Circumstances surrounding the death of a boy at Hassockfield Secure Training Centre on 8 August 2004

Report by the Prisons and Probation Ombudsman for England and Wales

April 2006

A boy hanged himself at Hassockfield Secure Training Centre in County Durham on 8 August 2004. He was just 14 years old. There can be few more stark ways to begin an Ombudsman's report.

I have met with the boy's mother and grandmother, and have seen the grief and anger they feel over his death. Words in a formal document can seem empty, but I repeat here the heartfelt sympathies I have offered elsewhere in person.

The death of a child in such circumstances inevitably prompts questions about the way the State deals with juvenile offenders. The boy had a handful of convictions. With the exception of a charge of section 18 wounding (outstanding at the time of his death), his crimes were not serious. Nevertheless, he found himself remanded to a custodial institution well over 100 miles from his home in Burnley.

I am very critical of much I have discovered during the course of this investigation. The shortcomings I uncovered were many and varied, and the language used in this report pulls no punches. The boy's story is simply unacceptable. However, it is right that I should record that staff responded quickly and professionally when he was found hanging and did all they could to resuscitate him. They are to be commended for those actions.

Following the boy's death, the Youth Justice Board (YJB) mounted an investigation. Progress was hampered by ongoing police inquiries. Some 13 months after the boy's death, in September 2005, the YJB asked me to take on the investigation. I agreed, on the understanding that I would begin afresh. This report records the results of my investigation (the methodology for which is set out at section 1 of the Annexes), but also draws on evidence collated earlier by the YJB.

I am grateful to all who have assisted me. I am especially indebted to my colleague, Miss Ali McMurray.

Stephen Shaw CBE
Prisons and Probation Ombudsman **April 2006**

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Summary

The boy was 14 years old when he was sent to Hassockfield Secure Training Centre. By that time he had received a reprimand for being drunk and disorderly and accrued five community penalties for offences including criminal damage, possession of cannabis, possession of an offensive weapon burglary, being carried and breaching a supervision order. On 29 June, he was given a Court Ordered Secure Remand for an alleged offence of section 18 wounding. He had stated that he wanted to be placed in custody and that he would not comply with any further community penalties.

Because of the unavailability of secure places, the boy was initially remanded to Mill House in Leyland, a non-secure children's home. He absconded on the way there, but presented himself at court on 1 July. In the absence once again of any secure places, he was found a place at Elm Tree Farm, a local private children's home.

The boy settled well at Elm Tree Farm, but when he returned to court on 8 July he was again given a Court Ordered Secure Remand. When a place became available at Hassockfield Secure Training Centre (STC) in County Durham he was allocated a place there even though it was more than 100 miles from his home. On learning of this placement, the boy absconded. His mum reported him, and on 10 July he was taken to Hassockfield, arriving after midnight.

On arrival at the centre, he was seen by a nurse who checked his general health (he had a fracture to his right hand, which required a follow-up appointment at the hospital) and assessed him for risk of self-harm or suicide. She noted his history of drug use and self-harm and that he was extremely low in mood. She considered him to be at immediate risk of self-harm and opened a HRAT (High Risk Assessment Team) book, instructing that he was to be observed every five minutes.

A key worker was allocated to the boy, but in the event was off work sick for most of the boy's stay. A training plan was also drawn up for him.

A HRAT review took place on 12 July, when it was concluded that the boy should remain on five minute observations. At a further review on 16 July, however, it was noted that he appeared to be settling. Observations were reduced to every 10 minutes. On 19 July, the boy was apparently distressed by the cancellation of a court appearance. He was also missing home and said he had been thinking a lot about suicide that day. Five minutes observations were restored and a support plan drawn up once again.

On 20 July, a remand planning meeting took place. The meeting noted that the boy had settled on his unit and was meeting his targets. However, his mood was very low and he "seemed quite desperate" for a move nearer home. A transfer request was duly faxed to the Youth Justice Board (YJB) the same day. The reason for the request was given as distance from home

and increased vulnerability. No information about the boy being considered to be at high risk of self-harm or suicide was given.

After the remand planning meeting, the boy went to hospital with a suspected fracture to his wrist. He had told the nurse he had fallen over, but other trainees said he had punched a wall. When an officer checked him in his room about an hour after his return, he found the boy crying and his stereo smashed. He had apparently been cut off during a phonecall with his mum.

The boy went back to hospital the following day, but fell off his chair following his return and was again taken back to the hospital.

By the date of the next HRAT review on 23 July, the boy appeared to have settled again and was coping better. Observations were again reduced to every 10 minutes. At a further review on 27 July, observations were reduced again to every 15 minutes.

The boy also saw his solicitor on 27 July. He said he wanted to get out of Hassockfield and asked about bail procedures. His solicitor advised him that a further bail application was not appropriate at that time, and the boy apparently accepted this. Nevertheless, the next day he wrote a letter to the Judge promising to mend his ways. (The letter was not sent.)

Following a HRAT review on 29 July, the Duty Director signed the form to authorise termination of the HRAT procedures.

On 3 August, the boy was taken to hospital yet again with a suspected fracture of his right hand following a “play fight”.

The boy’s solicitor said that, in the run-up to his court appearance on 5 August, the boy phoned her office daily to check on progress on bail. On 5 August, she explained that there was no question of making a further bail application at that time. She said the boy accepted this and that he ceased calling her office every day. She assumed he was resigned to the situation.

Apart from concerns about the likelihood of the boy self-harming, he appears to have done well at Hassockfield, achieving positive reports from education and unit staff alike. He also attained the highest level on the Rewards and Sanctions scheme.

On 7 August, however, the boy was found in possession of some cigarettes passed to him by his family during a visit. This was against the rules and the boy was reduced to the lowest level of the scheme for 24 hours and had his television removed from his room. He was (exceptionally) allowed to retain his CD player. The boy was angry when told he had not been awarded any points for the day, and threw a cup, hitting a member of staff. He apologised immediately and took himself to his room. He was placed on “time out” for 20 minutes.

The following day, the boy was involved in an altercation with staff when he refused to hand over a note written by another trainee. He was told to go to his room for time out, but refused. When staff tried to take him there he hung on to a table leg. He was then removed to his room by four members of staff using Physical Care and Control (PCC) procedures. The boy continued to struggle and tried to bite the staff. A "nose distraction" was therefore applied, giving him a bloody nose. The boy was then lifted off his feet and (incorrectly) carried face down to his room. He was placed on time out and continued to shout and bang on his door. He eventually calmed down and was let out.

During the evening he mixed as normal with other trainees. He was upset about the injury to his nose, however, and phoned his solicitor twice. He also said he intended to submit a complaint about it. The boy also asked to be allowed to retrieve property he had previously packed in readiness for a court hearing the next day. He had been expecting to be released on bail but told staff the hearing had been cancelled.

After lock up, staff check on trainees every 15 minutes. Ordinarily, they use an electronic system (the Morse Watchman) to record these checks, but believing the equipment not to be working, they did not do so on 8 August. During the evening, one of the two officers on the unit left for a prolonged period, initially to try to find batteries for the torches used to shine into trainees' rooms. The other officer reported seeing the boy standing at his door on a couple of occasions. When he checked the room again at around midnight (with the other officer still absent), he discovered the boy had hanged himself. He immediately called for assistance. A number of staff attended and tried to resuscitate the boy, but it was to no avail.

Following the boy's death, it was discovered that the CCTV which should have captured events on the unit had been switched off.

The boy had left a note saying that, "things have been very hard for me and it's just all got to the point where my head goes".

Evidence from other trainees on the unit was that the boy was all right when he went to his room. They commented, however, on the cancellation of his hearing the next day and described the demoralising effect PCC had on trainees. They also confirmed that checks were carried out by staff during the course of the evening.

The experience of the boy's family

In Part IV of the report, I describe the boy's family's experience following his death. The boy's mum complained about a lack of engagement by both the centre (in his defence, the centre Director said the boy's mum had been clear she wanted nothing more to do with them) and the YJB. She said that, some 14 months after her son's death, she knew no more about the circumstances of it than she did following her visit to the centre on the day after he died. The YJB have said they felt constrained in sharing information for fear of

compromising the inquest. I make recommendations about engagement with bereaved families following a death.

The boy's mum also complained that some of her son's property had not been returned to her. She had been offered compensation, but this was not the point. Unfortunately, I have been unable to discover what happened to the property.

The boy's mum had a number of other concerns. These were:

- That the court ordered a secure remand when no places were available and when her son was doing well in a non-secure environment;
- That no secure accommodation could be found for her son nearer his home;
- The failure promptly to arrange a transfer nearer home for her son;
- The absence of a key worker for her son;
- Her son's general management at the centre;
- Difficulty over visiting arrangements at Hassockfield;
- The use of force on the boy;
- The experience and training of staff for dealing with vulnerable and challenging youngsters; and
- How physical safety at the STC compared with that in a secure home.

Examination of the issues

In Part V, I examine the issues arising from my investigation. I consider the appropriateness of the secure remand and conclude that, especially given that this was the boy's express wish, there was probably little alternative. I also note that in some respects, the boy appears to have benefited from the structured environment. However, I also suggest that his abscond on learning of his placement to Hassockfield should have set off alarm bells and that an alternative might have been put before the court.

I then examine the process for placing youngsters in secure accommodation. I note that the booking form did not alert the YJB to any special concerns in the boy's case properly to inform their decision as to placement. There is also no evidence that the YJB reviewed attached paperwork that might have alerted them to concerns about the boy. I note changes that the YJB has made to its various forms further to recommendations made following a previous death elsewhere, but record my concerns that the Placement Alert form is still inadequate in several respects. Finally, I draw to the YJB's attention the boy's mum's belief that an inquiry should be conducted into the shortage of secure accommodation places.

I am critical of both the delay in requesting a transfer for the boy and of the lack of relevant information provided with the request to highlight its urgency. I note that no action appeared to have been taken on the request in the 19 days between its submission and the boy's death. I also recommend changes to the forms and processes for securing a transfer.

I consider the significance of the absence of the boy's allocated key worker on sick leave. I conclude that it would have been helpful for the boy to have had a nominated member of staff to whom to turn and suggest that an alternative key worker should have been identified for him.

I review Hassockfield's suicide and self-harm prevention strategy and its implementation in the boy's case. I record that I am satisfied that the boy's care and management was appropriate to the circumstances obtaining at each point that his situation was reviewed. However, I am critical of the lack of consistency in the make-up of the HRAT and suggest that at the very least the key worker should taken part in all reviews. I am also critical of the lack of inquiry into the boy's self-harming behaviour and what might trigger further episodes. Information that the boy self-harmed when angry was not communicated. I consider the boy's reactions on the Saturday and Sunday before his death in light of this. Finally, I am critical of the lack of inquiry into the repeated injuries to the boy's hand and wrist.

In light of the boy's mum's concern about visiting arrangements, I review both the entitlement to visits and consider the environment in which they take place. I recommend that trainees on remand should be entitled to daily visits and that those visits should be taken in congenial surroundings.

I turn next to the way staff handled the boy's being found in possession of cigarettes. I find guidance on the appropriate penalty to be imposed confusing and conclude that taking away all the boy's points for the day (and confiscating his television) was heavy handed given that this was his first offence. I suggest that the boy would have been struck with an acute sense of injustice and resentment as a result.

I go on to consider the handling of the incident where the boy was physically restrained and removed to his room. I note that the Secure Training Centre Rules do not allow for trainees to be sent to time out in the particular circumstances that obtained. I also suggest that it was heavy handed to call a First Response, since this would automatically ensure the immediate attendance of at least three officers and a nurse. I note that the Secure Training Centre Rules do not allow use of PCC simply to effect compliance with staff instructions (while noting that this is at odds with the primary legislation) and that Hassockfield's own policy document on PCC specifically prohibits this. I question whether it should have been employed against the boy. I also question its application and express concerns about the use of the "nose distraction" on young people. I go on to make some general observations about the frequent use of PCC (and the need rigorously to control and monitor it) and about the need for staff to be properly trained to deal with young people without resorting so readily to physical restraint.

Next, I consider the adequacy of training for those promoted to management positions and for all staff in relation to responding to incidents of self-harm. I conclude that both could be improved.

I note the lack of a handover on the evening of the boy's death and recommend that the system of handovers should be reviewed.

I consider the absence for over an hour of the second officer allocated to the boy's unit (the nurse was also away from her station at the time the alarm was raised). I accept it will be necessary for staff to attend other parts of the centre from time to time, but recommend that this is always done in a structured way.

I examine the failure of staff to use the Morse Watchman equipment on the night of the boy's death. I find that the equipment probably was working, but that there was a breakdown in communication. (I note that I am satisfied, however, that the requisite checks were carried out by staff.)

I also consider the fact that the recording facility for the CCTV in the boy's unit had been switched off. I come to no firm conclusions about how this came about but recommend that safeguards be put in place to ensure there can be no recurrence.

There were issues around other items of equipment that were either not working or were not where they were meant to be. I recommend that the centre Director introduces systems for addressing this point. I am also critical of the inadequacy of systems and processes to ensure the smooth running of the centre.

I consider physical safety in the centre and the general environment. I am critical of the curtain rails used at the time of the boy's death (his method of attaching a ligature was ingenious, but I found there were other ways of doing so). More generally, I note the practice of those commissioning secure accommodation for young people in obtaining professional advice on design from experts in child care in secure settings and recommend the same practice be followed by the YJB.

Finally, I consider the support offered to staff following the boy's death and conclude that it was adequate.

Taking together all the concerns identified by my investigation, I say that this is a uniquely troubling story. While tragedy is not a word to be used lightly, if the boy's death does not constitute a tragedy the word has lost all meaning.

I make 49 recommendations.

PART I - Background

Section 1: The boy

The boy was 14 years old when he died. He was the third of four children, and grew up in Burnley, Lancashire. I asked his mum to provide a few words about him. She wrote:

> "[My son] had a lot of problems that needed looking after. These seemed to get worse after the death of his Granddad/Grandpa who he was very close to. He was a little rascal and sometimes difficult to handle. We know that he used to drink and smoke cannabis but think that he would say he did other drugs to be cool. He used to hang around with kids older than him but was really a little boy trying to be a man. He liked clothes and wanted to look nice and was always well dressed."

At some stage while he was at Hassockfield, the boy completed a Trainee Feedback sheet on not reacting to others. In words that I find painful coming from a 14 year old, he wrote:

> "I have now learned not to react but to walk away from any trouble now. The biggest man walks away from any fights or violence or crime. Just like when I get out I am staying away from trouble because I don't want to be in and out of prison. I want to be with my family and make something of my life. Even though I have done things in the past.
>
> "The convicted prisoners are aggressive at me and others but I just keep calm and don't react. I just walk away from any trouble just like I will on the out. When I get out I have a job waiting for me at my mate's car valeting shop."

On another form, the boy was asked to account for things that happened to him. The options were whether, when something bad or good happened to him, he blamed/praised himself for making it happen, or whether he put it down to good/bad luck or something else. The boy said that, when something bad happened to him, he usually blamed himself, but when something good happened he put it down to good luck.

Offending history and penalties

The boy's offences and the penalties imposed were as follows:

September 2002	Reprimand for being drunk and disorderly;
May 2003	Referral order for criminal damage and possession of cannabis (completed);
September 2003	Reparation order for possession of an offensive weapon (completed);

February 2004	Action Plan Order for domestic burglary (committed before the offence of possession of an offensive weapon);
April 2004	Supervision Order with Intensive Supervision and Surveillance Programme (ISSP) for being carried;
24 June 2004	Curfew Order for breach of the Supervision Order;
29 June	Court Ordered Secure Remand (COSR) for an alleged offence of section 18 wounding.

At the first planning meeting for the Supervision Order with ISSP on 15 April 2004, the following programme was agreed:

- Offending behaviour work - to include car offenders' programme, citizenship programme, anger management;
- Reparation - mediation with the burglary victim, wheels within wheels, letter of apology;
- Education - attending Windsmoor School, Connexions;
- Individual issues - substance misuse, referral to Beyond Sport, mentor involvement through LYA [Lancashire Youth Association].

The boy apparently said he understood the requirements and agreed with the supervision plan. His mum, on the other hand, was recorded as saying that she would be very surprised if he complied with and completed the programme.

Section 2: How the boy came to be at Hassockfield

A Youth Offending Team (YOT) worker completed an ASSET Core Profile on 18 June 2004. [1] This recorded that:

- "… having been made subject to orders [the boy] point blank refused to comply, he states that he would rather go to custody to sort his head out. Claims to be offending daily and using drugs."

- "Behaviour can be reckless without any real thought or planning, he will sometimes stay away from home without his Mum's knowledge of his whereabouts and has no personal income. Claims to be committing offences to fund drug use."

- "Claims to be using Cocaine and committing offences to feed this habit, unclear about levels of usage. Alcohol has been a problem for some time with [the boy] said to have drunk excessive amounts for some time."

[1] The ASSET is a standardised 12 page assessment tool designed to aid the identification of "factors associated with offending" and "inform pre-sentence reports and sentence planning". It includes a section headed "Indicators of Vulnerability".

- "Whilst unwilling to fully admit it he appears confused and apprehensive seeing no way out of his current situation."

- "Has a great deal of difficulty coping with those in authority whom he distrusts. [The boy] feels he is on a set pattern of offending."

- "Will destroy property if angered and believes he can manipulate others and gain control simply by refusing to do something."

- "Sees future offending as inevitable due to drug use and says he wants to be locked up."

- "Attempts have been made to work with [the boy] in the community, but he refuses to cooperate and attend any appointments and this has resulted in breach proceedings. [The boy] fully understands the consequences of his actions and says he wants to be given a custodial sentence."

- "[The boy] believes the turning point would be a custodial sentence despite efforts of YOT and his solicitor to persuade him otherwise."

- "Evidence would suggest there is little support from the family. Mum believes he would be 'better off inside'."

- "If given a custodial sentence it will be his first experience of this and despite his bravado he may possibly be at risk."

A pre-sentence report was prepared before the boy's appearance in court on 24 June. The YOT worker noted that the boy had failed to comply with both the conditions of the Action Plan Order and with the Supervision Order with ISSP. The boy was not attending school and was not prepared to comply with boundaries set at home. The risk of him re-offending was therefore considered to be high. The risk of direct harm to the public was assessed as being medium, due to the dangers of being involved in car related crime.

The YOT worker concluded:

> "[The boy] is before the court today having breached previous court orders that had been imposed in the hope that inter agency involvement would reduce his offending behaviour and resolve the problem areas in his life that were increasing the likelihood of him re-offending.
>
> "I am of the opinion that a great deal of progress could be achieved with [the boy] if he would comply with orders and work with agencies, and his family. However he has made it clear both at interview and at previous court hearings that he will not comply, and has stated that his personal wish is to be placed in custody.

> "Attempts have been made to persuade [the boy] that there are better options than this if as he says 'he wants to sort himself out', but no amount of discussion has had an impact. I am therefore unfortunately unable to offer the court any community sentence with confidence that he would not breach the order from the outset and reluctantly conclude that the only option is therefore custody."

The Court sentenced the boy to a Curfew Order for breach of the Supervision Order.

A court ordered secure remand (COSR) was made on 29 June in response to the alleged offence of wounding, despite the court being advised by the YOT that there were no secure places available. This was because of the seriousness of the offence (the boy had allegedly stabbed someone in the street – a note by a YOT officer explaining the boy's various placements reports that the alleged victim was in a critical condition at the time), protection of the public, the likelihood of further offending and the potential for interference with witnesses.

Given that no secure bed was available, accommodation was found instead in a private children's home, Mill House, in Leyland. [2] Because the boy was being taken to a non-secure environment, secure escorts were not used. He absconded. The boy produced himself in court on 1 July, however, and was again made subject to a COSR. In the absence again of any secure beds, he was found a placement at Elm Tree Farm, a (local) private children's home. The home was newly opened and the boy was the only resident to begin with, though there were others by the time he left. He did well there and received positive reports. The YOT officer reported:

> "[The boy] remained at Elm Tree Farm for that week during which time a Planning Meeting was convened on 5th July (Social Worker [named] and the boy's mother in attendance in addition to YOT). I had discussion with s/w and although there was consideration of a change in placement to Northern Care SSD [Social Services Department] colleagues [three named] all consulted and agreed that as the boy appeared to be settled in the placement, and that Elm Tree Farm did

[2] In its response to the Area Child Protection Committee's (ACPC's) Serious Case Review dated 29 July 2005, the YJB said, "it is important to note that [the boy] cannot be considered in custody when he has been made subject to a Court Ordered Secure Remand, as he is deemed to have been a Looked After Child with a security attachment. As such, his placement would be the responsibility of the Local Authority and not the Police. It would not be legal to detain someone 'in custody' with this order.
"The YJB supports your comment and recommendation at paragraph 93 of the same section. A 14 year old child should not receive a Court Ordered Secure Remand if there is no suitable bed available. A court is required to consult with a designated authority before imposing a security requirement to ensure that the local authority has the opportunity to inform the court of the availability of secure and non-secure beds before such an order is made. With this in mind, the YJB fully endorses recommendation 7 which suggests appropriate training must be provided to magistrates' clerks and those who sit in the Youth Court in this important area."

not have any other resident to care for (and it was felt that this issue was also relevant given his current charge), it was agreed that the continued placement would be maintained but reviewed at regular intervals."

Following a further court appearance on 8 July, the boy was again given a COSR and returned to Elm Tree Farm. Miss Ali McMurray, the Assistant Ombudsman who conducted the investigation on my behalf, asked the YOT officer whether consideration had been given to suggesting to the court that the boy be remanded back to Elm Tree Farm, given that he was apparently doing well there. The YOT advised that the boy's status was already established as Court Ordered Secure Remand. They said the court was fully aware that the boy was being accommodated at Elm Tree Farm and that his solicitor canvassed at each available opportunity the option of magistrates considering alternatives to secure accommodation (there is a limit of two bail applications, after which it becomes a matter for Judge in Chambers). However, the court rejected defence submissions and re-imposed the COSR.

The YOT officer reported that, by this time, the boy's solicitor had made two applications for bail, but these had been refused.[3]

On 9 July, a secure bed became available at Hassockfield, a secure training centre run by a private contractor, over 100 miles away in County Durham. Staff at Elm Tree Farm were asked not to tell the boy he was moving, but they did so nevertheless and he absconded. He went home to his mum. She informed the police and the boy was collected the next day (a Saturday) and taken to Hassockfield. Neither YOT nor EDT [Emergency Duty Team (Social Services)] staff were informed, and as a result, no information was sent to Hassockfield about him.

