 adjudications resulting

[16] Prison Ombudsman (2001), *Listening to Young Prisoners: A Review of Complaints Procedures in Young Offender Institutions.*

[17] The great majority of adjudications results in findings of guilt. Out of an average of about 110,000 adjudications taking place each year, in 1999 for example 104,400 led to findings of guilt. Prisons Ombudsman 2000-2001 Annual Report.

in just 23 appeals. The Prisons Ombudsman has recommended that the prison service ensures all young prisoners are fully aware of the appeals system following adjudications.

Amnesty International believes that particular care should be taken to ensure that complaints are accessible to children and young people who may be less inclined to ask for help and may have fewer resources at their disposal.

The organization is also concerned that conditions of detention in several young offenders institutions amount to cruel, inhuman and degrading treatment; are in violation of international human rights law; and are not consistent with internationally recognized standards for the treatment of children and young people in detention.

2.1. ALLEGATIONS OF GRAVE PHYSICAL AND VERBAL ABUSE OF INMATES AT PORTLAND YOUNG OFFENDERS INSTITUTION: A PATTERN OF VIOLATIONS

In February 2000, the Director General of the prison service -- referring, among other institutions, to Portland -- admitted that there was a "culture of violence" in the country's worst jails where prison officers were able to abuse inmates with impunity, and that in many cases prison staff were too scared to report abuse by colleagues.[18]

According to information collected by the Howard League for Penal Reform, a non-governmental organization, and by the law firm Hickman and Rose Solicitors, an atmosphere of intimidation of children and young people characterized Portland for decades and proved "fertile ground for violence to breed".[19] Verbal humiliation and threats were meted out to inmates on a daily basis in Portland and at times could escalate to physical abuse. There were allegations that excessive force was used as punishment and retribution; that force was used when none was required; and that more force than was necessary was used during restraint. According to testimonies given to the Howard League for Penal Reform by some serving staff members, on the understanding that their identities were not revealed, all staff at Portland seemed to be aware of verbal abuse and physical assaults against inmates, but many staff members were inhibited from reporting the abuses for fear of being ostracized by colleagues. Governors and prison service managers did not take effective action to address reports of mistreatment and brutality repeatedly brought to their attention, including by the Chief Inspector of Prisons in his critical reports following inspections at Portland in 1993, 1997 and 2000.

Evidence collected and compiled in 2000 by the Howard League for Penal Reform and Hickman and Rose Solicitors included complaints of assault by six inmates in which civil claims

[18] *The Observer*, 13 February 2000.

[19] *Mistreatment of young people at Portland YOI, A summary of evidence collected by the Howard League for Penal Reform and Hickman and Rose Solicitors*, August 2000.

were brought and details of which had been forwarded to the Treasury Solicitor. All six assaults -- which were alleged to have occurred between December 1997 and March 2000 -- involved the same prison officer as the main assailant. Other officers reportedly either participated in the assault, witnessed it, or colluded in pressurizing inmates to withdraw complaints. The assaults reportedly involved violent punches and kicks; throwing inmates against walls and to the floor; banging their heads on the floor; bending their arms behind their backs in order to cause acute pain; kneeing them in the ribs, back and groin; and stamping on the hands of an inmate lying on the floor. In one case, an inmate complained to a governor after an assault in the course of which his head was reportedly slammed on the floor three times. The inmate was subsequently found guilty of assaulting a prison officer in the course of a prison disciplinary hearing. However, after being reviewed by the competent unit within the Home Office, the finding of guilt was later quashed.[20]

A number of former Portland inmates spontaneously approached the Howard League for Penal Reform after seeing publicity surrounding the allegations of brutality at the young offenders institution. They reported similar assaults to those which were the subject of the civil claims, including being banged against the wall, placed in a headlock, pinned against a wall, whipped with the leather strap of the prison officer's truncheon, and kicked while restrained on the ground. They also reported that prison officers had kneeled on the back of an inmate restrained on the ground; applied pressure with their fingers to either side of an inmate's windpipe, almost obstructing his breathing; stamped on the face of an inmate restrained on the ground; and pushed an inmate against a hot pipe. Some also reported that they had been left without clothes in the segregation unit overnight and had been refused permission to see a doctor after being beaten.