The YOT officer was apparently informed by Hassockfield of the boy's admission on 12 July. He noted that he had agreed visiting for named family and arranged a Remand Planning Meeting for 20 July. He also faxed through a copy of a post court report completed following the boy's court appearance on 9 July. This noted that the boy did not require urgent treatment for substance misuse but recorded that he was particularly vulnerable, and that his vulnerability had increased as a result of the court appearance. The boy's supervising officer commented that he was a "Young man who has previously said he would commit suicide. Appears visibly shaken." Under recommended action, he wrote, "Needs careful monitoring. First time in custody."

[3] Commenting on a draft of this report, the Lancashire YOT advised that the two bail applications were made by the boy's solicitor in consultation with the YOT Court officer. They said full applications were made and all information given to the court with regard to alternatives to a Court Ordered Secure Remand and the fact that he had done well in the non-secure placement. Social Care were willing to fund the boy's placement. The court rejected the applications.

The YOT officer also contacted the boy's mum. She mentioned to the officer the possibility of securing a transfer to somewhere nearer home. The YOT officer agreed this would be appropriate.

The Meetings and Contacts document shows that, the following day, the YOT officer discussed with case manager at Hassockfield:

> "… the issue of transferring [the boy] at the earliest point to a secure establishment closer to home – as [his mum] is having difficulty in getting up to see her son due to the distance. [The case manager] agreed that this would be discussed and supported though an application which will be made on the day of the meeting."

A note on the Lancashire Constabulary file dated 12 July records the non-availability for court of one of the principal witnesses in the assault charge. The witness said:

> "I have been in touch a number of times with [the officer in charge] to explain that I want to retract my statement. I have also been in touch with my solicitor and he said that's fine therefore I do not wish to attend court. Please contact me sooner rather than later to organise this."[4]

In her statement to the police after the boy's death, his solicitor said that the boy's mum had told her during the previous three or four weeks that the boy's alleged victim had been to see her to tell her that he had made a retraction statement. She said the boy was also aware of this.

Section 3: Hassockfield STC

Hassockfield Secure Training Centre (STC) in Medomsley, County Durham is a purpose built secure establishment. It opened in September 1999. The Youth Justice Board has contracted with Premier Training Services Ltd to run the centre according to the minimum contractual requirements, "National Standards for Youth Justice 2004", and the STC Rules as devised following the Crime & Disorder Act 1998. The YJB retains operational oversight of STCs on behalf of the Home Office.

The maximum capacity of the centre is 42 young people (both male and female) between the ages of 12 and 17 years old. There are three houseblocks, each containing 14 bedrooms divided into two units. On each unit there is an association area with a dining table, large television and pool table for young people to use over lunchtimes or in the evenings. One unit is female only and the rest male only. The three houseblocks overlook a green courtyard. The education and healthcare blocks occupy the fourth side of the quadrangle. To the left of this block and slightly set back from the main centre is the administration block, which also contains the visitors' centre and the substance misuse treatment centre as separate facilities.

[4] The Lancashire YOT noted that no action was taken to further this point in the legal system. They advised that the change in circumstance would have given the boy the grounds to apply for an Appeal to Judge in Chambers

PART II - At Hassockfield

Section 1: Arrival

The boy arrived at Hassockfield after midnight on 10/11 July 2004.

A Trainee Initial Screening – Remand form was completed with a date of 10 July. It noted that the boy had been diagnosed with severe emotional and conduct disorder and that mental health issues could be a factor in the future. It said he had "a history of self-harm and suicidal behaviour (depression). Very vulnerable." The form also noted that there were "issues with drugs. Spends approx £150 per week."

A nurse completed an Initial Custodial Reception Assessment. She noted that ASSET indicated that the boy was a risk to himself due to the dangers of drug use and its long term implications. She also noted that he might develop mental health problems as he got older and that he had self-harmed previously (an ecstasy overdose 12 months earlier that required hospital treatment and superficial scratches to his arms three weeks prior to his admission). The nurse assessed the boy as giving immediate cause for concern, describing him as extremely low in mood. She commented that he did not wish to phone his mum. (A note setting out HRAT (High Risk Assessment Team[5]) observations said in addition that the boy "showed no eye contact, very poor non-verbal communication and monotone response during conversation" and that the nurse had referred him to the Community Psychiatric Nurse (whom he saw on 26 July).)

The nurse noted that she had opened a HRAT book and that the boy was to be observed every five minutes. A key worker was to be identified for him and he was to be placed on a houseblock with new trainees. Since the boy had refused to contact his mum, the nurse said staff should ensure this was done the next day. She also noted that the boy should see a GP for an admission medical.

Under Risk Management Plan, the nurse noted:

> "HRAT opened – 5 minute observation level
> Ensure family contact is maintained
> Follow up hospital appointment for fracture to R hand for actual date
> Ensure adequate clothing
> To be seen by GP for admission and monthly following this and also to have initial dental assessment."

[5] HRAT is the system in place at Hassockfield for managing those judged to be at risk of self-harm. A multi disciplinary team comprising a psychologist, someone from healthcare and a residential member of staff review the case every few days and agree a course of action to manage and reduce the risk. Part of the strategy will be to determine the level of observation to be afforded the trainee. This might be every 15 minutes (as for trainees not at risk, but with heightened awareness), 10 minutes, five minutes or, in the most serious cases, two minutes.

The nurse's HRAT entry advised that staff should encourage the boy to discuss his problems and encourage him to interact appropriately with his peers.

The nurse said in her police statement:

> "The reason I felt [the boy] should be on a five minute watch was he had a history of self-harm, he had taken an overdose two years previously, he had run away prior to coming to Hassockfield indicating he did not want to be here and he was low in mood on admission."

The nurse also completed a Substance Misuse Entry form. The boy circled to show he had used alcohol, tobacco, cannabis, ecstasy, cocaine/crack, poppers, GHB, Amphetamines/speed and magic mushrooms. He indicated that he had used the first four of these within the last month. The boy the nurse that he had overdosed on ecstasy about 12 months ago, and had received counselling and hospital treatment in the past for substance use. The nurse wrote "yes" under "please e-mail the Substance Misuse Service for further assessment as soon as possible".[6]

An officer was allocated to be the boy's key worker. He interviewed the boy and gave him some basic information about the centre. He completed a trainee information form that noted uncertainty about mental health/behavioural issues, that the boy had been placed on five minute observations for his first night and that drugs/alcohol had been a factor in the boy's offending.

In the event, the key worker was sick for most of the duration of the boy's time at Hassockfield. No-one else was appointed to be his key worker. When asked during interview a duty manager, said "key worker sessions have never been a big thing … If [the boy] had a problem he just had to go and ask a member of staff." He added that he presumed some key workers and trainees would not even get on with each other. He commented that, "The system's there for contractual reasons but the basics of the job … is that everybody has different personalities and everybody gets on with different people …" However, he added that as a key worker he would "have to show an interest [in the trainee] because I would have to do the paperwork". He

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[6] Ms Yvonne Francis (who conducted a clinical review of the boy's care at Hassockfield on my behalf) reviewed Hassockfield's substance misuse policy. She noted: "The overall policy in section 2.4 is sound, re. timing of assessment, instigation of treatment etc. and the aim to give a more holistic assessment during induction is commendable.
"As far as the Annexes are concerned, I think they leave a lot to be desired compared with the depth and breadth of the CARATS assessments used in the Prison Service. The questions assume that the questioner has a good knowledge of drugs and addiction on which to frame detailed questions re. type of habit, drugs used, how much, how often, when last used, sharing 'works' etc.
"There is no policy, standard or protocol for the clinical management of substance misusers.
"The Prison Service standards are drawn from the National Treatment Agency standards and so should those used in YJB premises be."

said key worker sessions did take place and were getting more regular. (The interview took place in January 2005.)

A Trainee Risk Assessment noted that potential hazards for the boy were peer pressure, distance from family and heavy cannabis use, creating a risk of aggression due to withdrawal. The assessment concluded that the boy presented a risk of violent behaviour, absconding and escape from escort, posed serious behavioural issues and had a history of smoking and drug/solvent/alcohol abuse. The boy's risk rating was 20 out of a possible 25. It was recorded that the boy's behaviour should be monitored daily and he should be re-assessed if required.

A (undated) Training Plan was formulated. A number of goals and objectives were set. These were as follows:

- To promote family contact;
- Initiate work relating to drug abuse;
- Routine medical assessments completed;
- To attend and participate in ongoing health education programme;
- 100 per cent on task behaviour;
- To complete 1 AQA/Lead Body Unit award;
- To improve reading age month per month of stay;
- To improve numeracy levels;
- Liaise with Social Worker/YOT worker to ensure that appropriate support is in place for the boy upon his return;
- To offer support to the boy and encourage participation in the Citizenship Programme.

The Residential Care Daily Contact sheet recorded that the boy had mixed well with others on the unit on 11 July and that there were no issues or concerns.

A Contact Record entry (signature illegible) noted that the writer had spoken to the boy on 12 July and he had confirmed that he had all the basic essentials and understood the centre's rules and regulations. The writer recorded that the boy seemed fine and felt quite content at present.

Section 2: HRAT

A HRAT review was carried out on 12 July. A nurse, psychologist and a care officer attended. The psychologist noted that the boy had previously resorted to self-harm when he was angry but that he engaged well during the review. Given that he had only been admitted two days earlier, she advised he should remain on five minute observations. The other two members of the review team agreed. The rest of the support plan also remained as before.

The boy's level of risk was assessed again on 16 July. The nurse and the psychologist again attended, but this time another member of staff attended for residential staff. The psychologist recorded that she had discussed basic

coping strategies and relaxation skills with the boy, who engaged well and reported feeling settled, although he would have liked to be closer to his home. She said he reported no intention to self-harm and that he felt able to discuss any concerns with staff. She recommended observations be reduced to every ten minutes. The other two members agreed. In other respects, the support plan remained the same.

On 17 July, the boy was docked four points from the Incentives scheme for not taking part in Crime Avoidance. He was also sent to bed half an hour early.[7]

The boy's case manager recorded on a Case Manager Contact Sheet that she had explained to the boy on 19 July the reason why he had not attended court that day.[8] She noted that he seemed quite low in mood and was unhappy at being placed so far from home. She agreed to log a transfer request the next day.

The psychologist noted on the same day that the boy looked annoyed and was "very distressed" due, apparently, to a court appearance and missing home, and said he felt like committing suicide. She noted that he needed a transfer closer to home.

A HRAT review was also carried out on 19 July. None of those attending had been present at previous reviews. The psychologist noted that the boy was upset and tearful and stated that he had thought a lot about suicide that day. She recorded that the boy had thought he was going to court, but that he did not go. She recommended observations should revert to every five minutes. The nurse and the care officer agreed. The revised support plan was to support the boy through the next few days, encourage him to talk to staff about how he was feeling, ensure the case manager had regular contact (in fact there are only three entries recording her contact with the boy) and "regularly see [the boy] for support" (the form does not specify who should do this).[9]

The psychologist who took part in the first two reviews and a nurse who had taken part in the previous one (and assessed the boy on his arrival at the centre) both attended a HRAT review on 23 July. Yet another officer attended from the residential care side. The psychologist recorded that the boy stated he felt reasonably settled although he was upset after a bad phonecall.

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[7] Commenting on a draft of this report, the YJB noted that this was contrary to the provisions within STC contracts dealing with the use of separation.

[8] Whereas key workers are personal officers to whom trainees would refer on a day to day basis, case managers are responsible for managing the particular trainee's care.

[9] Commenting on a draft of this report, LuptonFawcett (solicitors acting for Hassockfield) noted: "Although the entries in the form may not be complete there is no doubt that support would have been given to [the boy] by the Case Manager, Teachers, Nurses, Residential Care Staff and in fact anyone who came into professional contact with [the boy], which also includes psychologists."
The point is, however, that it was not specified on the form who was responsible for implementing the support plan.

However, he did not wish to discuss this. She suggested observations every ten minutes. The nurse agreed that the boy appeared to be coping better at the centre and noted that no self-harm issues had been identified. The residential officer also commented that the boy was "coping a lot better than he was, mixing well on the unit". The revised support plan was to reduce observations to every ten minutes, encourage the boy to discuss issues with staff and to use basic coping strategies and relaxation techniques.

Section 3: Remand planning meeting

The National Standards for Youth Justice state that a remand planning meeting should have been organised within five days, but in the event none took place until 20 July. The Lancashire YOT Local Management Report says this was apparently due to difficulties arranging a suitable date for the STC, the YOT social worker and the family. (I note from the National Standards, however, that responsibility for arranging the meeting rests with the STC.)[10]

In the event, the meeting went ahead in the absence of the social worker after repeated unsuccessful attempts by the YOT to contact her. The case manager noted on the Remand Planning form that the boy had requested a move closer to home. He had very strong family ties and was finding it very difficult to adapt to life away from the family. She considered that the boy would benefit from a placement nearer to his home, noting that he appeared very down and low in mood. The case manager recorded that the boy had a history of self-harm and that this, together with his low mood, had led to him being placed on five minute observations.

The case manager noted that the boy was on a 25 hour per week education programme and was "achieving some good results".

She recorded that he was happy on his current housing unit and had stated that he did not want to be moved. Staff reports suggested that the boy was quiet but pleasant and well behaved. However, she went on to say that,

> "[The boy] is very low in mood, he is quite uncommunicative and not interacting well with staff. He has stated that he is finding things 'alright' but seems quite desperate to move to a placement nearer home."

The case manager concluded:

[10] Lancashire YOT commented that Burnley YOT were first notified that the boy had been placed at Hassockfield on Monday 12 July. On the same day (12 July), the YOT sent all the relevant paperwork to Hassockfield and arranged the remand meeting for the first available date that was suitable for all parties including the family. This was 20 July (seven working days). They said attempts were made to make contact with the Social Worker to invite them to this meeting, as the boy was a Looked After Child by virtue of the COSR status. As such the Looked After Procedures should have been followed.
Lancashire YOT said that, on the same day (12 July), the YOT officer enabled the family to visit the boy at Hassockfield by giving Hassockfield appropriate family names for visiting. He recorded that they made two visits prior to the remand meeting.

> "[The boy's] behaviour and achievements (at present) are on target. It is suggested that [the boy] continues with the standard programme – no specific target to be set."

A transfer request form, signed by representatives of both the STC and the YOT, was faxed to the YJB Placements Team the same day. This suggested the Dales Secure Unit as first choice with Barton Moss Secure Unit as second choice. The reason for the request was given as distance from home and increased vulnerability. No further details were given, despite a note on the form asking for "any additional information that may assist YJB in transferring young person to a more suitable placement".[11]

Section 4: 20 July – 7 August

After the remand planning meeting, the boy went to hospital with a suspected fracture to his wrist. A nurse said in her police statement that she had seen the boy about his fractured hand and he had told her he had fallen over, but other trainees said he had punched a wall. She said she did not challenge him as to how he had hurt his hand.

The Daily Supervision and Support Record noted that the boy seemed quiet on his return. The nurse asked staff to watch that he did not use the bandage on his wrist to harm himself. When an officer checked him in his room about an hour later, he found the boy crying and his stereo smashed. The officer found out from him that the phone had been cut off while he was speaking to his mum. The duty manager had authorised an additional phonecall.

He went back to hospital the following day, and returned in good spirits and with a 'back slab' on his wrist. However, he fell off his chair and was taken back to the hospital. He was still apparently in good spirits when he returned once again.

[11] LuptonFawcett commented: "It was unlikely that a transfer would be forthcoming so soon to admission due to the fact that he had recently been admitted from a Local Authority Home in that area [sic]. The information already given was definitive and there was no need for additional information."
I disagree. The YJB should have been informed that the boy was considered at high risk of self-harm or suicide and that this was exacerbated by his unhappiness at being so far from home.
The Lancashire YOT commented: "The transfer request indicated distance from home and increased vulnerability. At the time, the documentation did not require an assessment of level of vulnerability. In [the boy's] case 'increased vulnerability' meant just that. The form was completed by Hassockfield Secure Training Centre and sent to the YJB following the meeting. This meeting also agreed that [the boy] was to be put on a five minute watch and it was the responsibility of Hassockfield to inform the YJB of this action. If a child is on a five minute watch then it must be the institution that should be proactive in seeking the transfer. If they do not, then the presumption must be that they are able to cope with the increased risk."

On each of the occasions that the boy returned from hospital a new Review of Vulnerability Assessment was completed. These did not identify any cause for concern.

A nurse said in her police statement that the boy was fed up about having to wear the protective guard, as it meant he could not take part in sport. He took the guard off, but the nurse told him it made no difference – he still was not allowed to do PE until after the follow up appointment which was scheduled for 3 August.

On 21 July, the boy told an officer with whom he was discussing his remand planning meeting and offences that he had stabbed his victim for "touching him up". (This accords with the statement the boy made to the police.)

On 22 July, the Daily Supervision and Support Record noted that the boy had been "a bit abusive" to an officer when told he could not put out any more washing.

On 23 July, an officer reported that the boy tried to get on to the astro-turf pitch to play football. The officer said he told him he could not play because of health and safety issues relating to the plaster cast on his hand. The officer said that the boy was not happy and took off the cast.

The Residential Care Daily Contact sheet recorded that it had been a mixed day for the boy. His education record shows that he had "insisted on continuing playing one particular sound. Abusive verbally, the keyboard was removed and he kicked a chair across the room." His behaviour had then been good, but he had become angry late in day. He was awarded just six points under the incentives scheme. It was noted that the boy had lost points "for abuse at lockdown. Lost points for abuse in education and kicking chairs across class."

The boy started 27 July by refusing to go to education, but changed his mind after a long talk. The Daily Contact sheet recorded that he was no problem on the unit or at education.

Of the four members of staff who attended a HRAT review held on 27 July, only the nurse had been present previously. She noted that the boy engaged well and reported no thoughts or intentions of self-harm. She recommended that the observation level be reduced to every 15 minutes. The nurse recorded that the boy had been seen by the CPN the previous day and there were no concerns about self-harming behaviour or suicidal ideation. She agreed that observation "could be" decreased to 15 minutes. A member of residential staff commented that the boy "mixes well with trainees when he wants to, but can still keep himself to himself. Very clever young man." "Use of diversional therapy" was added to the original support plan.

A Psychology Contact sheet recorded that the psychologist had seen the boy on 27 July on the houseblock and that he had been informed her he was

having a bad day, “in contrast to yesterday when he seemed in good spirits”. She continued:

> “[The boy] has the kitchen job so it is not convenient to speak to me for long. [The boy] reports that he is ‘OK’ and that he does not need to talk to anyone, but will talk to staff if he feel he needs to. I assured him that staff are available for him to talk to and that he can request to see staff especially the psychology team for support.”

The boy’s solicitor said in her police statement that she had visited the boy on 27 July. He “seemed perfectly fine – his normal self”. She said she and the boy had talked about another boy who was due to leave the centre after four years there. The boy said he wanted to get out. The solicitor said the boy asked if she could get him out and they discussed the procedure for bail applications. The solicitor said she advised the boy that it would not be appropriate to apply for Judge in Chambers bail at that stage, because there were various matters pending. She said the boy accepted this without question and there was no reaction from him.

The following day, the boy wrote a letter addressed “Dear Judge”. In this, he said he had learned his lesson and intended to stay out of trouble in the future. He said that, if he was granted bail, he knew he had “to stick to it and I will for definite” because a friend had offered him a job. He said he had stopped smoking and would not smoke cannabis again. He said he wanted to change his life and start again. He asked the Judge to take into account how he was feeling about things and said he was “really upset and distressed”. He asked for the chance to prove that what he was saying was true.

That same day, the psychologist noted that she had offered the boy a support session but that he declined as he was watching a video in class.

At a HRAT review on 29 July the psychologist wrote that the boy engaged well and had not reported any thoughts of self-harm. She noted that he had had a bad telephone conversation with his mum earlier in the week, but had stated that this was now resolved. She wrote, “I recommend – mins obs” (sic). She summarised that the boy should remain on HRAT with a revised support plan of

> “Observation level – min;
> Location.”

On a HRAT termination form, however, she added, “No thoughts or intentions of self-harm. I recommend HRAT be terminated. The nurse wrote, “[The boy] appears settled. No self-harm issues. Recommend termination of HRAT”, and the care officer wrote, “[The boy] has settled down well, no concerns at the moment. I recommend HRAT to be terminated”.

All three members of the team signed to indicate their agreement that HRAT should be terminated. The Duty Director signed off the form.

The psychologist noted on a Psychology Contact sheet that support had been given to the boy at the same time as the HRAT review.

The Assistant Director said during interview that, when the boy first arrived:

> "… he was quiet, he was very withdrawn, he was spending a lot of time in his room, he wouldn't mix with any of the other young people, he wouldn't talk to staff – so they had concerns about him. So he was on a HRAT and stayed on HRAT and it was regularly reviewed. The care officers said things were much better. He was voluntarily coming out of his room, he was playing pool, he was talking to the other boys, he was asking when he could play football …"

The Assistant Director said the boy had "improved massively in his social interaction, behaviour, talking to staff, building relationships with the staff. Not the best relationships with staff but some like that have difficulty building relationships with trust issues."

The Assistant Director explained that all HRAT decisions had to be unanimous and that there was no attempt to persuade anybody to a different view. Where there was a difference of opinion, action was taken in line with the highest assessment of risk.

(A note from the Crown Prosecution Service on the Lancashire Constabulary file dated 3 August, said:

> "There has been some suggestion that the complainant in this case … may now want to retract. Is there any information in this regard?
>
> "It has also come to the attention of [the YOT officer] that D may have been overheard, whilst on remand, threatening a witness over the telephone. This needs to be investigated as it would obviously make things far more serious for the deft. if he is proved to be involved in witness intimidation.")

Also on 3 August, the boy was taken to hospital yet again with a suspected fracture of his right hand following a "play fight". The Review of Vulnerability Assessment completed on his return noted that there had been no concerns in relation to self-harm since the termination of HRAT.

A communications officer had escorted the boy to hospital on more than one occasion. He told the police he thought he had built up "a little bit of rapport with the boy during this time, about life in general, the future, the present." He said:

> "The impression I got from [the boy] was of [the boy's] looking forward, positive in terms of the court case, what he was going to do when he got home. I believe he was handcuffed to me the second time as he was classed as an escape risk. We were joking who could run faster.

He said, 'I hope I am out next court date. I'm not going to run', words to that effect.

"He was openly talking about why he was at the centre and confident that he was going to be found not guilty and that he was going home. That there was no case to answer … He was quite upbeat talking to me and seemed to take everything in his stride. I am aware that requests for the First Response[12] had been made in relation to [the boy] in the previous three weeks but I didn't become involved, not as comms officer. [There are no records of the boy being subject to requests for First Response before 8 August.]

"From the contact I had with [the boy] I was shocked on realising he had taken his own life. He was a trainee who would be the last person I would have thought would have done that."

A Review of Vulnerability Assessment form was completed on 5 August following the boy's return from court. This noted that there had been no concerns since the termination of HRAT.

Section 5: The boy's response to Hassockfield

Generally speaking, the boy appears to have done well at Hassockfield. Most entries in the daily contact sheets reported that he had had no problems and mixed well. Others were very positive:

- "An excellent day in education. (12 July)
- Excellent education report and mixed well with other trainees. (13 July)
- Another excellent day from [the boy]. No problems at school or on the unit. (14 July)
- No problems. Excellent day. (15 July)
- Excellent day in education. Still fairly quiet on the unit and keeps self to self but does mix well when he wants to. (22 July)
- Another excellent day. (24 July)
- Good day. Worked well on his jobs on unit. (28 July)
- An excellent day all round. Had a visit tonight. Seems OK. (4 August)
- [The boy] was at court all day but behaved excellent on return." (5 August)

Similarly, almost all the entries in the boy's education record show that his behaviour was good, his work rate 100 per cent, his co-operation with other trainees good and his language satisfactory.

During interview, the duty manager described the boy as "calm and deep". He said he had a couple of conversations with the boy when he had taken off his plaster to try to engineer a trip to hospital, and that the boy "wouldn't give much away. He just didn't want to say a lot or tell you what he was thinking a

[12] First Response is a radio call made by staff who need urgent assistance from colleagues. One officer from each houseblock is designated to respond to such calls.

lot of the time. But I did get on with [the boy] most of the time. I hadn't known him be the sort of boy who was constantly kicking off at things."

The nurse who saw the boy on his arrival said in her police statement that she saw the boy most days she was at work. She said:

> "I felt that [the boy] settled in quickly. He made friends and enjoyed his sport. He gave the impression he was quite a confident person. He tended to need others to make conversation with him although I felt I got on well with him. More recently I felt [the boy] had settled and was not having any problems. I was happy he was not on a higher level of observation."

The boy's solicitor said that, in the run up to the court appearance on 5 August, the boy had been ringing her office on a daily basis to enquire whether they had received information from Securicor regarding his previous breaches of a tagging order. (She explained that the boy was aware that the full facts of the frequency of his breaches were needed before they could apply for bail.) She noted that the issue was "obviously high on his agenda" on 5 August and he asked again whether she had received the information. She said she had not, and again advised him that there was no question of making a bail application at that time. She said he again accepted this without complaint. She added that the burglary charge against the boy was dropped that day, but the assault charge was committed to the Crown Court. She said this was the last time she saw the boy.

The solicitor said that, after 5 August, the boy stopped contacting her office every day regarding bail. She said she assumed he was resigned to the situation and was keeping his head down.

Section 6: Confiscation of cigarettes[13]

A statement from the Director of Hassockfield STC sets out information about bringing items into the centre. It advises, in bold, that visitors should contact the centre if they wish to bring in anything for a young person, adding,

> "**Action will be taken against any person found bringing contraband into the Centre.**
>
> "Such items include:
>
> Tobacco
> Cigarette papers

[13] Cigarettes and tobacco are forbidden by the STC Rules:
"17. - (2) No trainee shall be allowed to smoke or to have any tobacco or tobacco products in his possession.
(3) Smoking shall not be permitted in any part of the centre or its grounds except in a designated smoking room set aside for use only by officers or other members of staff or visitors to the centre."

Matches
Drugs

> "There are two major issues you should be aware of if a trainee is caught with items that are banned; it could result in restriction, or even prohibiting your visits. The other issue, which is of equal importance, is the issue of bullying. Young people could be bullied by other trainees if they have something that they should not. It is for that reason we are very strict in what we do or do not allow into the centre.
>
> "In closing I would like to say that in bringing in or attempting to bring in contraband you are not helping your child. We always find things within the first 24 hours!"

In a statement to the internal investigation conducted by the contractor, Premier, the duty manager said that, at about 2 pm on 7 August, he was informed by two officers that they had seen something being passed to the boy during a family visit. The duty manager said the visit was almost finished and he instructed the officers to wait until it had done so and then search the boy. They found two cigarettes and some matches. The duty manager said that, from this point, the boy's behaviour deteriorated on the house unit.

Trainee rewards and sanctions

The Hassockfield policy document on Trainee Rewards and Sanctions says that the purpose of the system "is to ensure a safe, well ordered and constructive environment in which the whole regime as well as more specific regime elements and programmes can provide a positive influence on young people." The system operates on a 4-tier approach, and adopts the format of a football league. The higher the league the trainee attains, the higher the reward.

Each trainee is allocated 10 points at the start of a 24 hour period. Inappropriate behaviour results in him/her being deducted a number of points, up to a maximum of 10. The documents says, "The number of points deducted will be determined by the reviewing officer and will take into account factors such as: severity and frequency. Trainees are not to be informed of any sanction score until the end of the day." It continues, "If a young person commits an action that is deemed serious, then that person will be relegated to the Conference League [the lowest level] for a minimum period of 24 hours and maximum of 48 hours." Actions falling into this category are listed in an annex. The annex says:

> "The following actions all carry a maximum penalty of the young person receiving 0 points for that particular day. Also, the Duty Director will authorise the individual to be relegated to the Conference League for a minimum period of 24 hours and a maximum period of 48 hours."

The list of actions is as follows:

- Assault on any other person
- Deliberate damage to Centre property
- Flooding of bedrooms/classrooms etc
- Contraband find
- Offences of a sexual nature
- Racism
- Smoking (proven)

The document says that, "It must be stressed that the above sanctions are only to be used as a guide. The reviewing officer will decide on the final sanction score and should use such factors as severity and frequency to determine an individual sanction score." In the event, the boy lost all his points on 7 August and was relegated to the Conference League.

A care officer said that, at some time during 7 August, he was told to remove the boy's television as a punishment. He said he went to the boy's room and asked him if he knew his television was to be taken. The boy said he did. The care officer said he "seemed to take it like a man and didn't complain". The care officer said that he had totted up the trainees' good behaviour points during the day. He said the boy became angry when he was told that he had made no points that day due to the cigarette incident. (No trainee response is recorded on the points sheet, however, or on the daily log.[14]) He said the boy had a cup in his hand and threw it on to a table where another care officer was sitting. The care officer said the cup bounced off the table and hit the other care officer on the arm. He said he would have sent the boy for time out, but that he walked off to his room anyway.[15]

The officer who was struck submitted a report about this. This said that, at about 9:00 pm, he felt something hit him on the arm. When he looked on the floor, he saw it was a cup. He looked up and the boy started to walk to his room, apologising. He then started him on time out.

The Time Out Observation report noted that the boy was put on time out for throwing a cup which hit an officer on the arm. It recorded that the boy walked to time out himself at 9:05 pm, was sitting on his bed at 9:15 pm and that time out was terminated at 9:25 pm. From the papers I have seen, this appears to have been the first occasion on which the boy was given time out.[16]

[14] LuptonFawcett commented: "It is not usual practice to record the fact that responses are not given. Only where responses are verbal or by actions would any record be made on the points sheet, daily log, officer's statement or time-out form."
In this case, however, there clearly had been a response by the boy. The care officer said the boy became angry when given his score for the day.
[15] Under 'time out', the trainee is locked in his room for a period to allow him or her to calm down. He or she is observed at intervals not exceeding 15 minutes.
[16] The YJB has noted that 'time out' appears to have been used as a punishment. They suggest that, if the boy had apologised and was calm, some other form of sanction should have been used.

Another care officer said in his police statement that, although he had no dealings with the boy on 7 August, he was told by colleagues that the boy was angry towards staff and the establishment as a result of his punishment.

PART III - 8 August

Section 1: PCC[17]

On 8 August, an officer reported on an incident form:

> "[A trainee] was put into room for abuse to staff. First Response was called to 1B. I was left on the unit 2B by myself when trainees [the boy] and [another] were outside [the first trainee's] bedroom shouting abuse to me, [The first trainee] passed a cardboard note out calling me 'a cow. He would sort me out.' [The boy] picked it up and would not give it to me, passed it to [the other trainee]. Told them to go to their doors had abuse off them, started running in the association area. [The other trainee] went to his room. [The boy] refused after several times. First Response was called and PCC was used."

The officer told the police that she started working in the houseblocks, following her training, on 8 June. She said that, during the few weeks she had worked on houseblock 2, she had had no problems with the boy. She had had various conversations with him, when he had told her about his girlfriend, family and sister. She said that the boy got up at about 10:00 am on 8 August. Some time during the morning, he approached her with his belongings in a bag and told her that he was going to court the next day. He wanted to be able to collect his things from education. Accordingly, the officer put his belongings in the office.[18]

The officer recalled that, between 3:00 and 3:30 pm, she had seen the boy come in from playing football. At his request, she got him a towel with which to wipe off the sweat. She thought that, after that, he went to watch football on television.

At around 5:00 pm, another trainee was sent for time out because he was being hyperactive. About 50 minutes later, the other staff on the houseblock responded to a First Response call, leaving just the officer on the houseblock. At about that time, the trainee on time out called the boy to his (the other trainee's) room. The officer said she told the boy twice to come away, as the trainee was on time out. He did not do so, and she went over. As she did so, the trainee pushed a piece of cardboard under the door. The officer said it had something along the lines of, "You're a fucking cow", "I'm gonna fucking

[17] Physical Control and Care (PCC) refers to the approved techniques by which staff may physically restrain trainees. It was developed by the Prison Service to meet the specific needs of young persons in care and those employed to care for them. The techniques have been approved by the Youth Justice Board and consist of a system of holds that does not rely on pain compliance to regain control. The rules regarding the use of PCC in STCs are Secure Training Centres Rules 37 and 38.

[18] Lancashire YOT noted that, "Three days before [the boy]'s death, on 5 August, [the boy] expected to go back to Court – he did not have to attend as his case was remitted to Crown Court. [The boy] was expecting to go home at this point as he understood that the victim was retracting his statement. It would appear that these factors were considered in the assessment of the boy's emotional state at the time."

sort you out" written on it, which she took to be directed at her. However, before she finished reading it the boy snatched it from her hand. The officer said she tried to get it back but the boy and a third trainee were passing it between them. She said she told them to pack it in and give her the card, but the boy and the other boy were abusive to her. The officer said she then took hold of the boy's arm and told him he was going to his room. She said he tensed up, became rigid and would not move, saying, "You'll never take me."

She told the third trainee to go to his room, which he did. The officer said she tried to talk the boy into going to his room, but by this time he had sat down at the association table and was holding on to it.

The care officer who had taken the boy's television and told him of his Incentives score the previous day then arrived and the told him what had happened. She said she asked the boy once again to go to his room and tried to move him away from the table but he just tightened his grip. The care officer then called First Response.

Three care officers attended, along with the Acting Team Leader. One of the care officers told the original officer to go to another area to cover for staff. By the time she returned, about 10 minutes later, colleagues were completing PCC paperwork having put the boy in his room.

The first care officer on the scene said in his police statement that, although the boy was "a quiet lad", he had always got on well with him and found him to be "a sound kid". He was always very clean in his personal appearance and kept his room tidy. He worked in the kitchen and was always very tidy in his work. The care officer said the boy's behaviour was "always pretty good".

He said that some trainees had misbehaved throughout the day on 8 August. This had not been serious but enough to cause a nuisance. He explained that Sunday could be a bad day, as the trainees knew they had to go back to education the next day.

The care officer said that, on returning from a First Response call, he found the boy sitting at the dining table with the female officer standing behind him. He said the woman told him that she had told the boy to go to his room for time out but he had refused. The care officer said he did not know why the boy was being sent to his room, but he spoke to him and told him that he had been told to go to his room and would have to do so. He said the boy said he was not going to go, as he had done nothing wrong. The care officer said he tried to reason with the boy and told him to walk to his room or he (the care officer) would call for assistance and would take him to his room. The boy still refused. The care officer said he warned the boy one last time that if he would not go to his room they would restrain him. The boy still refused to go, so the care officer called for assistance over his radio. He said that, once he knew help was on the way, he continued to try to reason with the boy, but "he wouldn't have it. He kept saying he had done nothing wrong."

The care officer said that, when the other officers arrived, they again tried to reason with the boy but he refused. He said he then took hold of the boy's wrist/forearm whilst another care officer took the other arm and they lifted the boy to his feet. The first care officer said they were using a "figure of four technique", which was used to gain control of a person who was sitting down. He said the boy started to struggle a bit, trying to wrestle from their hold, and was shouting.

The care officer said they bent the boy forward so that his face was horizontal, allowing a third officer to take control of his head to stop him headbutting or biting. He said heard the third officer say, "Don't try to bite me" or words to that effect. The first officer said the boy then shouted, "I'll kill you, you bastard", "I'll kill you when you let us go", "You've bust me nose, I'm gonna bite your nose off". He said that he knew from this that the third officer must have used a nose distraction on the boy and that, at some point, he saw blood on the boy's face.[19] He said they tried to move the boy to his room, but he was trying to stamp and kick them and to wrap his legs round theirs. A fourth care officer then took hold of the boy's legs and they carried him to his room. They placed him face down and held him there for a moment to get him to calm down, then brought him up into a kneeling position. The first care officer said the boy was still shouting and struggling and that his anger seemed to be directed at the third officer for the "nose strike".[20] The officers left the room while the third officer kept his hands on the boy's shoulders, keeping him on his knees. The third officer was the last officer out.

The second care officer said in his police statement that the boy had taken part in various sports activities during the day and had been in high spirits. He said that, when he arrived in houseblock 2, the boy was sitting at the table, with the first care officer standing nearby. The third officer arrived just after he did, and said, "[Name of boy] are you going to walk?" He said the boy replied, "Am I fuck" in a threatening tone. The second care officer said a number of officers asked the boy if he was going to walk to time out, but he refused each time "using foul language". The third care officer reasoned with the boy that it was better to walk than be restrained and forced to go, but the boy still refused. He said the third officer then said, "OK we'll walk him". The second care officer then took hold of one of the boy's arms and placed it in a figure of four hold. The first care officer did the same on the boy's other side. He said the boy was still seated, but began to struggle. They lifted him up and moved him away from the table. He said the boy kicked his foot and tried to stamp on officers' feet. He "thrashed his head around violently". "For his own safety and the safety of staff", the third officer then took control of the boy's head, bringing it down to waist level. The third officer said, "He's biting" and told the boy that if he did not stop, he would use the nose distraction technique. The

[19] A "nose distraction" is a technique designed to make a trainee desist from doing something. It takes the form of a sharp upward pressure being applied to the base of the nose with the side of the forefinger.

[20] I deprecate the term "nose strike" since it suggests the application of a blow to the nose. The YJB has rightly pointed out that it is not a term used in the PCC manual (which refers to "nose distraction technique") but its use by staff can only encourage improper use of the technique. It should be strongly discouraged.

second care officer said that, after the third care officer used the nose distraction technique, the boy stopped struggling for a couple of seconds, but then realised his nose was bleeding. The boy then shouted, “You can’t fucking do that to me. My nose is bleeding”, and began struggling more violently than before. The second care officer said he noticed blood on the floor. The boy kicked out at all three officers and tried to hook his leg round theirs to trip them up. A fourth officer then took control of the boy’s legs and they carried him face down to his room. The second care officer said they carried him face down to prevent blood running down his throat. Once in his room, they stood the boy on his feet. The boy again kicked out and the third care officer instructed him to go to his knees. The boy complied and the officers exited the room while the third officer held the boy’s head. The second care officer said he noticed at this point that the boy had blood running from his nose “which is common after the nose distraction technique has been administered”. He said the boy ran at the door shouting, “I’ll bite your fucking nose off” to the third officer and repeatedly punched the door. He subsequently refused to be examined by the nurse.

The fourth care officer said in his police statement that, most days, there was at least one call for First Response; “often there is a lot more”. He said that, when he attended the First Response call, he saw the boy sitting at the table. He said that, after the female officer had left the room, the first care officer on the scene asked the boy “at least two times” to go to his room and the boy refused. He said other members of staff tried to persuade him, but with no effect. At this stage, the first care officer and another took hold of the boy in a figure of four and lifted him to his feet. The fourth care officer said the boy started to struggle “violently”. He thought the two care officers might then have changed to a “double embrace”. He said a third officer lowered the boy’s head by placing one hand on the top of his head and the other under his chin. He said the boy became more violent at this point and started to stamp and kick at staff. The boy tried to bite the third officer and was told to calm down, but he did not. The fourth care officer said the third officer then used the nose distraction technique, but this had little effect and the boy continued to kick out. The fourth care officer said that, to prevent any injury to the boy or to staff, he took hold of the boy’s legs and held them off the ground. They then carried the boy to his room.

The fourth care officer said that, once there, he placed the boy on his feet. The boy was then instructed to kneel, which he did. The third care officer took hold of the boy’s shoulders and the others left the room. The fourth care officer said the whole incident lasted about five minutes. He had instructed the Acting Team Leader to film it and assumed that she had done so.

The third care officer said in his statement to the Premier investigation that, when he attended the houseblock for the First Response, the boy was sitting at the table. He said he tried to talk him into going into his room, but he was abusive and refused several times. Two officers took hold of the boy’s arms and pulled him to his feet. The boy began to struggle and the third care officer took control of his head “in the prescribed manner”. The third care officer said the boy tried to bite his right hand as he struggled. The third care

officer said he talked to the boy and tried to calm him down, but he was "shouting and kicking and becoming uncontrollable". The officer said he warned the boy that if he did not stop he would apply a nose distraction, but the boy "just kept kicking and struggling". He said he then "delivered the nose distraction in a flicking movement". The statement said the boy shouted "my nose" and after a few seconds, the officer saw that his nose was bleeding, "but not heavily". The boy continued to struggle, so a fourth care officer took control of the boy's legs, picking them up so that the boy was horizontal. The officers then took him to his room. The third officer said fourth officer released the boy's legs so that he was standing in his room. He said the boy started to kick again so the officers told him they were taking him to his knees. They did so, talking to him throughout to de-escalate the situation. They then exited the room in the prescribed manner. When the third care officer tried to speak to the boy through the door, the boy shouted at and threatened him.

In his statement to the police, the third care officer noted that the boy "seemed to be calm" when he first arrived on houseblock 2. He said the first care officer on the scene told him that the boy had been winding up other trainees by kicking the doors of their rooms and had been "generally disruptive, making a nuisance of himself" and that he wanted the boy to go to time out. The third care officer said that, since the boy was calm, he asked him to go to his room. He said he refused on approximately six occasions. He added, "Although [the boy] was relatively calm, because he had been winding up other trainees we felt that, should we leave him in the association area, he would continue to cause problems. We therefore insisted he went for time out." He said that, after his attempts verbally to persuade the boy to go to his room, the boy was becoming agitated and was trying to make a joke of the situation. He said he told the boy he would have to go to his room and reasoned with him that it was better to walk than be restrained and forced into it. The officer said the boy told him to "fuck off". He said two trainees nearby were laughing at the boy and this seemed to encourage him to continue to refuse. He said he feared that if he "did not take control of the situation and resolve it, the other trainees would become involved."

The third care officer said he gave the boy a last chance to comply but he refused. He therefore told two officers to take the boy's arms. As they lifted the boy to his feet he began to struggle, pushing against the table and struggling to free himself. The officer said the boy repeatedly thrashed his head around and he decided to take control of it for the boy's safety and that of his colleagues. He did this using the approved technique (the officer was a PCC Instructor). The boy continued to struggle violently, and kicked the officer five or six times on the shins and repeatedly tried to bite his right hand. He said he asked the boy "on numerous occasions" to calm down, but he "continued to struggle and became almost uncontrollable". He said he warned the boy that, if he continued, he would use the nose distraction technique. He warned him once again before carrying out the procedure. On this occasion, the officer described it as "using the edge of my index finger to apply pressure between his top lip and the base of his nostrils. This technique is not delivered as a blow but applies by placing my hand onto the area before applying pressure to the area in order to generate a short period

of pain." He said the boy shouted, "My nose" and the officer noticed after a few seconds that it was bleeding – "but not heavily".

The officer said they carried the boy to his room and stood him on his feet. The boy again began to struggle, so the officers told him they were taking him to his knees. He said they did this by going down on their knees and using their bodyweight to bring him down. He said he continued to talk to the boy in an attempt to de-escalate the situation. He then held the boy's shoulders whilst his colleagues exited the room.

The first care officer on the scene said the boy must have jumped straight up and run after them, as he heard banging on the door where he was kicking or punching it. He said the boy was still shouting about the third care officer, saying, "You fucking fat cunt, I'll bite your nose off". The boy spat on the glass of the door, and the first care officer could see blood mixed with the spit. He was also throwing things around his room. The officers then moved away to let him calm down. At some point, the boy smeared toothpaste on the door window and squeezed shampoo under the door.

The duty manager arrived on the unit when it was all over. He said during interview that he went into the boy's room to ask, "What's this all about?" but that he "had completely and utterly lost it and I'd never seen him like that before".

A Time Out Observation form noted the reasons for the time out as being the boy's refusal to go to his room, abuse to staff and his attempt to bite staff. The following observations were noted:

18:05 - Time out started
18:15 - Kicking doors and throwing objects at door.
18:20 - Covered viewing hatch with toothpaste
18:30 - Time out finished.

The nurse who attended the First Response noted that the boy had a nose bleed, but that the injury was minor. However, she added that she had been unable to examine him "due to aggression and threats towards staff".

The duty manager said in his Premier statement that he went to speak to the boy during his time out, but he threw a cup at his hatch and was angry and saying he would kill the third care officer. The duty manager said he returned after the boy was released from time out and the boy confirmed that he was okay.

The boy wrote his own statement relating to the PCC. He said:

> "On the 8th August at approx 06:50 pm I was sat at the table on the wing 2 Bravo. And my friend was messing about, so he was put in his cell for 30 minutes (time out). When my friend was in his cell he asked me to go over to his door. When I went over he slid a piece of paper under the door and asked me to give it to a female member of staff.