In addition to the six cases in which civil claims were brought and to the accounts of former inmates, the Howard League for Penal Reform conducted separate interviews of a random sample of 10 children aged between 15 and 17 years who had spent time in Portland in 1999. From their very similar accounts it emerged that verbal abuse was constant and that assaults took place on a regular basis in the segregation unit and occasionally also on the wings. Asked whether they complained about such treatment, all the children reportedly made it clear that complaints were pointless because the prison officer's version would always be believed. They stated that complaints had to be given to a prison officer, who would read it and then fail to forward it to the governor. Even a request to see a member of the board of visitors[21] had to

[20] *The Guardian*, 17 November 1999.

[21] Board of visitors were established in 1952. The Home Secretary appoints one board of visitors for each prison in England and Wales. They are made up of members of the public from the local community, who are unpaid volunteers, independent of the prison service. The purpose of boards of visitors is to act as independent watchdogs, on behalf of the Home Office, to ensure the prison is run fairly and in accordance with prison rules. Each board of visitors member can carry out unannounced visits and has access to any part of the prison and any prisoner, at any time. Matters giving cause for concern are raised with the governor or reported to the Home Secretary. The board of

be handed to a prison officer. Some of the boys reported widespread racist abuse by staff and by other inmates. The interviewees also reported extensive and violent bullying among inmates.

The Howard League for Penal Reform also obtained information from a number of former or current members of staff at Portland, three of whom agreed to make statements. The content of their statements was consistent with allegations made by inmates. They stated that the prison authorities and the board of visitors were all aware of the abuses, intimidation and assaults. One said that he had witnessed an inmate being violently beaten by prison officers in the punishment block. He had reported the incident to the governor and an investigation was initiated. However, the victim was reportedly too frightened to make a statement and the prison officers accused of beating the boy denied the allegation. The governor closed the investigation. A Quaker minister, who had formerly been a prison visitor at Portland, underlined how allegations by inmates repeatedly involved the same prison officers. She also stated that she had herself been bullied by several prison officers on one occasion and that she had witnessed very serious verbal abuse. The three statements by current or former staff members record how staff were reluctant to report abuses for fear of being bullied or ostracized by their colleagues.

In August 2000 Dorset police opened an investigation into allegations of assault and intimidation by prison officers against inmates at Portland over a period of 14 years. In March 2001 concern over Portland persuaded the Home Office to transfer more than 150 inmates aged 18 years or under from Portland and to decide that Portland would no longer hold children aged under 18 years.[22] Yet, in July 2001 the Crown Prosecution Service (CPS) decided that none of the prison officers who had been suspended in connection with the police investigation would have to stand trial because of insufficient evidence. Police had reportedly sent files regarding 31 allegations to the CPS. There were allegations that the investigation had been hampered by the refusal of a number of officers to cooperate. Five prison officers remained suspended and the prison service announced an internal investigation into the allegations of assault, whose outcome was unknown at the time of writing.

2.2. ILL-TREATMENT BY STAFF AND INTER-PRISONER VIOLENCE

Amnesty International has been concerned at the findings of inspections carried out by the Chief Inspector of Prisons at some young offenders institutions, regarding allegations of ill-treatment by staff, bullying and inter-prisoner violence.

Stoke Heath in Shropshire was inspected in October 2000. The Chief Inspector of Prisons reported that violence was endemic and the number of injuries resulting from it unprecedented, rendering it an unsafe place for children and young persons. Although significant improvement was achieved and documented in a further Chief Inspector of Prisons' report after

visitors also receives complaints from prisoners. Prisoners can apply to see a member of the board of visitors either via a written request or by approaching a board member during a visit.

[22] *The Guardian*, 21 March 2001.

a second visit in May 2001, allegations of assault both by other inmates and prison staff continued.

Following a visit to Brinsford in Wolverhampton in June 2000 the Chief Inspector of Prisons stated that its regime put its juvenile population at risk, indicators of which were in particular the level of bullying, suicides -- five between October 1999 and May 2000 -- and self-harm incidents. A second inspection in May 2001 showed improvements, but responses to a questionnaire by inmates used by the Chief Inspector of Prisons during the latest inspection revealed that levels of bullying, in all its manifestations, seemed not to have diminished. The Chief Inspector of Prisons, however, noted that there was now a strategy in place that would hopefully begin to have an impact.