When I gave the paper to her she told me to get in my room. I asked why and she said, "Just go in". Then at that point I refused because there were no explicit reason for this. Then she called for first response (assistance from other staff). When the other staff came they all jumped on me and started to put my arms up my back and hitting me in the nose, so I then tried to bite one of the staff's hand because they were really hurting me. My nose started bleeding and swelled up. It didn't stop bleeding for about one hour and afterwards it was swelled badly and really sore and hurting me a lot. When I calmed down I asked them why they hit me in the nose and jumped on me. They said it was because I wouldn't go in my room, so I said, 'What gives them the right to hit a 14 year old child in the nose and draw blood?' and they said it was a restraint. When I asked the nurse to see me she would not order an escort to take me to hospital and just stated it was badly swelled and will continue to do so."

Camcorder filming

The Acting Team Leader advised the police that, "A First Response call is where staff are asking for assistance with a trainee who is causing problems urgently." She said she responded to the houseblock 2 First Response call with a nurse. She saw the boy sitting at the table and a number of staff dealing with the situation. She said she heard staff tell the boy to go to his room and then take hold of him from behind whilst one took control of his head. She said she saw that no-one had brought the camcorder, so went to get it herself from the staff office which was just off the association area. She said she had to unlock doors and that by the time she returned and switched on the camera, the boy was being carried towards his room. She said that, once there, the boy was placed on his knees and that staff exited quickly as the door was locked and the boy ran at it. She said she stopped recording at that point, but the boy was shouting and banging on his door, shouting abuse and spitting at the door's viewing panel. The Acting Team Leader said she could see blood in the spit. She then returned the camcorder to the office.[21]

The health and safety officer explained to the police that the centre had five camcorders on which to record any incidents involving trainees. He said there was no procedure for recording the use of the camcorders, but that if one was used to record an incident, staff would "highlight" the matter to him and he would take possession of the tape and lock it in a safe. He said the nightshift duty manager replaced the tapes in each camcorder at around midnight. The tapes that had been removed were then kept in the duty manager's office, until they were handed over to health and safety oficer when he arrived on duty the next day. He downloaded the contents on to a full format VHS tape, which was dated and retained. The camcorder tape was then ready for re-use.

[21] LuptonFawcett commented: "Good practice causes us to use hand-held camcorders, where time, resources and circumstances permit. There is no obligation nor requirement, but where possible we have found it a useful practice. All staff are trained in the use of handheld video, refreshers are given as and when required." I consider this to be good practice.

The officer said that, on 9 August, he was asked to view the tape from the houseblock 2 camcorder to find the footage of the boy's restraint. He was told that the tape was already set up on his own camcorder ready to view and that a colleague had started to view it and had seen footage of the restraint of a particular trainee. The officer said he was surprised, as that trainee was no longer at the centre whereas he always re-wound the tapes before re-issuing them. He said he and a colleague spent most of the day trying to find the footage of the boy who is the subject of this report, but without success. The officer explained that the tapes were not marked in any way, so he had viewed nine different tapes thinking there might have been a mix up.

Eventually, the footage was tracked down as the result of the Acting Team Leader recognising a comment she made during the boy's restraint. The officer said the footage was hard to find because it was in the middle of the footage of the restraint of the trainee who was no longer at the centre. All that could be seen was a group of staff restraining someone and all that could be seen of the trainee was the stockinged soles of his feet.

After the PCC

The third care officer involved in the PCC submitted a Security Intelligence Report following the restraint. He said that, whilst he was being restrained, the boy had threatened to bite his (the officer's) fingers off:

> "After several threats he attempted to bite my hand. After leaving his room he kept shouting that he was going to bite my nose off and that he was going to punch my face off."

The first care officer said the boy was in time out for about 25 – 30 minutes. After this time, he said the boy started to calm down and he went into his room to talk to him. He said his face was "covered in blood, as was his room, which was a mess". He said that, because the boy had calmed down, he started to tell him off and that there was no need for any of it to have happened. The officer said the boy seemed to accept this, and knew that he should have walked to his room but maintained he had done nothing wrong. He said the boy was angry about the nose distraction "bursting his nose", but that he seemed okay about everything else.

The officer said he told the boy to clean his room and gave him a mop and some towels.[22] He said the boy started to clean up, but he was quiet and the officer knew he was still angry. After cleaning his room, the boy returned to association. The officer said he seemed okay.

The third care officer said in his Premier statement that, about an hour after the restraint, he decided he needed to explain to the boy what had happened. The boy had calmed down by this time and was cleaning his room. When

[22] LuptonFawcett advised that the boy had earlier flooded his room and ejected water under the door. The mop and the towels were provided for him to clean up the water on his floor.

asked, he said he was okay. The officer reported that the boy was "clearly ready to talk", so he asked him what it had all been about. The boy said "Nothing". The officer said he explained to the boy that no-one wanted to use PCC, and that it was better if the trainee went of his own accord. He said the boy said, "I know". The officer said the boy kept saying that he was alright, and began to show that he did not want to talk about it.

Section 2: During the evening

The officer said that the boy had subsequently gone to the office, as he wanted to phone his solicitor and the phone in his room was not working. He said that, when the boy spoke to his solicitor, he said he had been restrained and his nose had been broken by one of the officers. The officer said that the officer who had take the boy's legs during the PCC spoke briefly with the solicitor before handing back the phone. The boy then asked the solicitor to let his mum know. The officer who had administered the nose distraction said he again asked the boy if he was alright and he said he was. The boy then returned to his room.

The boy's solicitor said in her police statement that the boy first contacted her on 8 August at 16:00 hours (sic) on the emergency number. She said he seemed composed but was saying, "They've broken my nose. They've broken my nose." She said he did not explain what had happened. She asked to speak to one of the officers who told her that the boy had been restrained but had refused to see a nurse. The solicitor said she told the boy he had to see the nurse and he had said, "You need to come now". She explained that that was not how it worked and that she would speak the next day to the department that dealt with complaints and, if necessary, would visit him. At that, the conversation finished with the boy asking her to phone his mother. He added, "They've taken my CD player and TV off me because of some fags."

The female officer with whom the altercation had first started said that, at about 7:45 pm, the boy told her he wanted to call his solicitor again. She put his call through to the gatehouse, spoke to the solicitor and then put the boy on the phone. She said he told the solicitor what had happened during the afternoon: that he had been restrained for no reason and had received a nose bleed. She said he had a piece of paper in his hand with "Statement" written on it. She thought the boy was on the phone for about 10 minutes.

The solicitor said she contacted the boy's mother, as asked, to let her know what had happened. She said that, within two hours of the first call, the boy rang again. He again seemed composed. During this discussion, they talked in more detail about what had actually happened and why he had been restrained. The boy had told her that the trainee on time out had passed the note under the door and asked him to give it to the female officer. He had done so, and she became cross with the boy and told him to get in his room. The solicitor said the boy had told her he said, "Why should I? I've not done anything wrong." The female officer had then pressed the panic button for reinforcements. The boy told the solcitor that, "They pushed me down and

one of them hit me on the nose." The solicitor again told the boy she would speak to the complaints department the next day and, if necessary, visit him.

The solicitor added that the boy's mum had told her that the boy was expecting a bail application to be made the following day. She had raised this with the boy during the second phone call, explaining the procedure once again and that there would be no application the next day. She said the boy was quiet, but did not say anything that caused her any concern. She said she then warned him about his behaviour whilst in custody, that it was not a children's home but a prison and they would make him toe the line. She said he did not say anything and the conversation was left on the understanding that she would follow it up the next day.

The solicitor said she was aware that the boy had threatened self-harm and suicide in the past, but he had never expressed any thoughts of that nature to her, nor had he ever behaved or said anything to give her cause for concern. She said she was very shocked when she learned the boy had hanged himself.

The care officer who had taken the boy's legs during the PCC said that, after the phonecall, the boy had asked to see the nurse and this was duly arranged. He said the nurse came down to the houseblock between 7:30 and 8:00 pm. The officer had nothing more to do with the boy. He said he was shocked to learn of his death, as there had "never been any indication that [the boy] would harm himself in this way".

The nurse who had assessed the boy on arrival at the centre said she came on duty on 8 August at 7:30 pm. She was informed by the dayshift nurse that the boy had been involved in an incident at 6:00 pm where he had been restrained. The other nurse told her that the boy had been violent and threatening and had tried to bite members of staff. He had refused to see the nurse, despite having a nose bleed. (The nurse observed that she had had to treat trainees previously for nose bleeds occasioned by the use of the nose distraction technique.)

The nurse said that the officer phoned her at about 7:45 pm. He told her that the boy had spoken to his solicitor and now wanted to see a nurse. She saw the boy in his room at about 8:00 pm. She said he had dried blood around his nose and mouth. She told him to wash it off so she could examine him but he refused, saying that he wanted a photograph taken as evidence. The nurse explained that she could not examine him until the blood was cleaned away, and he agreed. On examination, she found "a tiny amount of swelling over the bridge of his nose but no deviation. There was no bruising and he was able to easily breathe through both nostrils."

The nurse said the boy told her that his solicitor had said he should go to hospital for an x-ray, but she (the nurse) said it was up to her and she did not believe it was necessary. She said a GP would see him the following day. The boy complained that he had been assaulted, and the nurse explained that staff would have only used the nose distraction technique as a last resort.

She advised him he would need to make a complaint and that the incident would have been caught by both the hand-held camera and the CCTV cameras.

(The post mortem report said that "possible swelling to the bridge of the nose was noted externally but this was not confirmed on internal examination". The examiner noted three small abrasions of differing lengths on and beneath the boy's nose. He concluded that these were consistent with the restraining procedure that had been described to him.)

The care officer who had initiated the First Response said that, at around 8:00 pm, he made the boy four slices of toast and a cup of tea. By that time, the boy seemed to be back to normal. He and the other trainees were watching MTV in the video room and were dancing about and jumping around.

The duty manager said in his Premier statement that he received a call from the boy's mum saying that she understood from the solicitor that the boy had a broken nose and had been beaten up by staff. The duty manager said he promised to investigate.

The duty manager said he then phoned the boy's mum to reassure her.

The care officer who had initiated the First Response said that, at about 9:00 pm, the boy told him that he had hurt his hand banging on the cell door. He said the boy's hand was already swollen, as he had broken it previously. The officer told him he would have to have it looked at the next day, as it was too late then. He said the boy also asked for his bag of clothes, explaining that he was no longer going to court. (The officer said that staff were under the impression that the boy was going to court the next day for Judge in Chambers bail. The boy had told them earlier that he expected to be released.) He said he did not get time to ask the boy about this, as the boy took his things and went back to his room.[23]

The nurse who had examined the boy's nose said she too saw the boy again at around 9:00 pm. He was watching the television in the houseblock and told her that he was fine.

At about 9:30 pm, the care officer did his last check of the unit and spoke to the boy. He recalled that the boy said he would see him the next day. He said the boy seemed okay by this time and they said goodnight.

The care officer, who had been acting team leader since 7:45 pm, said he told the night shift that the trainees had been in staff's faces all day, but he did not mention the boy's "incident". Neither did he make an entry in the communication book.

[23] LuptonFawcett commented: "Had the staff been concerned that he was acting in an unusual way they would have initiated an HRAT. The fact that this did not happen meant the staff did not believe him to be at risk."

The female officer said that, before going off shift at 9:40 pm, she recorded the fact that the boy had been put in time out in the unit diary, which was used to pass on information from one shift to another. The entry said:

> "[The boy] was PCC'd would not go to his room for messing about and being abusive; resulted in a nose distraction."[24]

The duty manager said in his Premier statement that he subsequently went to check on the boy at about 9:35 pm. The boy told him that he was okay but that he was going to make a complaint. The duty manager said he asked the boy if he had been punched on the nose, but the boy said he had not. However, the boy complained about the officer and how he had carried out the nose distraction. The boy said the officer had squeezed his nose and caused it to bleed. The duty manager said he offered to help the boy compose the complaint, but the boy said he would do it during the night.

Change in the boy's behaviour

The duty manager said he then spoke to the boy about the change in his behaviour. He said the boy told him that he had been angry at first but that he now realised "that it was not their fault and the finding of the cigarettes was the reason". The duty manager said he confirmed once again with the boy that he was okay and then asked him to go to the office to speak to his mum. The boy asked the duty manager to tell her he was fine and that he would speak to her the next day. The duty manager noticed that the boy did not have a TV in his room and asked him where it was. The boy said it had been taken away because of the incident with the cigarettes the day before. The duty manager allowed him to retain his CD player (even though this too should have been confiscated) to help the boy "chill out". The duty manager said he told the boy that, so long as he maintained his current standard of behaviour, he would intercede for him to help him regain his place in the Champions League (the top level of the incentives scheme).

The duty manager said during interview that, by this time, the boy was "very calm, quiet … not totally apologetic but nice and calm. He'd got over the PCC by that time." The duty manager agreed that he assumed the boy was back to his normal self. He said the boy did not ask about his television and was not bothered about it. He said he did not pick up anything at all to suggest that the boy intended to harm himself.

The care officer whom the boy had struck with a cup the previous day confirmed that the duty manager spoke to the boy for about ten minutes.

A team leader said in her police statement that, when she started work at 7:45 pm on 8 August, she discussed the boy with the day shift duty manager. She said she was told that the boy had been relegated for 48 hours for having cigarettes in his possession. She was also informed that the boy had been

[24] LuptonFawcett noted that the 'unit diary' and 'communications book' are the same. I am concerned, however, that the care officer who had initiated the First Response did not record anything in it – he did not know that the female officer would do so.

restrained earlier that evening. She commented that she was "quite shocked as [the boy] never usually kicks off with members of staff". Accordingly, she read the relevant paperwork which confirmed what she had been told. She said the duty manager told her that the boy had now calmed down and that he was going to have a chat with him before he went off duty. The team leader said, "At this point there was no cause for concern. I was just being told about what had happened before I started work."

The team leader took over as duty manager when the previous duty manager left at 9:45 pm.

The Assistant Director was on the HRAT board, was involved with decision making when the boy was on HRAT and was aware of his issues. She was asked whether the contraband incident gave her any concerns in light of his HRAT history. The Assistant Director said it did not. She said that, after the contraband incident:

> "Having spoken to [the duty manager, who] was very, very descriptive of the type of conversation he'd had with [the boy] and things they'd been saying, the mood he was in. I actually had no concerns whatsoever. From my point of view, I would never ever take anybody off a HRAT who I even had the vaguest doubt about. I genuinely had no concerns."

The interviewer asked her how a HRAT re-review would be triggered. The Assistant Director replied:

> "It's really a multi-discipline thing. It's the care officers who know these young people far better than anybody else. With the best will in the world, it doesn't matter whether you are a nurse, a teacher, a psychologist, a psychiatrist, you come in and talk to a young person and you do an assessment. That young person tells you what they want you to know, it's as simple as that. But the care officers are the people who spend time with these young people. They are with them all through school during the day, sitting in the classrooms with them, they are down with them on a night time, they are with them on activities, playing football and whatever. They are the ones who really, really get to know them."

Section 3: 9:45 pm - midnight

An officer told the police that his shift on 8 August was from 7:45 pm to 8:30 am. He said there was no specific handover when he started work, as the others were not going off duty immediately. He said all that was mentioned was that the trainees had been "up a height" all day. He said he would not expect to be informed of a trainee having been restrained and removed to his room unless it had been a particularly serious incident, as "restraint can be as common as twice a day". Once the day shift left, only he and his colleague (the officer who had been struck by the cup the previous day) were left on houseblock 2 (Alpha and Bravo).

The officer said he went to collect some food at about 9:45 pm, returning to the houseblock at 10:05 pm. He and his colleague then ate the food, all the time responding to requests from trainees. He said he did not answer any calls from the boy's room.

The officer explained that, once the trainees were locked in their rooms, he and his colleague were required to check on them once every fifteen minutes. He said he usually either used a torch for this or switched on the light. He said they generally used a system called Morse Watchman, which was an electronic device for monitoring whether the checks had been carried out. However, this had not been working since his return from leave a few days earlier.

The officer was asked about this at interview. He explained that a member of the night shift staff generally went to the duty manager's office to get the Morse Watchman and a torch straight after lock-down. He did not say if this had happened on 8 August, but said he could tell the equipment was not working because it did not bleep (which it normally would once the code was punched in). He was asked if he tried it on 8 August and what happened. The officer said, "just the same, it was dead. I can't even remember using it." When pressed on this, the officer said, "If it was there I would have tried it. I'm positive I did but …" The interviewer clarified that no-one had told the officer that it was not working, but that he just thought it was not working and it did not seem to be working correctly. The officer agreed, adding, "It was like that throughout the night shift as far as I can remember." He said he thought it had been like that for the previous week, but he could not be certain.

The officer also said that on 8 August no torch was available on the unit and they had been disturbing the trainees when they switched on the lights to carry out their checks. His colleague therefore left the unit at one point to find a torch.

The colleague said in his police statement that he went to houseblock 2 at about 9:30pm, having previously been working on houseblock 3. During interview, he said there was no handover that night and that he was not given any information about anyone or anything to look out for. He said that, usually during handover, he would expect to be told what had happened during the day and whether there had been any incident. He would also be told what tasks he was expected to complete.[25]

He said that it was only his fourth shift working on the boy's block, and that he did not therefore know the boy that well. He said that, although there was no handover as such, he was aware from his previous shift that the boy had lost his privileges after some cigarettes had been smuggled in. He said that on the Saturday night the boy seemed upset at the loss of his privileges, but had gone to his room and seemed okay.

[25] LuptonFawcett noted that an entry had been made in the unit diary. I am concerned, however, by the lack of detail in that entry and that no-one separately ensured that night staff were aware of what had occurred in respect of the boy.

This officer said his Sunday shift started at 7:45 pm. The trainees had already been locked in their rooms when he arrived on houseblock 2. He said he saw the duty manager speaking to the boy after lock up, but did not know why he was speaking to him. Nor did he hear the conversation except they were discussing the boy's points and getting his privileges back. When the conversation ended, the officer locked the boy's door and said goodnight to him.

The officer said the Morse Watchman system was not working, so was not being used. He said they had "had problems in the past where the machine has not always scanned properly". He added that, as the system was not working, there was no record of the checks carried out. He said he did one of the regular checks between 9:30 pm and 11:00 pm, but that the other officer did the rest. He confirmed that all the checks were done during this period. He said that, when he did his check, the boy was lying on his back on his bed. He could not recall what the time was.

The officer said they did not have a torch at the start of the shift and that, shortly before 11:00 pm, he left the block to take some paperwork to the duty manager on houseblock 1. He said he spoke to her for about 20 minutes (at interview, he said "a good 25 minutes to half an hour") and that she then asked him to go to the office to get a torch to take to healthcare. The duty manager also wanted him to have a look at the electrics in one of the rooms in healthcare because the light was not working. The officer said he also wanted a torch for houseblock 2. There were three torches in the duty manager's office, but two of them were not working. The officer therefore went to the gatehouse to see if they had any batteries. He spoke to someone in the gatehouse for a while (at interview, he said 5 – 8 minutes), before taking the torch to healthcare. He then spent about 15 minutes in healthcare. The duty manager then asked him to cover the healthcare block whilst she and the nurse went to education. He said they were gone about three minutes. The officer said he returned to the gatehouse, having previously forgotten to ask about batteries, and found a torch and a lantern, neither of which was working. The gatehouse officer played around with it and got it to work. He gave it to the officer to take back to the unit. As the officer was about to leave, he said there was a call over the radio from the other officer on the unit, asking for assistance and the duty nurse. The officer said he returned to the houseblock, arriving just after an Acting Team Leader)not the same one previously referred to), and the nurse who had examined the boy earlier.

The officer said it was not uncommon for an officer to be away from his houseblock for some time during a night shift, as there were other duties that had to be carried out. He said one such occasional duty was a full search of the education block. This would take a couple of hours. In addition, a new arrival late at night might take an officer away for a couple of hours – "especially if he comes in with a lot of property and you have to go through all the property". Staff training also took place during the night shift. The officer said there had been an occasion when a colleague he was working with was

taken off to do some training, leaving him "to take three houses". However, he added, "at the end of the day, there's only one person who finally does the checks anyway".

The officer who had remained on the unit said he started a round of observations at 11:15 pm, starting with the boy's room, and that the door window was covered with a sheet of A4 paper. The boy removed it when told to do so and the officer continued on his round.

During interview, the officer explained that it was quite common for trainees to cover their windows, if they did not want to be disturbed or if the light from the unit was disturbing them.

The officer said that, when he conducted his next checks at 11:30 pm, the boy was standing right up by his door window. However, he did not speak and they had no conversation.

During the next check at 11:45 pm, the boy was again standing at his door. The officer said he appeared "in order, not distressed at all". He said he just thought the boy wanted a change of view from looking round his room.

When asked during interview, the officer said he thought that, during the earlier checks, the boy had been on his bed with the light off. He said that, on the previous four nights, the boy had got his head down and gone straight to sleep. He could not say what the boy's normal pattern of behaviour was as he had only worked the four night shifts on that block.

Section 4: Discovery of the boy's death

The officer said he carried out his next check at about midnight, once again starting with the boy's room. He said the room light was dimly illuminated. The boy was sitting to the right of his bench in the corner opposite the door. He said his head was tilted slightly down, with his body towards the door and he could see a ligature coming from around the right side of his neck and apparently attached to the curtain rail. (In fact, the boy had attached a ligature over the end of the curtain rail, holding it in place with a piece of sticking plaster until the tension was sufficient to hold the ligature in place.) He said his initial reaction was that the boy was joking and he banged on the door to get his attention. When he did not respond immediately, he said he shouted on the radio to have the door magnets released and the nurse to attend. He said at interview that he did not mention what had happened to the boy, he just asked for help. (The officer said during interview that he could not recall whether he had seen anything advising what he should do if he found a trainee who had tried to kill himself.[26])

[26] LuptonFawcett commented that, "All staff including [the officer who discovered the boy hanging] had full training on suicide awareness with regular refreshers". The issue here, however, is not about suicide awareness, it is about whether staff in general, and the officer who discovered the death in particular, had been given training in what to do on discovering an incident of self-harm.

Generally speaking, the doors are centrally locked magnetically as well as being on the key. The communications officer explained to the police that, due to the move of the communications office to a different site, the magnetic lock was not in operation on 8 August. He said that, even so, staff were required to go through him for permission from the duty manager to enter the room. He said that, on this occasion, because of the tone of the unit officer's voice he told him to go straight in.

The officer on the unit said the door magnets were released by the control room and he went into the room. (At interview, he said he thought he might have been told by the control room that he could go straight in, but he was not absolutely certain.)

He lightly slapped the boy's cheek, hoping to get a response, but there was none. He said he then took hold of the boy in a bear hug from the front and lifted him to take the weight off the ligature. The officer said he tried to reach up to release the ligature but could not do so. He said a couple of seconds later the nurse and the Acting Team Leader arrived.

The latter shouted for the "cut down knife", which appeared almost immediately. The officer who found the boy hanging said the Acting Team Leader cut through the ligature and together they lay the boy on the floor. The Acting Team Leader and the nurse then attempted resuscitation. The officer said he just stood by the door, stunned. He said the Acting Team Leader shouted for an ambulance and that, by this time, other staff had arrived. Subsequently, the officer was told to go to the gate to await the ambulance.

The officer who had been absent from the unit said that, when he arrived on the houseblock, he found the nurse and the Acting Team Leader in the boy's room, with his colleague supporting the boy's body. He said they put the boy onto the floor on his back. At this point, the officer said he saw a mark round the boy's neck and realised he must have been hanging. He said the Acting Team Leader shouted for someone to get an ambulance. The night duty manager had arrived by this time, and she said she would call the ambulance and that the officer who had just returned should go to the middle gate to await its arrival. (The duty manager said during interview that it was not possible to call 999 from the unit. She therefore phoned the communications room for them to call the ambulance. She explained that she could not use her radio because the battery had gone flat.) The officer did as he was told and followed the ambulance down to houseblock 2. Whilst the paramedics attended to the boy, the officer checked on the other trainees and closed all the observation hatches. He said they were shouting and banging and asking what was going on.

A female care officer said she heard the call over the radio asking for the nurse to attend houseblock 2 immediately. She said her first thought was that it would be to attend to a particular female trainee who could be demanding. Seconds later, the female care officer received a phonecall from the duty manager asking her to go to houseblock 2. She said she ran straight over

and, as she did so, heard a call from the communications officer asking for the lights to be put on in the unit. She knew this was to enable the CCTV cameras to pick up more clearly what was going on.

When she got to the houseblock, she could see a trainee on his back on the floor with the Acting Team Leader giving mouth to mouth and the nurse giving chest compressions. The female officer offered to take over, but her offer was declined. She said the boy's face was grey and his lips and ears were blue. The duty manager then asked her to check on the progress of the ambulance and to find out whether the duty director was on her way. After making the phonecall, the officer said she went around all the trainees' rooms and closed the viewing panels to prevent them seeing what was going on. She said they were all awake by this time. She told them to be quiet and let staff get on and that the boy was not well. One of the trainees shouted for the others to look under their doors to see what was going on. The officer said she placed a towel across the foot of his door to prevent him looking.

She said she returned to the room and asked if she could help. The Acting Team Leader asked for some gloves. She checked the first aid kit but could not find any. She was asked to fetch towels or cloths, which she did, and then waited for the ambulance. This arrived a couple of minutes later, at about 12:25 or 12:30 am.

The acting Team Leader said in his police statement that he was talking to the nurse in houseblock 3 when, at about 11:55 pm, a message came over the radio asking the nurse to go immediately to houseblock 2. The Acting Team Leader said he would walk over with her. He said they actually ran to the houseblock and, as they reached it, he heard the officer there calling to him for help. He said that, as he and the nurse ran towards the boy's room, a call came over the radio asking someone to put the light on. The nurse went to do this as the Acting Team Leader continued to the boy's room. Once there, he found the officer supporting the boy's body. The Acting Team Leader said he jumped onto the bed and tried to release the ligature by pulling it from around the boy's neck. He said he thought he would be able to snap it, but could not do so. He said he "screamed" at the nurse to get the cut down knife, and she did so very quickly. He then cut through the ligature and they laid the boy on the floor.

The Acting Team Leader said he checked to see if there were any signs of life, but could not find any. He shouted for the duty manager to call an ambulance. He then gave mouth to mouth resuscitation while the nurse administered chest compressions. The Acting Team Leader said he smelled vomit and hoped this was a sign the boy was coming round. He therefore turned him on his side. There was still no sign of life, however, and they continued to try to resuscitate him.

The Acting Team Leader said that, when the ambulance crew arrived, they inserted an airway and gave the boy oxygen. Meanwhile, he and the nurse continued with cardio-pulmonary resuscitation (CPR). The crew also used a

defibrillator, but detected no sign of life. He said they eventually lifted the boy onto a trolley and took him to the ambulance.

During interview, the Acting Team Leader said all staff were trained in emergency operating procedures, although they tended to focus on the part of the process in which their responsibilities were most likely to lie. He said there was continuous training at the centre which took place every nine weeks. He said that, since the boy's death, he had impressed on new staff what they would need to do in the event of another suicide attempt.

The nurse said she went to houseblock 3 at about 10:30 pm to share a takeaway meal with other members of staff. She said she was still there when she received a radio message telling her to go to houseblock 2B immediately. She said the Acting Team Leader from houseblock 3 went with her. She said he walked ahead of her and she locked the block door before following him. Once inside, she saw a door to one of the bedrooms standing open. The Acting Team Leader was standing in the doorway and she could see the officer holding the boy beyond him. She said the Acting Team Leader shouted to her to get the cut down knife, whilst someone else shouted for the unit lights to be switched on. The nurse said she ran to the office, turning the lights on as she went. She got the knife and gave it to the Acting Team Leader. He used the knife to cut the ligature and the boy was placed on the floor.

The nurse said she and the Acting Team Leader checked for vital signs, but there were none. They then started CPR, with the Acting Team Leader giving mouth to mouth, whilst she administered chest compressions. The duty manager arrived and they shouted for her to call an ambulance.

The nurse said she and the Acting Team leader continued with the CPR. She said that, at some point, the boy must have vomited. Having lost his gag reflex, he swallowed it. They therefore kept clearing the vomit from the boy's mouth.

The nurse said they continued with this until the ambulance arrived. She thought this was between 12:20 and 12:25 am. A second ambulance then arrived carrying paramedics. She said she and the Acting Team Leader continued with CPR while the ambulance crew set up their equipment. The ambulance staff initially had problems getting a tube down the boy's throat, but once this was done the boy was taken into the first ambulance where the paramedics took over. She said they worked on the boy for a few minutes before leaving for the hospital.

(The nurse left Premier's employment shortly after the boy's death and was not interviewed by YJB staff. I have quoted throughout from her police statement.)

A member of the ambulance crew said they received a call to attend Hassockfield at 11:54 pm. He was told that staff were administering CPR and had called for paramedic back-up. He said they arrived at Hassockfield at

12:07 am. He was taken to the boy's room while his female colleague, an advanced technician, brought the ambulance through the gates and as near to the houseblock as she could. The ambulanceman said that, when he arrived at the boy's room, two members of staff were administering CPR. The boy did not seem to be responding and his skin was very pallid. He said the boy's lips were blue and there was a pool of vomit by his head.

The ambulanceman said he used a portable suction unit to clear vomit from the boy's throat and checked for signs of breathing. These proved negative. He then placed an airway into the boy's mouth and an oxygen mask over his nose and mouth. The ambulanceman gave him two breaths of oxygen. The boy's chest did not appear to rise, so he gave a further three breaths. When the boy's chest still did not rise, he inserted a larger airway but still the boy's chest did not rise. During this time, the nurse had administered chest compressions.

The ambulanceman said his colleague then arrived with the defibrillator and placed the paddles on the boy's chest. The machine showed there was no electrical activity in the boy's heart.

The advanced technician then went to fetch a pharyngeal mask which has a tube that goes down the throat and into the airway. This was connected to the oxygen system. This proved successful at getting air into the boy's lungs. The male paramedic then fitted a surgical collar and they removed the boy to the ambulance. The Acting Team Leader gave chest compressions during this process, whilst the advanced technician administered oxygen.

The advanced technician said she received a call at 11:54 pm to attend at Hassockfield. She was told staff were administering CPR and suspected that someone had hung themself. She therefore requested paramedic back-up. She said she and her colleague arrived at the centre at 12:07 am. Her colleague took the First Response bag and the oxygen. She followed a few seconds later with the defibrillator. When she arrived at the room, her colleague was securing an airway using a portable suction device. She said that, after clearing the airway, her colleague used a bag and mask to give air to the patient. She then attached the defibrillator. This showed that there was no electrical activity in the heart. They then attached a surgical collar. The ambulanceman said he was concerned that air might not have reached the boy's lungs as his chest had not appeared to rise and fall. The advanced technician said that chest compressions were administered throughout by her colleague and the Acting Team Leader.

The advanced technician returned to the ambulance for a pharyngeal mask airway (she suspected the boy had trauma or a blockage in his windpipe). Following insertion of the tube, she established that air was reaching both lungs. She then went to fetch a stretcher and the boy was taken out to the ambulance. The advanced technician said oxygen was administered throughout the removal, but she could not recall if anyone continued with chest compressions. After that, paramedics took over.

A trainee technician said that, when they got the call for assistance, they made their way to Hassockfield using the blue light. They arrived at 12:19 am. The other ambulance was parked directly outside the training centre, with the boy inside on a board. His colleague began to administer treatment to get more oxygen into the boy (he had a restricted airway). The man from the ambulance crew was administering CPR. The trainee technician took over from him.

The trainee technician's colleague said in his police statement that they received the call at about 12:06 am that a male had attempted to hang himself. They were told that an ambulance was in attendance and had requested back-up. He said that, when he got into the ambulance, he could see the boy was wearing a surgical collar. His complexion was very pale and he was showing signs of cyanosis (a blue colouring of his skin) around his mouth. The ambulance staff told him that they were unhappy with the amount of air they were able to administer, so he carried out a laryngoscopy, which allowed him to view the vocal cords and the larynx. He saw that the boy's airway was blocked with mucus and vomit and used a suction to clear it. He then inserted an endotracheal tube into the boy's airway. The boy was then connected to 100 per cent oxygen and ventilation was continued. During this time, CPR was administered by other members of the crew. The paramedic said he established that the boy had no cardiac output and therefore administered epinephrine and atropine via his left arm. They then informed the hospital that they were en route. The trainee technician and the ambulanceman and Mr Handley remained in the back administering CPR during the journey. They left the centre at 12:36 am.

During interview, the officer who had been absent from the unit was also asked whether he was aware of a contingency plan to be followed in case of a death or major injury. He said he was not – "Things weren't clear to us as to what you should do. There was talk of what employees should do and what you shouldn't do but there was nothing definite to say exactly."[27]

The officer said that at no time was he given any cause for concern about the boy or any reason to think he would take his own life. Nor had he seen a ligature attached either to the boy's neck or to the rail during any of his checks.

Section 5: The boy's note

The boy left a note. This was addressed to various family members, his girlfriend and "all of my loved ones". It reads:

> "Sorry! Sorry! Sorry!
>
> "Lately over the past two months or so things have been very hard for me and it's just all got to the point where my head goes. As most of

[27] LuptonFawcett commented, "As indicated previously all members of staff receive regular suicide awareness training."

> you all know I bottle things up too much but I guess that's just me. I can't help but cry whilst I'm writing this letter even though that doesn't help."

He went on to say that he would now be with his grandparents and would be able to look after them and make sure they were all right. He also gave some instructions relating to his funeral.

Section 6: Evidence from trainees

The police interviewed the six other trainees on the unit.

One described staff stamping on the boy's feet to get him to stand up at the start of the PCC. He also said that, when the boy was carried to his room, his arms were behind him and he was face down. However, the trainee said the boy was smiling when he came out of his room.

A second trainee also referred to staff stamping on the boy's feet (the boy did not have any shoes on), and said they "threw him" into his room. He said he too had had a nose bleed as a result of the nose distraction technique. The trainee said, "I think it makes you worse when they restrain you … I got restrained it made me feel like doing things … I think being restrained makes you feel down … makes you a lot worse."

A third trainee said that, if nose distraction did not work, staff "grab hold of your legs and that carry you in … Put you on the floor in a figure of four with your legs and then all run out and lock the door."

A fourth trainee said that the boy had received a telephone call from his solicitor earlier on 8 August (but after the PCC), informing him that she had forgotten to put in an application for Judge in Chambers. He thought this might have upset him. He said that when the boy emerged from the phonecall he was "swearing and that bastard this, bastard that … He'd lost his Judge in Chambers and after that he was in a mood for about ten minutes then started having a laugh again …"

A fifth trainee told the police that the boy did not want to wipe the blood off his face, because:

> "… he wanted to hold it till he sees his solicitor to try and help him get out, cos he wanted to go, cos he was meant to get Judge and Chambers as well I think on Monday … to get released but then the solicitor didn't put it through the application for something, for some reason I don't know and then he thought that would help him if he shows her that he's got a bleeding nose and that and then after a while I think he just rubbed it off, washed it off and then he looked a bit upset for the rest of the day … I thought it was to do with cos he wasn't getting released and his restraint and then just about nine o'clock something like that we was all in the room, TV room and was playing some music, and then we were all kind of dancing and he was sitting in

> the corner and looked a bit like, keeping himself to himself … and then I think he went to his room a bit earlier that night."

The third trainee also referred to the Judge in Chambers application. He said the boy thought he was getting it, but that his solicitor "forgot to put the paperwork in or something … Well he said, he was saying or I'm getting Judge and Chambers, I'm getting out tomorrow and he had his bags packed and in the office but then he took his bags back and some lads on the unit told me that he didn't get it, his solicitor forgot to put them in or something, and … [the second trainee] said to [the boy], 'You're having a hard time in here in't you', and [the boy] said 'Yea', he's having a hard time and that."

A sixth trainee said that, at about 9:15 pm, he used the phone in the boy's room to speak to his (own) mother. He said that the boy was laughing and talking to his (the trainee's) mother. The trainee told the police that the boy "seemed happy … when he was in his room … Nothing wrong with him at all … or so it seemed like."

The second trainee also said the boy seemed alright when he went to his room for lock down – "Just like any other night, like he goes in his room locked in, didn't look like he was going to do things or anything just looked like all the other nights."

Asked why he thought that staff had entered the boy's room at about 12:00 am, the sixth trainee said:

> "Cos, they did, do, they do check on you at quarter to, but sometimes they don't open your flap, they just beat the thing, and then they did at twelve o'clock or they did the last time before I heard [the officer who remained on the unit throughout], they looked at me and that, and then I heard them open all the other flaps and beeping thing. And then they got to the boy's door, must have got to the boy's door so they're saying, and I heard "Get an ambulance" and that all started running about getting dead nervous and that … They don't check on you sometimes though … They just beep the door. They've got these little things, they think, the Home Office think they're checked, they just bleep the thing. [They are supposed to] look at you. Supposed to, if your light's off and that they're supposed to shine a torch on your face … but sometimes they don't."

However, the trainee said they did carry out the checks properly on the Sunday. The third trainee also confirmed that staff had carried out the first three checks (he said he went to sleep after the third).

He added, "You know what I think happened, I think he might have been upset, yeah, I think they'll try to make out he was suicidal to the staff, it wasn't like, he accidentally took it too far."

A number of the trainees described hearing staff enter the boy's room about midnight and staff counting in order to administer CPR correctly. They said this went on for some time.

At the end of his interview, the sixth trainee asked what had been in the boy's note and whether there was anything about "us or anything like that or …" The third trainee was also interested in the note, asking "Was there anything about us?" I have considered whether this suggested that the boys felt guilty for the boy's death for some reason. However, my investigation has found nothing to suggest that the boy was being bullied by these boys or by others. Nevertheless, the boy's comment that "The convicted prisoners are aggressive at me and others …" (quoted on page 10 above) may give an insight into some of the pressures within Hassockfield to which he was subject.

Section 7: Post mortem

The post mortem recorded that the boy was pronounced dead at 12:54 am. The report said:

> "All of the old and fresh injuries are essentially trivial in nature and did not contribute to death in any way. The cause of death was pressure to the neck brought about by hanging. The ligature mark on the deceased was entirely consistent with the pieces of ligature … There was no evidence of physical restraint and there was nothing at post mortem to suggest that the deceased was anything other than a willing participant.
>
> "The ligature mark was fresh but there was no way of telling at post-mortem whether the deceased had been suspended for 15 minutes or less or indeed for a longer period."

PART IV - The boy's family

Section 1: Engagement by the centre with the family

Miss McMurray and I met the boy's mother on 18 October 2005 in the offices of her solicitors, Bhatt Murphy. The boy's mum said she was 'disgusted' with the way she had been treated. She said it was the police who originally informed her of her son's death. She did not have a problem with this, but she was angry that no-one from Hassockfield had contacted her and that they had not even sent a letter of condolence. The boy's mum said that no-one told her her son had left a note when he died. She had learned about it from another trainee. The ramifications of this could have been traumatic, as the boy had been very specific in his note about arrangements for the funeral and where he was to be buried.

The boy's mum said that she visited the centre on the Tuesday after her son's death. During the visit, it had been suggested that "once it was all over and done with" she might like to visit the centre again to attend a service for her son. She said she told them in no uncertain terms that she was not interested. The boy's mum said she had since indicated she would like to go, but had received no response from the YJB to her request.

The boy's mum told me that the undertakers had taken it upon themselves to approach the centre about the payment of funeral expenses. These had been forthcoming.

The centre Director told me that the police instructed that the boy's mother should not be contacted until after the boy's death had been confirmed by a doctor and subsequently undertook to inform her themselves. He said the centre tried a number of times to contact her during the Monday after the boy's death, but were unable to get hold of her. She then arrived unannounced at the centre on the Tuesday. The Director said he spoke to her for some time, but she was clearly very angry and virtually accused him of murdering her son. He had suggested she might like to visit the centre in due course and perhaps attend a service for her son but she had left abruptly, saying that she did not want any further contact. After that, solicitors had become involved and any further communication had been on a solicitor to solicitor basis.

Hassockfield's Emergency Response Plan for Death in Custody says:

> "News of the death of a close relative or friend in Centre, particularly if it is an apparent suicide, may be extremely distressing and it is important that it is transmitted with as much sensitivity as possible. In some cases the most practicable way may be for the next of kin to be visited by an agency in the home area, possibly the Probation Service or the Police. It is desirable for the establishment to make direct contact as soon as possible and responsibility should not be left entirely in the hands of other agencies. If it is not possible for a member of staff to pay an immediate visit, the Director should arrange

for a suitable expression of sympathy to be conveyed over the telephone or by letter as soon as the next of kin has been notified.

"… the next of kin should be allowed to visit the establishment if they wish to do so. In the event of such a visit, the Director should ensure:

- That a senior member of staff and Chaplain, if he/she is available, should meet the visitors and escort them throughout
- That security precautions are kept to a minimum and exercised discreetly and sensitively
- That a nurse is available on call should the relative(s) need assistance.

"Arrangements should also be made for the next of kin … to receive a follow up visit wherever this is practicable and provided of course that the offer is not refused.

"… He or she should be prepared for close questioning about the events that led up to the death and the details of the death itself. The family is likely to be distressed and may feel considerable anger and desperation. Though the visit may be lengthy and extremely uncomfortable, personal contact with the bereaved at this early stage is likely to prove helpful in the long term, both to the family and to the establishment's relationship with the community.

"If it is not possible to make a follow up visit, or the visit is not welcome, the Director should ensure that a detailed letter is sent to the next of kin or family, giving as much information as possible about the death, the inquest proceedings and other relevant matters."

It seems to me that these plans are entirely appropriate.

In principle, there must always be some direct contact between an establishment and the family of the person who has died. However, this becomes problematic where a relative has expressly said they do not want such contact. It might be considered to be intrusive and insensitive for an establishment to go ahead and make contact nevertheless. On the other hand, it is entirely natural that relatives will be angry after a death and much may be said in the heat of the moment. In such circumstances, I consider it behoves the establishment to try one more time to make direct contact, albeit after a space of a week or so. This would most appropriately be by means of a letter, which should include an invitation to visit once again.

I do not know whether the Director would have contacted the boy's mum in due course, but it appears that as soon as a solicitor acted for her all further correspondence was routed via Premier's solicitor. This is extremely unfortunate. In the event, it appears to have prevented meaningful communication between the two parties, thereby closing off a significant part of the grieving process to the boy's mum. It is of course appropriate for both

parties to seek legal advice, but this should not prevent direct communications between them.[28]

I recommend that, notwithstanding any request to the contrary by solicitors, in circumstances where communication has been abruptly terminated immediately after a death, the centre should write directly to the family within 10 days, offering condolences and setting out as much information as possible. The form of any subsequent communication should be determined by the particular circumstances.

When I met the boy's mum, it was her express wish that I should write to the Chief Executive of the Youth Justice Board emphasising the need for each STC to have comprehensive contingency plans covering contact with families after a death. Accordingly, I wrote to the Chief Executive on 21 October 2005, suggesting that contingency plans should, as a minimum stipulate that:

- A senior figure from the centre contact the family as soon as possible after the death to offer condolences (where another agency has informed the family of the death);
- The family be invited to visit the centre (and all staff be alerted to treat them sensitively);
- They be offered the opportunity to visit the location where the death occurred;
- They be offered the opportunity to pray; and
- Property should be returned in a sensitive manner."

The Chief Executive replied on 29 November 2005. She said she fully supported my view "that each Secure Training Centre should have in place a contingency plan for dealing with a death in custody which includes comprehensive arrangements covering contact with the bereaved family and which should ensure that the specific issues you mention are satisfactorily addressed." She advised that she had written to each of the centres, asking them to review and where necessary strengthen the family liaison aspect of their contingency plans, and to let her know how they intended to ensure that liaison with families was given appropriate priority should a young person die in their care.

I am very grateful to the Chief Executive for the content and tenor of her response.

Section 2: Communication between the YJB and the family

The boy's mum was also critical of the lack of any information from the Youth Justice Board during the course of their investigation. She said a positive

[28] LuptonFawcett commented: "Bhatt Murphy had instituted legal proceedings on behalf of [the boy's mum] against Premier, and as was necessary, these were passed to our Legal advisors. [The boy's mother's] Solicitors were advised on three occasions that she and members of her family were welcome to visit the Centre and special arrangements would be made for them to do so."

start had been made and that the YJB facilitated the involvement of the organisation INQUEST. They had met the Chief Executive, together with some of her colleagues, and the boy's mum had been impressed by the Chief Executive's genuine sympathy and the way she had personalised the loss. However, since then she had heard nothing, despite the YJB undertaking to act as go-between between the various parties. They had learned from the Treasury Solicitors that I had taken over the investigation.