The Chief Inspector of Prisons found very high levels of bullying, fights and assaults also at Onley, near Rugby, in Warwickshire. During the inspection, in July 2001, the Chief Inspector of Prisons received numerous complaints by children and young people that they felt intimidated by staff, that they were bullied and subjected to a range of informal and illegal punishments. It emerged also that there was an alarmingly frequent use of "control and restraint" techniques. In the report of the inspection, the Chief Inspector of Prisons clarified that the allegations could not be substantiated during the short visit, but that the complaints were reiterated across the prison. According to reports, the Chief Inspector of Prisons also stated that if the 1989 Children Act -- incorporating the Convention on the Rights of the Child into domestic law -- applied to young offenders institutions, an emergency protection order could be used to remove from Onley some of the children at risk of significant harm.[23]

2.3. SEGREGATION AND 'CONTROL AND RESTRAINT' TECHNIQUES

Amnesty International was particularly concerned at reports that thousands of teenage inmates were physically restrained by prison officers and were placed in isolation cells as punishment.

According to Home Office figures,[24] prison officers had used "control and restraint" techniques against 3,600 children in the 22 months to February 2002. These techniques included placing the inmate on the floor or holding their arms behind their backs. "Control and restraint" techniques were used 511 times in Feltham; 450 times at Castington, and 436 times at Huntercombe, Oxfordshire.

In the same period more than 4,400 male children had been held in segregation cells. Prison discipline offences which can be punished with segregation include swearing at a prison officer, stealing and bullying. Segregation takes place in special cells, where the children are locked up for periods ranging from a few hours to 28 days, without access to television, radio or personal possessions. They may be allowed out of the cell for exercise, a weekly family visit

[23] *The Guardian*, 21 May 2002.

[24] The figures were disclosed in a parliamentary answer by a Home Office minister. *The Independent*, 11 February 2002.

and, sometimes, for lessons. There appeared to be wide variation in the use of segregation at different young offender institutions. For example, since April 2000, it had been used 882 times in Castington, Newcastle; 661 times in Onley, Warwickshire; and 660 times in Stoke Heath, Shropshire.

Amnesty International is concerned that the use of solitary confinement as a punishment for children could adversely affect their physical and mental health.

For over two decades Amnesty International has documented the effects of the use of isolation and solitary confinement. Its findings, and those of several expert studies, have raised serious concerns that prolonged isolation and solitary confinement may have serious and detrimental effects on the physical and mental health of people deprived of their liberty and may amount to cruel, inhuman and degrading treatment. Prolonged solitary confinement which causes mental suffering violates international human rights law and standards. The UN Human Rights Committee has made it clear that the prohibition of torture and cruel, inhuman or degrading treatment or punishment set out in Article 7 of the International Covenant on Civil and Political Rights includes "acts that cause mental suffering to the victim" and that "prolonged solitary confinement of the detained or imprisoned person may amount to acts prohibited by Article 7".[25]

Placing children in solitary confinement may violate Article 37 (a) of the Convention on the Rights of the Child, that states that "No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment." It may also be inconsistent with internationally recognized minimum standards for the treatment of prisoners, and in particular for the treatment of children in detention. For example, Rule 67 of the United Nations Rules for the Protection of Juveniles Deprived of their Liberty states that: "All disciplinary measures constituting cruel, inhuman or degrading treatment shall be strictly prohibited, including corporal punishment, placement in a dark cell, closed or solitary confinement or any other punishment that may compromise the physical or mental health of the juvenile concerned". A further safeguard for children is to be found in Rule 87(a) which prohibits even the use of "harsh" treatment or punishment against children. Harsh treatment implies a lower level of suffering for the child than cruel treatment.[26]

Children's inherent physical and mental vulnerability implies that particular form of treatment or punishment, which may not be prohibited when inflicted upon adults, may amount to cruel and degrading treatment when applied to children. It has been noted that "It is arguable...that solitary confinement, regardless of conditions and duration, amounts to cruel punishment when applied to children. This has important consequences, as there are not any treaties which expressly prohibit the imposition of solitary confinement for children, although restrictions in relation to children and adults arguably do exist in non-binding rules. If solitary

[25] General Comment No. 20(44), paragraphs 5 and 6.