Bhatt Murphy forwarded to Miss McMurray copies of the correspondence he had exchanged with the YJB. This showed that they were first instructed by the boy's mother on 12 August 2004. They said that, when they spoke to her on 17 August, she had had no contact from the YJB. Subsequently, the YJB contacted her to arrange a meeting for 26 August. On 25 August, Bhatt Murphy wrote to the YJB to request "disclosure of documentation and information in this matter". They also asked for the meeting scheduled for the next day to be re-scheduled to enable them and INQUEST to attend. In a further letter dated 9 September, Bhatt Murphy again asked for disclosure and information. They noted that they had hoped by then to have a revised date for a meeting, adding that the boy's mum was anxious for this to take place.

The Chief Executive wrote separately to the boy's mum and Bhatt Murphy on 7 September (received by him on 13 September). In the letter to the boy's mum, she said the purpose of meeting "would be not only to express our condolences in person, but it would also be an occasion for you to share any of your concerns about the circumstances of [her son's] death". She said in her letter to Bhatt Murphy:

> "… we would like to offer [the boy's mother] the opportunity to express her concerns to us surrounding her son's tragic death as soon as possible. Following consultation with your client, the Youth Justice Board will endeavour to look into [the boy's mother's] areas of concern as part of our Serious Incident Review. Where we are able, we will provide her with the fullest answers to her questions …
>
> "In your letter, you suggest that [the boy's mother] is concerned at the lack of precise information that she has received about [her son]. I assure you the Youth Justice Board will share as much information as we can when it is appropriate to do so. We are in direct contact with the coroner, who has primacy of disclosure while the Inquest is ongoing and we will be sharing the findings of our investigation with him. Unfortunately, at this stage we are not in a position to share information with you or your client about [the boy's] death."

Bhatt Murphy said that, at the meeting on 20 September, the Chief Executive indicated that she was in favour of early disclosure "and could see no reason why this should be denied if the Coroner had no objections". It was agreed that the YJB would act as intermediary between the various agencies.

Bhatt Murphy said they next spoke to a member of the YJB on 15 December and faxed a letter to her on 20 December. This letter expressed concerns

that, due to the ongoing police investigation, the YJB did not yet have all the documentation necessary to progress the investigation. Bhatt Murphy advised that their client had "faced difficult times following [her son's] death and this is compounded by lack of available information of events leading up to [his] death and lack of disclosure of contemporaneous records". They asked for the YJB to liaise with the Coroner as soon as possible on this 35matter. Bhatt Murphy said they would work with their client to outline her concerns in writing, but suggested that more questions might arise as more information became available. Finally, they said the boy's mum had heard nothing from Hassockfield about some missing property and enclosed copies of relevant correspondence.

There followed some confusion about whether Bhatt Murphy continued to represent the boy's mother, but on 30 December the YJB wrote to advise they were continuing to consult with the Coroner and the police in relation to disclosure of contemporaneous documents. The YJB hoped to be able to forward the appropriate documents as soon as possible.

In a letter dated 12 January 2005, Bhatt Murphy advised that the boy's mum "regrettably does feel excluded from the various investigations into her son's death and the grieving process is not being assisted by the lack of prompt disclosure of documentation". They asked for the documents now to be provided. They also asked for further advice in relation to the boy's clothing and for an update on progress with the various inquiries underway. Finally, Bhatt Murphy said they hoped to be in a position to provide the YJB with "some of the many questions my client has about the boy's time at the Secure Training Centre" but noted that this might be delayed as the result of other commitments.

This letter was returned to Bhatt Murphy, who re-sent it on 18 January.

By 8 April, Bhatt Murphy said they had not received a response, so they wrote again. They noted that certain documentation had now been disclosed and asked the YJB to facilitate disclosure to the boy's mum. They asked once more about the missing property.

Having apparently still received no reply, Bhatt Murphy wrote to the Chief Executive on 20 April. They wrote:

> "We do regret that despite assurances being given at our meeting with you and others from the Youth Justice Board together with our client that there appears to have been no attempt to share any information with our client nor a substantive response to our client's query concerning the missing property belonging to [her son]. We would be grateful if we could now at least have the courtesy of a reply."

The Chief Executive replied on 4 May. She said:

> "The YJB is keen to facilitate requests from yourselves and [the boy's] family but we have received no correspondence with either of you until

last month. We are therefore unclear as to why you consider we have not replied to correspondence.

"As my staff outlined in an earlier meeting with you we are committed to share what information we have at this stage with you but we would like the Coroner's agreement before we do so. The Coroner has asked us to bear with him because of other workload commitments and we expect the issue of disclosure will be resolved in the Pre-Inquest Review on 17th May …

"In relation to [the boy's] missing clothes, we had been advised that the issue of the missing property had been resolved directly with Hassockfield STC, in the form of a settlement. If this matter is still outstanding we will be more than happy to pursue it with Hassockfield as we understand the distress that this may have caused the family."

Bhatt Murphy replied on 16 May, enclosing copies of the earlier letters. They advised that, despite agreement to the contrary, no financial settlement had been made in relation to the boy's clothes. They added, "In any event though our client would wish to have the return of her son's clothing or a detailed explanation as to what has become of it."[29]

On 30 June, the YJB advised that the "joint report with the PPO"[30] should be available within the next couple of weeks. Bhatt Murphy asked to have documentation before his meeting with the boy's mother on 21 July. In a follow up letter of 7 July, they said that they had still not received "a proper response" in relation to the boy's clothing and asked for the matter now to be dealt with. They also advised that the boy's mum wished to visit the centre and asked the YJB to revert back to them about the practical arrangements for this.

On 25 July (after their meeting with the boy's mother), Bhatt Murphy received a letter from the YJB dated 19 July. This advised:

"I write to inform you that despite our efforts the Prisons and Probation Ombudsman report[31] has been unavoidably delayed and we will therefore unfortunately not be able to provide you with a copy of the draft report into [the boy's] death by 21st July as we had hoped."

The YJB said they expected a draft of the report to be completed by 26 August. The YJB would then share the report with the Youth Offending Team and the STC in order for them to check for factual accuracy and would:

"… indicate to them that if they have any objection to our sharing the report with yourselves as representatives of [the boy's] family they must indicate and justify their objections within fourteen days. We will

[29] LuptonFawcett advised that a cheque was sent, but was returned.
[30] This was an unfortunate phrase. My office had offered advice and assistance to the YJB about its investigation but it had never been intended that we would issue a joint report.
[31] This was an even more unfortunate phrase.

> stress the importance of sharing this document with you as soon as possible. If no objection is made we expect to share the document with you in mid-September 2005."

The YJB advised that "clearly" the dates were subject to change and that they would keep Bhatt Murphy informed. The letter added that it was understood that a cheque had now been forwarded to Premier's legal team for onward passage to the boy's mother. Finally, the letter asked Bhatt Murphy to "pass on our sincere apologies to [the boy's mother]".

Bhatt Murphy replied on 9 August, complaining that the letter had not been faxed even though the YJB was aware that they were meeting their client on 21 July. They went on:

> "It would be right for us to say at the outset that the way that the YJB has dealt with this matter and the lack of disclosure or information from the YJB to date has been a source of great distress to our client. It has led to her feeling entirely excluded from the investigatory processes that are being conducted by the YJB and the Prison and Probation Ombudsman (PPO) into her son's death and a perception that she is considered by the YJB and PPO to have a lesser interest in her son's death than the agencies in whose 'care' he died and with whom the YJB feels comfortable sharing information."

Bhatt Murphy asked for an explanation of the unavoidable delay in the completion of the report and asked for a copy of the YJB protocol on disclosure of documentation and reports carried out following deaths in custody. They added that delay in completing the report was not a reason to refuse disclosure, and suggested that the documentation on which the YJB had drawn in drafting its report should be made available unless there was good reason not to do so. They again asked for disclosure of documentation or an explanation of why it was not forthcoming. Bhatt Murphy also noted that they had received no information about the boy's clothing, commenting that it was not simply a question of financial compensation but also the return of the clothing and a detailed explanation of why it had not been returned earlier. Finally, Bhatt Murphy said they had not received a reply to his letter of 7 July and reminded the YJB about the boy's mum's wish to visit the centre. They asked for a substantive reply to both letters by return of fax.

On 25 August, Bhatt Murphy received a letter from Treasury Solicitors asking them to correspond through them. They said they were looking into the "queries about disclosure" and would revert back as soon as possible.

Treasury Solicitors wrote again on 21 September to advise that the Coroner had recently released additional material "which must be considered before the investigation can be properly concluded and this will give rise to further delay". The letter added:

> "Moreover, the Youth Justice Board has taken this opportunity to ask the PPO to take over the investigation to reflect its anticipated statutory role of investigating children's deaths in secure training centres.
>
> "I do not believe that this decision should result in any substantial delay to the completion of the final report but it is important that you are aware of the decision and the reasons for this."

Bhatt Murphy said they were subsequently copied into the YJB's letter to the Coroner explaining the decision to pass the investigation to my office.

Miss McMurray questioned an official in the Serious Incidents section of the YJB, about the YJB's alleged lack of engagement with the boy's mum. The official said that, following the initial meeting, the YJB was expecting to receive a letter from Bhatt Murphy setting out the boy's mother's concerns about her son's care. This was to enable the YJB to address her concerns as part of its investigation. By December, they had heard nothing from Bhatt Murphy. Added to this, the official said the Coroner wanted to retain control of all the documentation and the YJB deferred to his request that if anyone were to release documents it would be him. The official acknowledged that the YJB was unclear of how to proceed and that its position of investigator and contractor did not sit easily together. As a result, where it was unsure, it erred on the side of not disclosing without the Coroner's express permission.

(By coincidence, the official joined my office as an investigator in January 2006.)

I do not believe the relationship with the boy's mother was at all well handled by the YJB.[32] By the first anniversary of the boy's death, no report had been produced and his mum knew little more than she did after her visit to the centre two days after her son died. In the event, the YJB decided the independence and balance of their investigation and report would potentially be compromised by their differing relationships with Premier and the Lancashire YOT, and it was agreed I should investigate instead. As I indicated at the beginning of this report, I accepted this commission on the basis that I would be starting afresh.

I recommend that the YJB apologises for the lack of meaningful and timely engagement with the boy's mum following her son's death.

Given my independence from any of the bodies involved in the management of juvenile offenders, I have now agreed with the YJB that I will undertake any future investigation of a death in a STC. It is the Government's intention that this role in respect of any future tragedies in STCs should be established in statute.[33] However, to reinforce this point:

[32] The YJB has advised that the Regional Manager for the North West attended the boy's funeral on behalf of the YJB. I welcome this information.

[33] Commenting on a draft of this report, the YJB wrote: "YJB accepts that since initially embarking on the investigation of [the boy's] death, lessons have been learned by the YJB. The YJB is not constituted as a formal investigatory body, and our role as commissioner of

I formally recommend that the Prisons and Probation Ombudsman should investigate all deaths in STCs and that this function should be enshrined in legislation at the earliest opportunity.

Section 3: Property

The boy's mum told me that, when she visited Hassockfield after her son's death, it took staff between 30 and 40 minutes to get his property together. Even so, some of her son's clothing (including a jumper costing £50 that she had taken him on 4 August) had not been returned. Instead of answers to her questions about what had happened to it, she received financial compensation only. The boy's mum said the money was not the issue – they wanted all her son's property back for emotional reasons. The boy's mum thought there had been a complete lack of sensitivity in the way her son's property had been dealt with. She complained that Hassockfield had taken a very casual approach and did not believe that other children could have taken the property.

The items the boy's mum said were missing were a waterproof green Berghaus coat, a Berghaus fleece jacket, a Bear USA navy blue/green overhead coat, a hooded white Nike jumper and a black Diesel jumper. Miss McMurray obtained a copy of the boy's property records. There is no record of him having had a white Nike hooded jumper whilst at Hassockfield. Both the Diesel jumper and the Bear USA coat were placed in stored property, although the latter is also marked "handed out" on the same date (4 August). A "Berghaus jacket hooded" is shown as in the boy's stored property on 10 July, whilst on the same date a "Berghaus jacket green" is shown as being in his possession. It is not clear whether these two entries refer to the same jacket, or one to the Berghaus coat and one to the Berghaus jacket. There is no other reference to any of these items of property anywhere on the boy's property cards.

Miss McMurray also spoke to the centre Director about the property. He told her that the normal procedure would be for items of property to be ticked off against a trainee's property card when they were returned either to him or to someone else. This would ensure that nothing was missed and any problems could be resolved on the spot. However, in this case, it was considered that this would be an insensitive way of proceeding. As a result, the boy's property was not systematically checked at the time. This led to a lack of certainty about what had been returned, and also meant that there had been no search for the alleged missing items at the time.

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places in the secure estate for children and young people, including those at Hassockfield, means that it would not have been possible, even in collaboration with the PPO, to conduct an investigation of sufficient independence or rigour. However, this section of the draft PPO report is unduly negative about the role of the YJB, and fails to acknowledge that procedures for the investigation of deaths in STCs were at the time of [the boy's] death untried and untested. Credit should be accorded to the YJB for requesting the PPO to undertake the investigation, albeit belatedly. In doing so the YJB has helped to establish the future expectation, supported by a joint protocol with the PPO, that any future deaths occurring in an STC should be automatically investigated by the PPO, pending legislation to that effect."

Miss McMurray pressed the Director on what might have happened to the property and what efforts had been made to find it. He said that they had a system at the centre whereby any odds and ends of unaccounted for property were picked up quarterly and efforts made to identify the rightful owners. In addition, they had double checked the stored property area specifically in response to the boy's mother's complaint. The boy's clothing had not been found. The Director said it was simply not possible to resolve the question of what had happened to it. I am afraid I can reach no conclusion on this either.

I recommend that, immediately following a death, an officer and a manager should assemble the trainee's property, record each item on a discrete form, check the property against the property records and place it carefully in a sealed container. Both members of staff should sign the form and the property record. (If the family member collecting the property then wants personally to check the property on the spot, this should of course be allowed.)

Section 3: Other issues

In a letter of 21 December 2005, Bhatt Murphy asked me to pursue a number of issues on behalf of the boy's mother. They said she:

- suggested that it is "bizarre" that a court ordered secure remand can be made "when there is no placement available and when a placement does become available the court appear to take no role in determining whether it is appropriate that the child should be remanded to a particular institution, in this case such a long distance away from home. On 8 July 2004 the COSR is again made albeit that it appears [her son] was doing well in a non-secure environment";

- was concerned about "the inability of the YJB to place [her son] in a suitable local LASCH [local authority secure accommodation] … Given the obvious shortage of appropriate placements in Lancashire, I do consider there needs to be proper exploration of the decision-making of the YJB (or lack of it) that has resulted in this lack of provision, particularly in the context that the YJB took the decision not to renew their contract for 'criminal' remand beds at the Dales Unit, where it was proposed that [her son] should be placed, leading to its closure"[34];

- was "particularly concerned that it appears that the transfer request was not initially made and when made does not have appeared to have been actioned and progressed";

- expressed concern about the absence of a key worker in her son's case, noting that "it appears that the Centre sees this as a contractual

[34] The YJB advised that the correct term should be "Secure Children's Homes (SCHs)" as they are not strictly managed by local councils and may also be owned and run by either a charity or a private operator. I have, however, used the term LASCH throughout this report, as this was the term used by those who provided evidence to the investigation.

obligation rather than serving a useful purpose for the child involved". The boy's mother was critical of the suggestion that this was not relevant because the individual and the child might not form a good relationship, and noted that the response in such a case should be to allocate an alternative key worker, rather than simply abandon the process;

- was critical of the management generally at the centre, "given his age and vulnerability, and particularly over the weekend of his tragic death". The boy's mum suggested that I commission a report by an appropriate expert to comment on the boy's care (I set out my consideration of this suggestion at Annex 1.);

- expressed concerns about difficulty over visiting arrangements at Hassockfield, in relation to the distance from her home and the frequency of such visits;

- was "extremely concerned" about the use of force on her son and about the apparent frequency of the use of PCC at Hassockfield.

- expressed "particular concerns about whether the staff involved with her son had proper experience and training of dealing with someone like her son who had complex needs. She also queried whether a LASCH might be safer in terms of potential ligature points.

I consider these matters in Part V.

PART V: - Examination of the issues

Section 1: Court Ordered Secure Remand

Although the boy appears to have been a troubled lad for some years, the relative rapidity with which he found himself on a court ordered secure remand is nevertheless surprising. His offending history was not prolific, nor had it been particularly serious until his last alleged offence. In addition, whilst nurturing and coaxing him through both his Referral and Reparation Orders was undoubtedly an uphill struggle, with many occasions when he failed for one reason or another to make appointments, he did complete them successfully. Although contact was poor during the Action Plan (the boy was issued with two final warnings) and he breached his Supervision Order, I see little indication that the boy was at this stage incorrigible or that a custodial order was by any means inevitable.

The boy appears to have simultaneously taken both a fatalistic line (that is, that he was by now set on a course of offending that he could not change) and to have believed that change was possible and, indeed, something that he wanted. It was for this reason that he set his mind on a custodial disposal, believing that this was the only way he could get himself back on the straight and narrow. His mum appears also to have believed this. In a sense, this was perhaps a shrewd perception. It seems that the boy's offending (such as it was) was fuelled by drug use and the company he kept. A custodial setting would free him, temporarily at least, from both these drivers. What is much less clear is whether the boy would have been able to maintain his distance from drugs and old acquaintances on his release. Ultimately, of course, he needed to learn how to cope in the community, not within the artificial constraint of a custodial environment. I do not know whether this was an argument that was put to the boy or one that he was capable of grasping. I note, however, that the boy's ASSET forms refer to the YOT worker and his solicitor both trying to persuade him that custody was not the answer.

All that said, Hassockfield did appear to do the boy some good for a while. Although his behaviour was not without blemish, he quickly made his way up the incentives leagues and attained Championship status. Staff refer to him as being polite, tidy and well behaved and many reports refer to his behaviour as excellent. He also appears to have done well in education. There is no way of knowing whether the boy would have managed to walk away from trouble on his release, but his determination to stay out of prison and to do something with his life appear to have been genuine and heartfelt. It could be that his first experience of custody had a salutary effect.

However, if the secure remand had its advantages, it was nevertheless inappropriate in other ways. Despite the boy wanting to be sent into custody, he absconded on learning that he was to go to Hassockfield. This should have set off alarm bells. There is no indication that anyone spoke to the boy about this and sought to understand why, when he had said he wanted to be locked up, he did not want to go to Hassockfield. Presumably, even at this late stage it was not too late to seek an alternative order from the court.

I recommend that YOT workers be reminded of the need to be alert at remand stage to changes that might impact on the suitability of a particular court order and advise the court accordingly.

The boy's family remain concerned that the court ordered a secure remand when no suitable places were available. They have suggested that a full investigation should be carried out of "precisely what occurred at the various court hearings that [the boy] had".

I recommend that a copy of this report be sent to HM Courts Service for their consideration.

Section 2: Placement

Why was the boy sent to Hassockfield, a secure training centre on the other side of the country well over 100 miles from his home?

A team of 20 staff in the YJB undertakes placement work. It is managed by the Head of Placements who is accountable to the Director of Service Delivery. Key ingredients of the policy are that:

- 10-14 years olds, and the most vulnerable 15 and 16 years old, are placed in LASCHs [secure children's homes] and STCs;
- boys of the boy's age are where possible placed in STCs, leaving the LASCH beds for younger sentenced boys (and girls) and for court-ordered secure remands;
- young people should be placed within a 50 mile radius of their home address, although this is of less significance than the suitability of the placement itself.

The Placement Team deals with a high volume of referrals. At particularly busy times, this can require up to 100 placements being made in one day. The average rate is about 50 per day.

The process involves much of the youth justice system. To work effectively, it requires good information about both demand and supply. The key elements of the process are:

- Secure establishments notify vacancies to the Placements Team on a daily basis, so the Team has a constantly updated picture of the situation across all three sectors (LASCH, STC and Prison Service);
- YOTs notify the Placements Team of impending committals to custody, and confirm them once the courts have passed relevant sentences or orders.

Once a court has made an order, the YJB cannot defer or refuse to make a placement. (However, those made subject to a Court Ordered Secure Remand are deemed "Looked After Children" and remain the responsibility of the local authority. Effectively the YJB merely provides a service to the

authority in managing placements. If the YJB is unable to find a suitable place, the local authority must do so.)

YOTs are required to complete a booking form that asks them to suggest the most appropriate placement. It also has a section in which YOTs indicate whether they regard the young person as "vulnerable". If they do, they are required to identify the "key vulnerability factor" and to attach the "Vulnerability Section" of the ASSET assessment.

There are insufficient places outside Prison Service-run Young Offender Institutions (YOIs) for the number of young people assessed as vulnerable by YOTs. The Placements Team must therefore make judgements about "relative vulnerability" in order to prioritise the available accommodation for those deemed most at risk.

The key elements of this process are that:

- Decisions on relative vulnerability are only taken by three people – the Caseworker, the Operations Manager or the Head of Placement;
- Consideration is given to the current availability of placements, their distances from the young person's home and, in the case of someone of the boy's age, the preference to allocate to STC rather than LASCH in order to reserve LASCH places for younger and/or more vulnerable children.

These processes determine the young person's entry point into the secure estate. The Placements Team has developed further procedures for review of the placements of 15 and 16 year old boys and for the subsequent transfer of young people not optimally placed, when vacancies allow.

The Placement Booking form that was sent in the case of the boy who is the subject of this report has nothing recorded under "Key Vulnerability Factor". Neither does it suggest the most appropriate placement as required. There was therefore nothing to alert the Placement Team to any particular concerns with regard to the boy.[35]

Nevertheless, some additional information was available to the team via a pre sentence report and ASSET form that were sent with the booking form. Although the former does not mention the boy's previous self-harm (on the contrary, it says "there is no evidence that he is currently at risk of self-harm …"), the latter says "previously self-harmed by cutting wrists. The boy also

[35] Lancashire YOT commented, "The YJB decides which of the fourteen and under go into STC or LASCH and had a copy of [the boy's] ASSET which has on it the vulnerability section to help prioritise [the boy] and a copy of his Pre Sentence Report. The vulnerability assessment requested on the Placement Booking Form used at the time, was only in relation to fifteen/sixteen year olds going into prison custody. This needs to be made clear as it currently suggests that the LYOT made no assessment of vulnerability."
I note, however, that the instruction at the top of the form reads, "This form is to be used for all young offenders. Please complete all sections." The YJB has confirmed separately that all sections should be completed in all cases.

states that he has tried overdose at the age of 12 or 13". A later section of the form says:

> "Does not respond well to change in care arrangements … If given a custodial sentence it will be his first experience of this and despite his bravado he may possibly be at risk. [The boy] can become upset if he is placed in a situation where he does not want to be … The secure establishment to monitor his mood and behaviour."