[26] *The International Law on the Rights of the Child*, Geraldine Van Bueren, Mrtinus Nijhoff Publishers, 1995, pp. 223.

confinement amounts to cruel punishment when applied to children, then all of the States Parties to the majority of principal human rights treaties are prohibited from imposing solitary confinement on children."[27]

2.4. RACIAL ABUSE

Black children are over-represented in UK prisons. In 2000 it was reported that although black children made up only two per cent of the UK population aged between 15 and 17, they accounted for some 19 per cent of children in this age group in UK prisons.[28] In 2001 official figures showed that the proportion of people from an ethnic minority in prison was the highest since records began, accounting for more than 20 per cent of prisoners in England and Wales, while only 5.5 per cent of the population was from an ethnic minority.[29]

The second part of the prison service report into the circumstances surrounding the death of Zahid Mubarek in Feltham young offenders institution (see above) highlighted a number of serious concerns regarding institutional racism. There was evidence that a small number of staff sustained and promoted overtly racist behaviour as well as more subtle methods and staff from all ethnic groups reported an underlying culture that suggested the only way staff from minority ethnic groups could gain acceptance as part of the team was by enduring racist comments and racist banter. The fact that the inquiry team found that senior managers knew what they should have been doing but had not taken any action led the inquiry team to conclude that Feltham was institutionally racist.

The inquiry team found that:

- staff at all levels failed to take complaints of racist incidents seriously;
- the accuracy and veracity of records detailing which staff members had received race relations training was doubtful;
- prison officers were twice as likely to use "control and restraint" techniques against black or Asian inmates than against white inmates;
- inmates had no faith in the complaints system -- there were allegations from the board of visitors that prisoners were intimidated into keeping silent and that families were contacting the board of visitors rather than management to complain about racist incidents;
- the procedures in place for reporting and recording racist incidents were poor, inconsistent and not communicated to those who might need to use them and that the

[27] *The International Law on the Rights of the Child*, Geraldine Van Bueren, Mrtinus Nijhoff Publishers, 1995, pp. 223.

[28] *The Independent*, 21 November 2000.

[29] *The Observer*, 24 June 2001.

procedures for investigating such incidents were haphazard, incomplete and inconsistently applied.

2.5. CONDITIONS OF DETENTION

Article 10 of the International Covenant on Civil and Political Rights enshrines the right of all persons deprived of their liberty including children to be treated with humanity and with respect for the inherent dignity of the human person. Article 10(3) states: "The penitentiary system shall comprise treatment of prisoners the essential aim of which shall be their reformation and social rehabilitation. Juvenile offenders shall be segregated from adults and be accorded treatment appropriate to their age and legal status". Article 37(c) of the Convention on the Rights of the Child also enshrines the right of every child deprived of liberty to be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age. International minimum standards regarding treatment and conditions of detention of children and young persons are set out in a number of international instruments. For example, the UN Rules for the Protection of Juveniles Deprived of their Liberty state that juveniles[30] deprived of their liberty should benefit, among other things, from programmes of meaningful activities to promote and sustain their health and self-respect; from facilities and services that meet all the requirements of health and human dignity; from a suitable amount of time for daily free exercise, in the open air whenever whether permits; and from adequate medical care, both preventive and remedial, including mental health care.

In March 2002 the prison population of England and Wales reached 70,197, close to the maximum capacity of 71,800. Over 11,300 prisoners were under the age of 21.[31] Overcrowding causes a deterioration of the basic conditions of detention and can lead to abuses of prisoners' basic rights. Overcrowding can result in prisoners being denied adequate time for exercise, association, and other purposeful activities, and adequate access to medical care. This in turn leads to increased tension among prisoners and also among overworked staff. The Lord Chief Justice of England and Wales stated in January 2001 that overcrowding is more destructive of an effective prison system than any other single factor.[32]

Overcrowding has been a major concern at Feltham. One Deputy Governor of Feltham resigned in August 2000 after an inmate was returned to Feltham following a suicide attempt; the inmate had been on a life support machine for several days. Prior to his resignation the Deputy Governor had made repeated complaints to the prison service and asked them to stop

[30]Rule 11(a) states that a juvenile is every person under the age of 18.

[31] *The Guardian*, 22 March 2002, and Home Office data.

[32] *The Financial Times*, 1 February 2002. The Lord Chief Justice is President of the Criminal Division of the Court of Appeal and of the Queen's Bench Division of the High Court, and as such has overall responsibility for the judicial aspects of the criminal justice system.

sending inmates to Feltham. He said that one of the consequences of overcrowding at Feltham was that 105 children were locked up for 22 hours a day because they had to be placed in wings designed for inmates over 18 years of age.[33]

Reports by the Chief Inspector of Prisons, boards of visitors, non-governmental organizations, the news media and individual complaints have documented conditions in several young offenders institutions which are harsh and inadequate for the care of children and young people.

Amnesty International received other allegations of poor conditions and of violations of inmates' rights in Feltham, including a petition submitted in 2000 signed by over 100 relatives of inmates. They also reported that young inmates can be locked in their cells for 22 or 23 hours a day in virtual isolation and without adequate time for physical exercise, personal hygiene, association with their peers, and meaningful activities, including education.

Such reports are consistent with the criticisms made by expert non-governmental organizations and with the findings of reports by the Chief Inspector of Prisons, who visited Feltham in 1996 and 1998.

Amnesty International is concerned about the hours each day inmates are kept in their cells and the lack of access to fresh air and outdoor exercise in Feltham and in other young offenders institutions. In December 2000 the Association of Members of Boards of Visitors (AMBoV) was informed that in one unspecified institution boys who did not play football had not been outdoors since July that year.[34]

The need for detainees and prisoners to be engaged in purposeful activities of a varied nature outside their cells for at least eight hours has been underlined by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT). The CPT has stated that outdoor exercise is a basic safeguard for the well-being of prisoners and that all prisoners without exception (including those undergoing cellular confinement as a punishment) should be offered the possibility to take outdoor exercise daily. With specific reference to juveniles, the CPT has stated that "Although a lack of purposeful activity is detrimental for any prisoner, it is especially harmful for juveniles, who have a particular need for physical activity and intellectual stimulation. Juveniles deprived of their liberty should be offered a full program of education, sport, vocational training, recreation and other purposeful activities. Physical education should constitute an important part of that program."[35]

[33] *The Independent*, 11 August 2000.

[34] *The Independent*, 10 January 2001, from a letter of Rhona McMeekin, former editor of the AMBoV.

[35] *"Substantive" sections of the CPT's General Reports*, European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, CPT/Inf/E (99) 1 (REV."), October 2001.

There are reports that medical examination at reception is often cursory and carried out in conditions which differ substantially from health care standards for prisons in England and Wales which require an average of 10 minutes for each individual. Staff concern that they may appear "weak" if they take too long over each inmate or pressure resulting from the large number of young people being sent to young offenders institutions by the courts can lead to inadequate medical examinations and so contribute to the likelihood of inmates with health, including mental health, problems being overlooked.[36]

In April 2001 the British Medical Association (BMA) issued a report, *Prison medicine: a crisis waiting to break*. The report documented how doctors and prison health care staff experienced a lack of co-operation and, in some cases, active opposition from prison administrators, including some prison governors. According to the report, psychiatric nurses, substance abuse counsellors and clinical psychologists are needed to deal with the special health care needs of the prison population in the light of the higher than average rate of mental illness and substance abuse among prisoners and of the fact that many young people arrive in prison after having lived on the streets. However, prison doctors find it difficult to access such specialist health care. The BMA noted that prisoners have a basic human right to health care and called for a comprehensive needs analysis of the prison service, greater financial support and more clinical independence for prison doctors.

While these concerns were not specific to children and young people, the BMA noted that in the UK children and young people constitute a quarter of known offenders and are among those most likely to have health problems. The BMA observed that according to a study published in 1999, 17 per cent of young offenders were not registered with a general practitioner and generally had a low level of contact with primary health care. The BMA referred to the recommendation of the National Association for the Care and Resettlement of Offenders that the National Health Service should assume responsibility for the health care of all children and young people in detention.

Amnesty International was particularly concerned by the BMA's finding that prison doctors were under pressure to compromise clinical judgement. Prison doctors have a responsibility not only to their patients but also to assist the prison authorities in the efficient and economic running of the prison. This can result in prison doctors being put under pressure to prescribe cheaper drugs and not to refer inmates to a hospital outside the prison which will incur additional costs for guards to accompany the inmate. The BMA reported that in recent years it had received an increasing number of such complaints from prison doctors.

The BMA also stated that prisoners with mental illness often fail to receive appropriate care. Even though an inmate may have a significant mental health problem, he or she may not meet the criteria for transfer to a National Health Service institution where they would be under the care of a consultant psychiatrist rather than a prison doctor who may have little training in psychiatry.