Despite an instruction to the Placement Team at the top of its Key Indicators of Risk form to read all available documents and "identify if any of the factors listed below are present", none of this information was recorded on the form. The only section that has been completed records that the boy had been a "Looked After" child in the past. There is no reference on the form to the boy's previous suicide attempts or his previous episodes of self-harm, and no mention of his poly-drug use or of the diagnosis of "severe conduct disorder and emotional problems". The form has at the bottom the recommendation "STC".

An interim report on a death of a child at Rainsbrook Secure Training Centre examined the documentation used in the placement process. The report said:

> "The report of an independent review of the placement process … concluded that use of the [Placement] Team's 'Key Indicators of Risk' form 'did not achieve the purpose of discriminating and identifying those who pose the greatest risks in the system'. The review also expressed concern that YOTs did not have a full picture of the indicators of vulnerability being used by the Team. (Independent Review of the Youth Justice Board's Placement Function. 5 February (2004).)

The report recommended, amongst other things, that:

- "the YJB review its approach to determining vulnerability, covering the choice of indicators; how the information is assessed and final judgement applied; and the skills and training needed to undertake the various stages of the process"; and

- "a Board-led strategy to convey, to the whole youth justice system (in particular to Yots), the importance of priority being given to effective performance in the placement process."

The YJB accepted the recommendations. In addition, and in response to the Independent Review of the Youth Justice Board's Placement Function, in November 2004 the YJB issued a revised Booking Alert form with accompanying guidance and re-issued the Secure Facilities Guidance document. In addition, it has issued guidance to YOTs on the system employed by the YJB to prioritise young people in terms of vulnerability.

Having reviewed the revised form, I am concerned about a number of aspects of it. Although I am sure YJB staff are accustomed to focussing on specific areas of the form, there is a lot of print in a small area. As a result, the box for recording vulnerability is in danger of being lost. I believe it should be at the head of the form. I am also concerned about the use of the blanket term vulnerability, which encompasses a wide range of areas and which will mean different things to different people. I would prefer to see distinctions of types of vulnerability. (Space could be created for this important information by the condensation of the much larger boxes for ethnicity and offence categories.)

I recommend that the YJB revises the Placement Alert form to give much greater prominence to vulnerability.

I also note that the guidance document gives little advice on matters of vulnerability.

I recommend that the guidance document be amended to direct YOTs to consider specific areas of the young person's history, behaviour and current demeanour as well as their likely response to custody when assessing vulnerability.

(The relevant section of the ASSET form on which both YOTs and YJB staff are expected to draw is itself quite superficial in this respect.)

More generally, the boy's mother's solicitor has commented after seeing a draft of this report:

> "The inability of the YJB to place children in suitable accommodation arises in other cases and appears to be a systemic matter that we are of the view does require investigation. The PPO report does address the manner in which the YJB placed the boy and their response to the transfer request, it does not though deal with the more fundamental issue of why there is a chronic shortage of suitable local placements in Lancashire which led to a 14 year old child being sent to a STC 100 miles away from his home and family. An investigation is required into how this situation has come to arise and what steps are being taken by the YJB and/or the Courts and/or the Home Office to seek to remedy the position. The situation is even more alarming because as you will be aware, after [the boy's] death the Dales Unit, the LASCH in Lancashire, was closed down because the YJB took a decision not to renew their contract, not it appears because it was not needed but it can perhaps we inferred on a resources basis. We are of the view that the planning and decision-making of the YJB / the Courts and the Home Office requires investigation in order to comply with the Article 2 obligation. We are of the view that this type of investigation is probably outside the PPO's remit and in the event that it is, we would suggest that the appropriate way forward would be to include a recommendation in the report that such an investigation should be carried out."

I draw this to the attention of the YJB.

Section 3: Transfer request

The boy's mum said that she took up the question of her son's allocation with the YOT officer as soon as she heard her son was to be sent to Hassockfield. She said that on 20 July 2004 the officer admitted he had done nothing.[36]

The paperwork shows that the YOT officer agreed on 12 July that a transfer should be sought for the boy in light of his distance from home and his vulnerability. He had recorded on the post court report that the boy's vulnerability had increased as a result of his secure remand. Nevertheless, no formal request was made until 20 July. When it was, it was achieved by simply faxing through a form requesting a transfer. The reasons 'distance from home' and 'vulnerability' (that is, two of the 'standard' reasons for requesting a transfer) were ringed on the form, but no supporting information was offered describing the nature of the vulnerability (including, for example, that the boy had self-harmed in the past, that this was his first experience of custody and that his mood was extremely low) and no indication of any urgency was given. I have not seen any evidence that the form was acted upon in the 19 days before the boy's death.

In a Placement Report dated 2 September 2004, the YJB Head of Placements, noted that:

> "… in accordance with our procedures Hassockfield had identified [the boy] as a priority for a move due to the distance from Burnley. This was recorded on the weekly transfer spreadsheet for week ending 31 July that each STC is required to submit to the YJB.
>
> "Due to the significant lack of LASCH beds, in part as a result of the late opening of Oakhill STC, the transfer request was unable to be actioned. In any event at the time there were a number of unplaced COSRs that would have taken priority over a transfer request."

(I should say I do not see the relevance of unplaced COSRs taking priority. Whether or not the boy was moved to another secure bed would not have affected the number of available places in the system (that is, moving him elsewhere would not mean that someone else could not be placed), it would have simply altered the distribution of those places.)

In fact, the Placement Review shows the boy as priority A (that is, "immediate move") for a transfer, with four other trainees. There is no differentiation between them in terms of how pressing the need for a transfer was. For each of the five, "Distance" is recorded under 'Issues of Vulnerability – Give Details', 'Key Issues' and 'Reason/Request for Transfer'.

[36] Lancashire YOT commented that "the statement from [the boys mum] is her view, reported, and is not factual and it should be expressed as such. Several steps were taken by [the YOT officer] and these should be identified within this paragraph if it is to remain." They did not specify what these steps were.

Miss McMurray obtained a copy of the Daily Beds Vacancies for the period 28 June – 13 August and Bed Availability form for the period 29 June – 9 August. This shows that no places were available at Dales Secure Unit during this time but that there was a space available at Barton Moss Secure Unit on 14 /15 July and 20 – 27 July.

Another form shows that, during the period in which the boy was in custody, 34 young people given secure remands could not be placed. Some of these were in the North/North West.

The YJB have advised that a 14 year old newly sentenced male was placed in the Barton Moss bed on 15 July; a 14 year old newly sentenced male was placed in Barton Moss on [?27] July and another 14 year old newly sentenced male was placed at Barton Moss on 27 July. On 3 August, a 14 year old newly sentenced transferee from Eastmoor was placed at Barton Moss due to the distance from home and difficulties with his family visiting (his mother had four other children). His transfer request had been made on 24 June. Finally, a 14 year old newly sentenced male was placed at Barton Moss on 5 August.

The YJB Head of Placements advised:

> "During this period we had to prioritise LASCH beds for the under 15 sentenced young people due to the pressures on the population at the time. Even though a bed was potentially available at Barton Moss at the time we had no reason to transfer [the boy] from Hassockfield apart from the Yot's transfer request, as no-one had indicated any significant reason to do so urgently. Our view would have been that [the boy] was in a suitable placement. The Yot had indicated their first choice as Dales. We would have considered [the boy's] placement at the point of sentence."

Ultimately, therefore the failure to transfer the boy appears to have been due to the failure to alert the YJB to the urgency of the need.

Miss McMurray asked the YOT officer about the transfer request. The Lancashire YOT acknowledged that it had been agreed with the boy's mum on 12 July that a move closer to home would be beneficial. They advised that their practice was to seek the trainee's views on a move and that the initial planning meeting provided the opportunity to do that directly. (They added, however, that STC staff "were clearly in a position to discuss with [the boy] more readily". I agree.) The YOT said no further information was forthcoming before the meeting on 20 July (including during a telephone conversation on 16 July with the case manager) to suggest that the boy was at risk where he was. The transfer was discussed during that conversation only in the context of facilitating visits by the family (who, the YOT understood, had managed to visit twice during the first week).

The YOT advised that, at the remand planning meeting (which the YOT officer attended), the boy was very subdued and for the first time concern was

expressed by Hassockfield staff about him, commenting that he had been noticeably withdrawn. They said the meeting was also advised that five minute HRAT observations had been restored. As a result, consideration was given to changing the boy's unit at the STC pending his requested transfer. However, the boy said he wished to stay where he was until he could go to The Dales (Blackpool), which was apparently the only placement local to his home that he would consider.

Asked about the boy's vulnerability as compared with other similarly placed youngsters, the YOT said it was apparent that the boy had been expecting custody, "and indeed like some other young people appeared to be viewing it as a way of halting an uncontrollable train of events." They were aware that he appeared 'visibly shaken' on 9 July, but said that, despite his low mood, neither the family nor the STC contacted the YOT to indicate acute risk. They added that they had a number of complex and risky cases which presented high risk of harm and vulnerability at the time. They said the boy had been "identified for transfer with some priority this being his first time in custody, distance from home, previous self-harm etc", but upon arrival at Hassockfield, there "was no information communicated from either staff or family to suggest an escalation in risk."

Other than during the remand planning meeting, YOT staff had no direct contact with the boy during his period at Hassockfield (although there was communication between the YOT and the STC on 12, 16, 26, 27 and 29 July).

I recommend that the STC advises the YOT when a trainee is considered to be at risk of self-harm or suicide.

I also recommend that a member of the YOT attend all HRAT reviews. If this is not possible, copies of the record of each HRAT Review should be routinely faxed to the relevant YOT member.[37]

Nevertheless, the STC and YOT (representatives of both organisations signed the transfer request) were aware that the boy was on five minute observations on 20 July. I consider that this should have been sufficient to warrant an application for an urgent transfer and that the boy's HRAT status should have been highlighted in the application to the YJB.

The Transfer Request form (which has not been significantly amended since July 2004) refers only to increased or decreased vulnerability. There is no specific reference to risk of or actual self-harm. I consider there should be.

[37] Lancashire YOT commented, "This recommendation is not achievable. From Lancashire, the return distance to Hassockfield would be one full day for a member of staff – HRAT meetings could occur several times a week – the resources of any YOT would simply not support this recommendation. There is agreement, however, with this recommendation and a suggestion that Social Workers (with a responsibility for safeguarding) should be established within STCs, in line with the recent funding made available for Social Workers in prisons."

I recommend that the Transfer Request form be amended to include specific reference to risk of self-harm with a further space to indicate the nature and immediacy of the risk.

When Miss McMurray spoke to the YJB Head of Placements, he told her that there were several different types of transfers – planned, emergency, prison overcrowding drafts, and transfer following placement review. He advised that planned transfers could take weeks while the necessary moves took place to enable the appropriate placement to be made. Sometimes planned moves were thwarted at the last moment and the process had to begin again. This emphasises the need for urgent transfers to be flagged up, since clearly it would be unacceptable for a transfer on grounds of risk of self-harm to be delayed several weeks.

I recommend that the Transfer Request form be amended to enable the urgency of the request to be highlighted.

I also recommend that the YJB be required to respond to Transfer Requests with a likely timescale for transfer, so that the responsible local authority can be asked to find appropriate alternative accommodation (at least in the case of COSRs) instead.

Section 4: Key worker

A document entitled "Structure of Care and Intervention" sets out the aims of Hassockfield and how those aims are to be achieved. It says that a Key Worker will be appointed on admission for the 14 days period of induction. Thereafter, the continued involvement of that person will be confirmed or someone else appointed for the remainder of the trainee's stay. The document says that the Key Worker will usually be a member of staff allocated to the receiving unit of the trainee. However, where a psychologist or social worker is appointed, a named member of unit staff will be allocated as secondary Key Worker. It continues:

> "The Key Worker will ensure:
>
> - The information list is completed;
> - Information and reports are available for reviews;
> - Changes instigated at reviews to the Individual Training Plan are transposed to unit level care;
> - Liaison with the trainee, acting as a point of contact with respect to his/her Training Plan;
> - Promotion of the trainee's level of responsibility and ownership of his/her care;
> - Implementation of planned interventions
>
> "The allocated primary Key Worker, or designated secondary Key Worker, will have daily contact with the trainee.

> "Part of the Review Process is to support and supervise the role of the primary and secondary Key Workers in the delivery of care."

The shift system in operation at the centre, with constant changes of personnel on the units, renders a key worker system vital. It provides a trainee with a single member of staff who knows him/her well and to whom he/she can turn. An officer was initially allocated to be the boy's key worker, but he was unfortunately absent on sick leave for much of the boy's stay at Hassockfield. Despite this, no action appears to have been taken to provide cover for him and the boy was thus left without anyone to act in this role.

The duty manager downplayed the significance of this when interviewed. He suggested that simply allocating a key worker did not mean that the officer and the trainee would get on, and that it was just as likely that the trainee would identify a member of staff himself who he felt able to open up to and confide in. This is undoubtedly true, but it by no means lessens the importance of the key worker system. Many youngsters have difficulty establishing trusting relationships with adults (the Assistant Director noted that this was certainly true of the subject of this report). This process is made all the harder if they are with one member of staff for a few days, and then he or she disappears. In light of the difficulties trainees might have in forming relationships with adults (and the importance of them doing so), an adult must take the lead in forging a bond with a trainee. Inevitably, this might not work out on occasions, but that in no way undermines the importance of the key worker system. It is significant in this respect that none of the staff interviewed by either the police or the YJB claimed to know the boy very well, although most claimed they got on with him alright. This gap in the boy's care is a matter of concern.

The absence of the key worker is particularly worrying in light of the fact that part of the strategy for managing the risk the boy presented was to ensure he received support from staff. However, no-one appears to have been close enough to him to provide the level of support envisaged. Casual interaction during the course of the day - no matter how positive - was not what was required. While a number of officers said they spoke to the boy after the contraband incident and the PCC incident, what difference might have been made had the boy been able to talk at length about either incident to someone whom he trusted?

Another concern in this respect is that one of the key worker's responsibilities is to ensure the strategy agreed by the HRAT is "transposed" onto the residential units. It is not clear who undertook responsibility for this in the absence of the boy's key worker. This is the more worrying given that the HRAT plans do not assign responsibility to a specific individual – on 19 July, it was agreed that the boy should be supported through the next few days and encouraged to talk to staff about how he was feeling. The words "regularly see [the boy] for support" appear, but the plans do not say who should ensure this happened.

I recommend that the centre Director takes steps to raise the profile of the keyworker system and ensures it is properly implemented and monitored.

I also recommend that staff are given specific training for this role, which should include information about agencies to whom they can refer trainees when they identify particular issues or problems.

Section 5: Self-harm/suicide risk reduction

The Secure Training Centre Rules 1998, Statutory Instrument (SI) 472, say that every trainee must be assessed for risk of self-harm of suicide by a social worker and by a member of healthcare staff as soon as possible after admission to an STC and in any case within 24 hours and a written assessment made. The assessment must be reviewed at regular intervals throughout the period of the trainee's detention, and each trainee must be monitored by a social worker or member of healthcare staff for that purpose.

Hassockfield's self-harm/suicide risk reduction strategy says that its four main phases are:

- "An environment which is emotionally and physically safe;
- Identification of risk;
- Intervention to reduce risk and deliver support;
- Long-term intervention to facilitate sustainable change in behaviour."

The strategy includes:

- "A uniform approach, listing multi-professional skill and knowledge base;
- Staff training on recognition and identification of risk referral and delivery of care, which address periods of risk and provides longer-term interventions;
- A physical facilities environment and staff supervision to minimise the opportunity to self-harm;
- An admission process to identify risk and to devise an intervention plan to reduce the presenting risk and to effect sustainable change;
- The establishment of a High Risk Assessment Team (HRAT) to deliver such intervention;
- Referral systems to use support services and professional assessment services."

The document describes self-harm/suicide intent as "a manifestation and statement of intolerable inner distress, resulting from an inability to cope or deal with feelings, experience and/or the current situation". It suggests that the "intent/desire/urge to self-harm or commit suicide is usually extremely intense but short-lived. Consequently persons displaying such behaviour respond well to crisis intervention and longer-term support." In addition, "staff

will be trained in recognising behaviour which indicates risk and/or increasing intent to self-harm or suicide."

I can find no record that the boy's risk of suicide or self-harm was assessed by a social worker at Hassockfield, but it is clear that the first nurse who saw him carried out a detailed assessment. As a result, she placed him on five minute observations and referred him to a HRAT.

A HRAT convened first on 12 July. They judged the boy to be very vulnerable and placed him on five minute observations. In addition, the HRAT agreed that it should be ensured that family contact was maintained. They met a further five times, varying the level of observation according to their assessment of the level of risk he presented. As a result, the boy's observations were reduced before being increased, reduced again and finally ceased. Other elements of the strategy involved ensuring the boy was adequately supported by staff and was shown coping techniques. I am satisfied that the boy's care and management was appropriate to the circumstances obtaining at each point.

Membership of the HRAT

However, I am concerned by the lack of consistency in membership of the HRAT. The psychologist was the most consistent member, but while her expertise was undoubtedly helpful in assessing the boy's vulnerability she did not see him in his natural environment day to day. Those who had most contact with the boy were residential staff, but a different member of residential staff attended each HRAT review. (In fact, some 12 different people took part in the HRAT reviews. On 19 July, none of those in attendance had attended any previous meetings and on 27 July, only the psychologist had.) There was thus a lack of continuity – essential in assessing whether someone's demeanour/mood is better or worse than it was previously. The vital role of residential staff in the HRAT process was described by the Assistant Director during interview.

Given the shift system that obtains at Hassockfield, it is difficult to see how the requisite continuity and consistency can be achieved. (Significantly, the attendance by residential staff was the most lacking in continuity.) It may be of course that, had he not been sick, the boy's key worker would have attended all the HRAT reviews. Certainly, it would be appropriate for a key worker to do so.[38]

I recommend that the trainee's keyworker be required to take part in all HRAT reviews.

[38] LuptonFawcett advised: "Casework Manager is the common thread throughout the reviews. We take the view that the more people who are involved with each of the trainees the better and a change of membership in the HRAT aides communication throughout the Centre as to difficulties experienced by any given trainee."
I can see no evidence that the Casework Manager was involved in all the reviews and I disagree with the argument that the more people who are involved, the better. Consistency and continuity are, in my view, essential.

I also recommend that, as far as possible, the same members of staff form the two other members of the team with regard to a particular trainee.

Finally, I recommend that the centre be required to invite the next of kin or carer to take part in HRAT reviews.

Triggers

There are other aspects of the HRAT that give me concern. The boy's previous history of self-harm was properly noted, but it appears to have been taken at face value. The Assistant Director spoke about records of previous self-harm during her interview: "So we have a chat with the young person, raise the issue, find out more about it because you are safe-guarding their health, safety and well-being." But no-one seems to have asked the boy about why he had self-harmed, what the triggers were and whether he intended to kill himself. While simple information that someone has self-harmed in the past is useful as an indication that they might repeat the behaviour, it is not of itself very helpful in managing the risk. Crucially, there is almost no information about what particular events might trigger a further episode. Hence staff had no idea what to look out for and when to be concerned. Did they know, for example, that a transfer had been requested and that a knock back might cause the boy to self-harm? Did they know that the boy was desperate to be released from Hassockfield and had pinned his hopes on bail? It may or may not be significant that the boy learned on the evening of his death that no application for bail would be made the next day after all. But the point is that no-one addressed this with him.[39]

The psychologist identified that anger had previously prompted the boy to self-harm. This information is all but hidden in a Psychology Department HRAT assessment form and a HRAT review form. Information relating to what has led to self-harm in the past is one of the keys to understanding what might prompt similar action in the future and to managing that possibility. However, no information about this appears to have been shared - and certainly not explicitly with residential staff. Had it been, staff might have been more alarmed by the boy's anger (expressed in violence of a different sort in throwing a cup) at losing all his incentives points for 7 August. They should certainly have been concerned by the extreme nature of his rage on the Sunday. The duty manager described the boy as having "completely and utterly lost it". He said he had never seen him like that before. The boy smashed up his room in his fury. How might staff have responded had they known that anger might be a trigger to self-harm?

[39] The YJB has commented: "There is an issue here about the STC sharing information across staff to alert them to potential changes in vulnerability and thereafter having a system which is sufficiently flexible to adapt the watch on a trainee to changing circumstances. [The boy] clearly believed that he would be attending court the following day and that an application to Judge in Chambers had been made. In the knowledge that this was not the case, the STC should have been alert to the effect this may have had on [him]."

I recommend that potential triggers to self-harm are explicitly explored with the trainee (and his/her carer) and flagged up for all staff to see.

There were other potential triggers that may have been missed. One was the boy's repeatedly injuring his hand. Already fractured when he arrived at Hassockfield, he injured it two more times whilst he was there – apparently as a result of punching a wall and falling off a chair. The nurse said she was aware that the boy had punched a wall but did not challenge him about it. Either as the cause of an injury necessitating referral to hospital or just as an indication that all was not well, one might have expected that she would have done so. Similarly, the boy's fall from a chair seems to have been accepted without question. Were these coincidences, episodes of self-harm or an attempt to engineer a hospital referral to give him an opportunity to abscond? The lack of detail about these incidents is a matter for concern.

Being a victim of sexual abuse has also been identified as an indicator of possible self-harm. The boy told a member of staff that he had stabbed his victim because he had "touched him up" (his statement to the police alleged the same thing), but this does not seem to have been fed into the boy's risk profile at any stage.[40]

Section 6: Visits

The Secure Training Centre Rules say that each centre must have arrangements, approved by the Secretary of State, for trainees to receive visits. These arrangements must take account of:

- the importance of contact by a trainee with his family, and
- the need to keep to a minimum any disruption of his education and training.

Adult remand prisoners are entitled to daily visits. I am surprised that the Secure Training Centre Rules do not make similar provision for remanded juveniles, notwithstanding the need to ensure their education is not unduly disrupted. The importance of facilitating strong family ties has long been recognised as an important principle in itself, and as playing an important part in managing and reducing risk of self-harm. I consider the Rules need to be strengthened to enshrine a trainee's rights to a daily visit.

I recommend that an entitlement to daily visits for those on remand be incorporated in the STC Rules at the next opportunity.