[36] *The Guardian*, 13 November 2000, from a letter of Prof. Joe Sim, John Moores University, Liverpool.

Amnesty International has also received complaints about the treatment of visitors by prison staff at Feltham. There are reports, for example, of visitors being made to queue outdoors sometimes for more than two hours and not being allowed to take in clean clothes for inmates. When clean clothes are accepted in the institution, they are often reportedly misplaced or lost; the same is said to happen with reading material and money postal orders sent by relatives.

3. AMNESTY INTERNATIONAL'S CONCERNS AND RECOMMENDATIONS

Amnesty International is concerned that in recent years the authorities have failed to fulfil their obligations to protect the fundamental human rights of children and young people in prison. As a result children and young people's rights to life and not to be subjected to torture and other cruel, inhuman or degrading treatment or punishment have been violated. Failures highlighted in this report include:

- inadequate, ineffective or disregarded procedures and mechanisms to prevent suicide and self-harm (for example failing communications system between staff in young offenders institutions and among different agencies; lack of communication with the families of children and young people in prison custody and a disregard for their concerns and the information they can provide);
- failure of the authorities to ensure an impartial, independent and transparent system for investigating the circumstances of deaths in prison custody (inquests into an individual case may not examine the full circumstances in which the death took place and internal prison service inquiries do not allow for adequate public scrutiny and involvement of the victim's family);
- inadequate mechanisms to investigate ill-treatment, bullying and racial abuse by prison staff;
- lack of adequate measures and/or their insufficient application to prevent the risk of further ill-treatment, bullying and racial abuse of children and young persons by prison staff whose involvement in similar cases has been frequently reported in the past;
- inadequate or disregarded measures to prevent inter-prisoner violence and bullying, for example inadequate and flawed reception arrangements, resulting in a failure to identify inmates in need of special care, including mental health care;
- inadequate conditions of detention, and in particular failure to provide an adequate regime of purposeful activities to be conducted out of cells, including outdoor exercise and association; and failure to provide appropriate treatment for those with mental health problems or substance abuse and addiction problems;
- excessive use of "control and restraint" techniques and of solitary confinement.

Amnesty International is concerned that these failures constitute violations of the rights entrenched in international human rights treaties ratified by the UK (including the International Covenant on Civil and Political Rights; the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment; the Convention on the Rights of the Child and the

European Convention for the Protection of Human Rights and Fundamental Freedoms); and amount to noncompliance with international minimum standards (including the UN Rules for the Protection of Juveniles Deprived of their Liberty; the UN Guidelines for the Prevention of Juvenile Delinquency (The Riyadh Guidelines); and the UN Standard Minimum Rules for the Administration of Juvenile Justice (The Beijing Rules)).

Amnesty International calls for a wide-ranging, independent and public inquiry to be established by the UK government to examine how the prison system deals with children and young people including:

* all aspects of the treatment and conditions of detention of children and of young people;

* the causes for the failure of the existing mechanism to ensure that investigations into deaths in prison custody are thorough, impartial and independent and allow for the participation of the victim's family and for public scrutiny;

* the causes for the failure of the existing complaints mechanisms and of procedures to detect and deal with systematic abuse. The inquiry should examine the roles of all the bodies who receive and deal with complaints (namely governors, prison doctors, boards of visitors, prison chaplains, educational personnel, and any other body or organization that may have received complaints); and the role of the Prisons Ombudsman in relation to complaints of abuse. The option of giving the Prisons Ombudsman greater powers to carry out investigations into individual cases as well as powers to initiate and carry out in-depth investigations when there is evidence of a pattern of abuse should be considered;

* the causes of the young offenders institutions' reported inability to implement promptly recommendations for improvement such as those made by the Chief Inspector of Prisons;

* whether young offenders institutions are delivering the services for which they were created, which include ensuring that the mental and physical well-being of children and young people in custody are not adversely affected;

* the compatibility of the policy of detaining children in such institutions with the Convention on the Rights of the Child and the UN Rules for the Protection of Juveniles Deprived of their Liberty.

The inquiry's recommendations should aim at ensuring:

G the implementation of international minimum standards and of recommendations by international bodies, such as the European Committee for the Prevention of Torture, regarding the treatment and conditions of detention of children and young people deprived of their liberty, and in particular regarding the minimum hours that inmates are entitled to spend out of their cells engaged in purposeful activities, including outdoor exercise; and the access to full and adequate health care consistent with the medical needs of the patient. Guarantees that the clinical independence of prison doctors will be fully respected should be provided;

- **G** the establishment of easily accessible complaints mechanisms for children and young people which are seen to be trustworthy and meaningful and where complaints to the prison governor do not have to be made via prison officers;
- **G** the establishment of a new system for impartial and independent investigations into the circumstances of deaths in prison which allows for the participation of the victim's family and for public scrutiny. Consideration should be given to the recommendation made by the Chief Inspector of Prisons' in his 1999 report *Suicide is everyone's concern: a thematic review* that investigations into the circumstances surrounding a suicide should be independently monitored and the results published, and that the remits of either the Prison Ombudsman or the Chief Inspector of Prisons should be re-examined accordingly. The issue of corporate responsibility should be explored in cases where an independent and impartial investigation finds that a number of failures on the part of an establishment have significantly contributed to a death in prison, but where individual criminal responsibility is impossible to determine;
- **G** extreme care and restraint in applying solitary confinement and "control and restraint" techniques to children and young people in consideration of their inherent psychological vulnerability;
- **G** improved procedures to screen children and young people at reception, to ensure an adequate and comprehensive assessment of each individual child or young person, and the choice of an appropriate placement and regime to respond to his or her specific safety and medical requirements;
- **G** increased and improved training of prison officers to ensure that they are able to identify and address bullying and racial abuse, and deal appropriately with vulnerable inmates;
- **G** improved communication with the families of children and young people deprived of their liberty, in particular by keeping a record of communications from families and of their requests and concerns. Requests and concerns should receive a full answer and information provided by families regarding the health and emotional state of children and young people should receive adequate attention.

Amnesty International remains concerned that the very serious failures at Feltham may have contributed to creating the circumstances in which the killing of Zahid Mubarek took place. Although Amnesty International would welcome the establishment of a wide-ranging independent and public inquiry into all aspects of the detention of children and young persons, the organization considers that a public and independent investigation into all the circumstances which may have contributed to the killing of Zahid Mubarek could be an important step in starting to examine in a comprehensive way several problematic and overlapping issues -- namely racism, the treatment of mentally-ill detainees, the protection of vulnerable inmates and the monitoring of dangerous ones -- some of which are common to other young offenders institutions.

Amnesty International has noted government proposals to tackle crime committed by children and young people which include giving courts new powers to detain children aged between 12 and 15 awaiting trial in local authority secure units. Non-governmental organizations working on prison conditions and other experts have expressed concern that in order to accommodate these new detainees, other children and young people will have to be moved out of local authority secure units and into young offenders institutions, which in turn may involve young people in young offenders institutions being transferred to adult prisons, thus on one hand increasing the detention of children in young offenders institutions and on the other exacerbating overcrowding in adult prisons. Another contradictory aspect of this proposal is that local authority secure units, by taking in remand detainees, may lose their ability to focus on developing strong relationships with young people who are serving a sentence, which is arguably their main asset according to penal reform organizations.

The Committee on the Rights of the Child -- the body of international experts which examines state parties' progress in implementing the Convention on the Rights of the Child -- observed back in 1995 that "...the increasing trend for juvenile justice to become the subject of social and emotional pressure was a matter of particular concern, since it created opportunities to undermine respect for the best interests of the child" (Report on the tenth session, October-November 1995, CRC/C/46, para 220).

In its 1995 Concluding Observations following the examination of the initial report of the UK under Article 44 of the Convention on the Rights of the Child, the Committee on the Rights of the Child said to be concerned about the possibility of applying secure training orders on children aged 12 to 14 in England and Wales, and that the ethos of the guidelines for the administration and establishment of Secure Training Centres in England and Wales appeared to lay emphasis on imprisonment and punishment (CRC/C/15/Add.34).

Amnesty International calls on the UK to ensure that all the measures that are being taken or are planned to address juvenile delinquency are consistent with the state's obligations to ensure that the arrest, detention or imprisonment of a child shall be used only as a measure of last resort and for the shortest appropriate period of time, as requested under Article 37(b) of the Convention on the Rights of the Child; and that the best interests of the child are the primary consideration in all actions concerning children, including those undertaken by courts of law, administrative authorities and legislative bodies, as enshrined in Article 3 of the Convention on the Rights of the Child.