The leaflet, Information for Families and Carers, advises that sentenced young people at Hassockfield are entitled to two hours of visits per week. This may be taken over one or two visits. It continues, "A remanded trainee

[40] LuptonFawcett commented that, "No information accompanied [the boy] to Hassockfield regarding this incident." I accept that – but the boy himself told a member of staff that this was what had happened. This should have been sufficient to warrant his risk profile being updated.

could request daily family visits, where practicably possible, this will be facilitated."

In line with my comments above and pending any change in legislation, I consider that the centre should ensure that remanded trainees can indeed receive daily visits other than in the most exceptional circumstances. Given the need to avoid disrupting education (and also the difficulties many parents will face in getting time off work), this may mean facilitating evening visits.

I recommend that all STCs are required to facilitate daily visits to trainees on remand.

It is also important that those visits take place in a congenial environment. Hassockfield provides accommodation for visitors who need to stay overnight, and this is to be commended. However, the boy's grandmother was critical of the visiting facilities at Hassockfield, saying that they were over-regulated and uncongenial. Quality of contact is as important as quantity. Everything possible should be done to ensure that visits are conducted in a relaxed, natural atmosphere where people can relate naturally to each other.

I recommend that Hassockfield reviews its visiting arrangements to ensure that everything possible is done to ensure that visits take place in a relaxed, natural and congenial environment.

Section 7: Incentives scheme

Some staff have suggested that the incident where the boy was found in possession of cigarettes was a turning point for him. Clearly, it was wrong to try to smuggle cigarettes to him, but I have considered whether the incident was handled appropriately. It seems something was seen being passed to him and the matter was reported to the duty manager. Because the visit was nearing its end, he took the decision to let it continue but to search the boy afterwards. Given that this was the boy's first transgression, I have considered whether it might not have been more appropriate actually to challenge him during the visit itself and address the issue there and then, rather than letting the boy feel he had been "entrapped". However, it is possible that this might have led to denial and public confrontation in the visits room. This would have been unfair on the boy, his family and any other visitors.

The next question is whether the punishment the boy received was appropriate. The Incentives guidance makes it clear that the penalty for smuggling contraband and for smoking can be severe – instant relegation for a period of up to 48 hours to the Conference League – that is, the lowest level of privileges. However, the guidance also makes clear that the actual penalty to be imposed in a particular case is at the discretion of the reviewing officer taking account of "severity and frequency".

Legislation (STC Rules) does not allow smoking or possession of tobacco products by trainees and the possession of banned items is dangerous in any

closed institution, carrying as it does the risk of bullying. The matter was therefore a serious one. However, it was the boy's first offence and there is also a question as to the degree of his culpability. I do not know whether he asked his family to bring him cigarettes or if they simply thought it would be a kindness, but it was they who broke the rule by bringing in the cigarettes, not him. Arguably, of course, he should have refused to accept them, but this would have been a great deal to have asked of a 14 year old. (Like it or not, many 14 year old boys do smoke and have developed an addiction to tobacco. Vulnerable 14 years olds in custody receiving a visit from family are even less likely to decline a gift, whether it is permitted or not.) All in all, I believe it would have been sufficient simply to confiscate the cigarettes and warn the boy about his conduct. To take away all his points for that day was harsh.[41]

While the incentives guidance makes it clear that the actual penalty imposed is for the manager concerned, the strong impression is that the full penalty should be imposed – the addendum about discretion is added only at the bottom of the page. I find the drafting confusing.

I recommend that it is made clear that all incentives decisions are made on the particular merits of the case, referring to guidelines only to determine what the maximum penalty may be.

There can be little doubt of the effect this affair had on the boy – evidenced by the cup-throwing incident. He felt it was unfair (given that it was his family who brought in the cigarettes) and he would have felt the loss of points and privileges (and especially the loss of his television and CD at the weekend) keenly. He had quickly achieved Championship status and would have been proud of that (he said on one occasion on receiving ten points for the day that he was "King of the world"). He may also have felt there was no escaping trouble no matter how hard he tried. It is perhaps pertinent here to recall his judgement that, whilst luck was responsible for the good things that happened to him, he believed he alone was responsible for the bad things.[42]

[41] LuptonFawcett commented: "The policy is clear. It is important that there be consistency of sanctions across the Centre. The minimum relegation period is 24 hours and the maximum 48 hours. Some leniency was exercised by allowing [the boy] to retain his CD player, which should, by rights have been confiscated for a period of time. A mere warning on the finding of contraband would undermine the consistent approach as to the severity of the offence of contraband. Parents and trainees are fully aware (see enclosures) of the seriousness with which the Centre has to view contraband. Cigarettes are particularly dangerous within the Centre because they require lighters or matches with which to light them. It is inherently unsafe to allow matches or lighters into the Centre and if cigarettes are smuggled into the Centre there are fears that alternative methods of lighting them will be attempted causing a serious danger."

[42] The YJB has commented: "The cigarette incident may have played a significant role in determining what subsequently happened. The cigarettes were allegedly given to [the boy] by a visitor and this may have impacted upon [his] state of mind e.g. he may have been worried about the possibility of subsequent visits being restricted or banned altogether. As [the boy] was a young person identified as vulnerable, this incident should have been taken into account by the STC when considering his HRAT status."

Section 8: PCC

Legitimacy of use of PCC

A number of staff referred to a deterioration in the boy's behaviour after the contraband incident, but this is not supported by any contemporary written record – nothing was noted about the boy's behaviour on the Sunday prior to the incident with the note in the early evening. There is, however, a question whether the unfairness perceived by the boy in relation to the cigarettes influenced his behaviour once the incident involving the note was underway.

The incident began innocently enough. The trainees had apparently been "up a height" all day, which was not unusual for a Sunday. No doubt the boy was caught up in this restlessness. Another trainee passed him a note which he gave to an officer. The officer said he then snatched it back before she could finish reading it. When she asked for it back, the boy and another trainee passed it between them to prevent her getting it. She told them both to go to their rooms. The other trainee obeyed but the boy did not. He apparently said afterwards that he had done nothing wrong (according to his version of events he was sent to his room because of the note, not for keeping it from the officer). According to the records, the boy had only been on time out once before and that was the previous night, when he had thrown a cup which hit an officer. The perceived unfairness of the previous day may have made him refuse. Either way, the situation escalated and became confrontational. The boy grabbed the table leg and refused to move.

The Secure Training Centre Rules include regulations on "Removal from Association" and say that the governor (sic) may arrange for a trainee to be removed from association where there is a risk of him/her causing "significant harm" to himself, others or property. However, "A trainee shall not be removed under this rule unless all other appropriate methods of control have been applied without success." I doubt, therefore, whether the officer should have insisted the boy went to his room for time out – there is no indication that he was causing or that there was a risk of him causing significant harm, nor did he have a history of doing so.

Either she or another officer called First Response, thereby summoning at least three officers and a nurse. This seems to have been a heavy handed approach. First Response is intended to summon aid urgently and officers will arrive in the expectation of trouble. Yet the boy was small and slightly built. He had not been restrained before and there was no reason to suppose he would resist. If it really was necessary for the boy to go to his room, the two officers should at least have attempted to achieve this themselves before calling First Response.

What the First Response team found when they arrived was a trainee simply sitting at a table refusing to move. The officer who administered the nose distraction said in his statement that, when he arrived, the boy was quite calm. They tried to persuade him to go to his room but he continued to refuse –

possibly because by now they had made it impossible for him to comply without losing face, especially if there were other trainees looking on. The officer noted that, after a while the boy began to be agitated and tried to make a joke of it. With the benefit of hindsight, it can be seen that, at this point, the boy was trying in his own way to de-escalate the situation. Nevertheless, staff continued to try to get him to go to his room, eventually lifting him up to achieve this.

The STC Rules say under "Maintenance of order and discipline" that, "In the control of trainees, officers shall seek to influence them through their own example and leadership, and to enlist their willing co-operation."[43]

The Rule on "Use of Force" says that an officer should not use force unnecessarily and, where it is necessary, should not use more force than necessary. In addition, "No officer shall act deliberately in a manner calculated to provoke a trainee."

The Rule on "Physical Restraint" says:

> (1) "No trainee shall be physically restrained save where necessary for the purpose of preventing him from –
>
> (a) escaping from custody;
> (b) injuring himself or others;
> (c) damaging property; or
> (d) inciting another trainee to do anything specified in paragraphs (b) or (c))
>
> and then only where no alternative method of preventing the event specified in any of the paragraphs (a) to (d) above is available.

[43] The YJB advised that restraint practice and procedure differs between the three types of secure accommodation for juveniles. The Prison Service uses Control and Restraint (C&R), of which pain compliance is a significant component. STCs use PCC, in which pain compliance is a small component and Directors of LASCHs are able to use the restraint system that they elect, usually in accordance with their Local Authority policy. The YJB suggested that it would not be desirable to have the same restraint system across the three sectors because the demographics are quite different, with LASCHs accommodating very young people and welfare cases, not just criminal justice cases. However, the YJB had consulted on a Behaviour Management Code of Practice, resulting in "Managing Children and Young People's Behaviour in the Secure Estate: A Code of Practice", published on 7 February 2006. This Code of Practice acknowledges that restraint systems will be different because there are significant differences between the three sectors, but it tries to achieve consistency in the principles of behaviour management of which restraint is a small part. The YJB advised that the Code is one element of its review of restraint. In addition, a panel of experts had been commissioned to review the safety of PCC. A summary of their recommendations is on the YJB website. Finally, Boatman and Bleetman (expert witnesses for Northants Police following the death of another child … at Rainsbrook STC) had carried out a review of behaviour management in STCs. At the time of writing, the YJB was trying to establish with the police, CPS and Coroner whether publication of this report would compromise criminal or inquest proceedings.

> "(2) No trainee shall be physically restrained under this rule except in accordance with methods approved by the Secretary of State and by an officer who has undergone a course of training which is so approved."[44]

Hassockfield's policy document on the Use of Physical Restraint/Medication states that "Trainees will be physically restrained only as a last resort, and when no other alternative is available." It is only to be used:

- "To prevent a trainee from escaping;
- To prevent a trainee from harming him/herself or others;
- To prevent a trainee from damaging property;
- To prevent a trainee from inciting another trainee to harm him/herself or others or damage property.

Physical force will not be used for any other reason **or simply to obtain compliance with staff instructions**, it will be a measure of last resort" [my emphasis].

Given the undesirability and dangers of using any physical force against children in custody, I think the policy document sets the right parameters. However, in the case of the subject of this report, it seems to me that none of the criteria for resorting to PCC was met. The boy was being disobedient, but he was not actually causing any harm, nor was he inciting others to do so. I note that officers said afterwards that they were concerned that the boy's behaviour might have caused unrest amongst others. If his behaviour could actually have been said to have been inciting them to misbehave, PCC might have been justified – but I can see no evidence that this was the case, they were merely laughing at him. In all the circumstances, I very much doubt that it was appropriate to use PCC.

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[44] Commenting on a draft of this report, the YJB advised the report does not provide a complete picture with regard to PCC. The Criminal Justice and Public Order Act 1994 (s9) provides for custody officers to use reasonable force to 'ensure good order and discipline'. This power remains available to Custody Officers even though it is not repeated in the STC rules.

LuptonFawcett made the same point. They said: "… there is an anomaly in the law, Sect 9 (3)(c) of the Criminal Justice and Public Order Act 1994 empowers a Custody Officer performing custodial duties at a contracted out Secure Training Centre to use reasonable force to ensure 'Good Order and Discipline'. This is in conflict with Rule 38 of the Secure Training Centre Rules 1998. The primary legislation from which those regulations derive must take precedence over the regulations where, as in this case, there appears to be a conflict. The regulations stem from the primary legislation. The PCC Manual (section 4) refers to an incident were trainees refuse to move and staff are required to intervene. In these situations staff 'may have to use whatever force is necessary provided it is reasonable and proportionate in the circumstances as they see it'.
"Regulation 36 of the STC Rules 1998 allows the STC to arrange for the trainee's removal from association, where it appears to be necessary.
"Regulation 38 of the STC Rules 1998 could be considered to be in conflict with the above as well as in conflict with the primary legislation."

I also have concerns about the way the PCC was carried out. In the first place, it is clear that the boy was lifted completely off the ground and carried face down. The PCC manual provides for a lift manoeuvre, but the trainee is carried face up. This is the only approved lift. In addition, one of the officers refers to lying the boy face down on the floor in his room. If this is what actually happened (the other accounts differ), it was expressly against the rules.

Finally, I am worried about the administration of the nose distraction technique. The very concept is controversial, for reasons that need no explanation. However, I accept that, in extreme instances it may be both necessary and lawful to obtain compliance through pain, and it is clearly proper that there should be approved means of administering that pain rather than leaving officers to use their own methods. However, it is questionable whether the nose distraction technique should have been used on the boy.

A report by the YJB Regional Manager with responsibility for Hassockfield, dated 10 August 2004, said:

> "Other trainees had complained about the use of the nose distraction technique. As a result it was recently agreed at the meeting between STC Directors, the YJB Regional Manager and the National Youth Advocacy Service in 30 July that the technique should no longer be used for restraint but could be used as part of a breakaway technique. From the description of the incident that I have heard to date it would appear that the latter was the case."

I disagree. Various statements referred to the boy kicking and stamping and threatening and trying to bite an officer's hand, but none of them says he actually succeeded in doing so. A breakaway technique is what it says – a means of breaking away once the other person has attached themselves in some way (including biting). It is not about prevention. The officer's statement says that he warned the boy several times that he would use the nose distraction technique. This is not something he would have done if the boy was actually biting him.

I also have concerns about the way the technique was administered. The boy said the officer did not punch him in the nose (and the denial is in itself instructive) but said he squeezed his nose. The officer gave two accounts of his actions. In his statement to the police, he gave a text book account of a nose distraction technique. In his statement to Premier, however, he described a "flicking" motion. This would have breached the guidance on administering the technique and may have accounted for the nosebleed that the boy suffered.

More generally, I am disturbed by comments from staff and trainees that nose bleeds following nose distraction were not uncommon and by the nurse's statement that she often had to treat nose bleeds after the technique was used. It cannot be right that this sort of injury should result from an approved technique.

I recommend that the YJB conducts a review of the nose distraction technique and of the way it is taught.[45]

I consider that the boy was absolutely right in wishing to have his injury photographed. Such evidence is vital in resolving complaints about injuries by staff in determining whether or not there is a case to answer.

I also recommend that, where a trainee is injured during the course of PCC, photographic evidence is taken immediately afterwards.

I have reviewed a report to the Youth Justice Board by the then Head of the Juvenile Group in the Prison Service and an experienced and much respected prison governor, entitled 'Report on the Use and effectiveness of PCC in STCs'. The report suggested that PCC was "an inadequate method of control", taking too long to restrain some children thereby increasing the risk of injury to both staff and trainees. It also noted that, "It is likely that pain compliance techniques such as 'nose distraction' had increased due to the ineffectiveness of PCC holds. I saw this myself at Oakhill[46] and the National Instructors report on Hassockfield found that it was used in 9% of all cases."

The comments of a national Control and Restraint Instructor for the Prison Service on the PCC carried out on the boy are also instructive. He said of the PCC carried out on the boy:

> "The STC rules make no provision for restraint to be used for reasons of Good Order and Discipline as the Prison Rules do. It's therefore debatable for that reason, as to whether or not the use of force in these circumstances was lawful under the rules … The wisdom of [sending out a First Response call], which infers [sic] that immediate assistance is required, has to be questioned and could have escalated the situation rather than defuse it. It would appear from the evidence that at the time the call was put out [the boy], although abusive was calm in terms of any direct violence being offered … [the boy] should not have been carried face down. If a trainee needs to be carried there is only one approved method, which is set out in the PCC manual at paragraph 1.6. The team had every justification for lifting [the boy] under the guidelines but should not have carried him face down … if [the boy] was bleeding to the extent suggested then immediate medical assistance should have been sought, and the removal suspended until the medical problem had been resolved … If the nose distraction technique had been applied correctly then it should not cause an injury of any description … If [the boy] was placed in the prone position this is

[45] LuptonFawcett commented: "The PCC Manual states that no training that is effective, challenging, involves physical contact can be entirely free of risk of injury [sic]. This was a very minor injury. The nose distraction was applied when [the boy] was trying to bite the Officer and was moving his head around in a frantic attempt to do so.
"In operational terms there is a great deal of difference between applying a nose distraction in training with a compliant colleague and applying one in a true PCC environment."
[46] Another Secure Training Centre.

> clearly wrong … The evidence is inconsistent. If [the officer] is correct then the technique described by him does not fall within the ambit of PCC."[47]

Following receipt of this advice, the police investigated the incident as it appeared to them that an assault might have been committed on the boy. This was on the basis that, "as [the boy] was merely sitting at a table, albeit not doing what he was told, and that under the STC rules, the use of restraint was not allowed." The police report went on:

> "During the subsequent interviews several key issues came to light. It was apparent that all of the care staff concerned were aware that the carrying of [the boy] face down to his bedroom was not within the PCC techniques. They all seemed to believe that it had been necessary and safer for all concerned under the circumstances because of [the boy's] struggling. Likewise they all knew that the placing of [the boy] face down in his room was not within PCC and the approved technique involved the trainee being placed on their knees. It was noted that [two care officers], who were both PCC instructors, had not mentioned [the boy] being placed face down on the floor in their statements, something which [one officer] was quite clear about. It was put to them that they had merely written up the incident as it should have happened and not how it happened. [The officer who administered the nose distraction] stated that he did not recollect [the boy] being placed in the floor whereas [the officer who took one of the boy's arms] agreed that he might have reverted back to instructor's text in his statement.
>
> "None of the staff seemed to have a clear knowledge of the STC rules as to when PCC could be used although it was apparent that there was awareness that the techniques were not intended for making trainees do what they were told. It was also quite clear from all of those interviewed that PCC restraints are regularly being used in this type of situation at Hassockfield. It was pointed out by several of the care staff that the centre would grind to a halt if staff were unable to move trainees when they passively refused to do as they were told."

The report also mentions that trainee interviews "support the idea that the use of PCC is commonplace at Hassockfield and several trainees refer to the fact that the boy's stockinged feet were stamped on by staff during the restraint". (In the event, nobody involved with the PCC was charged.[48])

A number of staff referred to the frequency of First Response calls. Two a day was said not to be unusual. It should be. My fear is that staff may resort too readily to PCC. Indeed, I saw what may be evidence of this during a visit Miss McMurray and I paid to Hassockfield when the centre Director

[47] LuptonFawcett commented that, "[The officer who wrote the report] has never worked in an STC or used PCC operationally. He misunderstands the Regulations and is unaware of the conflict of Law previously referred to."

[48] I understand that this was because the primary legislation endowed them with the power to use PCC in the particular circumstances that obtained (see footnote 44).

demonstrated the new CCTV system. This enabled him to monitor from his office any part of the establishment he chose. As it happened, what we first saw was a trainee being removed from a classroom under PCC. It struck me as somewhat unlikely that we should chance on the use of PCC unless this was a fairly regular occurrence within the centre.

Contract monitoring reports tend to support this view. The numbers ranged from 150 instances in May 2003 to 45 in September 2003. The contract monitor notes the percentage increase or decrease for each month, but beyond some fairly superficial speculation as to the cause (for example, one particularly difficult trainee accounting for a large number of restraints) there is little attempt to analyse the figures. Nor is there a record of the number of occasions on which injury resulted from the restraint. This is a matter for concern as it means a possible problem with the administration of the nose distraction technique (or a problem with the technique itself as used on young people) went undetected.[49]

I recommend that the specific conditions under which PCC may be used are strongly impressed upon staff and that this message is constantly reinforced by managers and through training.

I recommend that the use of PCC (including the reason for it and any resulting injuries) be rigorously monitored by both centre managers and contract monitors and that investigations be carried out where:

- **the number of incidents in a particular month is high; or**
- **where one member of staff is involved in a high number of PCCs as compared with his/her colleagues; or**
- **where an injury has resulted.**

I also recommend that staff should be de-briefed following each instance of PCC and encouraged to consider what alternatives were open to them. Wherever possible, the trainee should be involved in this process.

Excessive use of PCC is oppressive to trainees and can also de-sensitise staff to just how traumatic it is.[50] It is worrying that its use with the subject of this report was not considered worthy of mention on handover. In this specific instance, it must have caused the boy enormous frustration (to lose an

[49] It is a matter for further concern that no monitoring reports were completed for the period March - July 2004 due to there being no contract monitor in post. The YJB Regional Manager advised that he visited the centre on a weekly basis until the appointment of a contract monitor but did not produce monthly reports. He added that he did, however, scrutinise the incident reports and had regular meetings with the STC centre manager.

[50] LuptonFawcett commented: "It is unfair … to assume that HSTC has excessive use of PCC without considering national statistics. In a report to the YJB it was found that HSTC figures for use of force were typical."
I should add that I am not suggesting that use of force at Hassockfield is higher than elsewhere in the secure estate for children and young people, but simply that it is too high in itself.

'argument' simply because he could be lifted up and taken away). He may also have felt some loss of face. He would almost certainly have felt a loss of self-esteem.

Taking the Saturday and Sunday incidents together, it is possible that the boy felt that there was no avoiding trouble - that no matter how hard he tried and how well he did over a given period, he would always end up in trouble.

Section 9: Staff training

Handling challenging young people

When we met, the boy's mother wanted to know what qualifications or training staff had to deal with youngsters such as her son who had severe emotional and conduct disorders.

In his report to the Youth Justice Board, Mr Waplington commented:

> "I was surprised at the high level of PCC recorded in every STC. Hassockfield's use of force figures are typical. In the year ending March 2004, they recorded 912 PCC incidents. 773 of these were planned. The Double Embrace (mostly with head support) was used on 574 occasions. This is a very high total compared to the rate of C&R in YOIs. The high number of planned interventions is also worrying. At two centres I asked whether the officer supervising had any guidance about alternatives to consider prior to use of force. They did not. One Director said he would welcome guidance. I think it is an essential tool and would be easy to develop.
>
> "Several staff told me that there was too much use of PCC and several attributed this to staff inexperience and lack of skill. One officer told me that she ran to incidents confident that if she got there in time PCC would not prove necessary. Similar views were expressed by some other staff. I attended one de-brief following an incident where I felt the Officer who had initiated PCC was in need of guidance as his handling skills were awful.
>
> "Overuse of PCC is, I believe, linked to the inadequacy of behaviour management policy in general. When children fail to respond to persuasion or commands PCC is usually the next step. A more imaginative, flexible and varied range of response us required."

The boy's mother asked about the training given to staff at STCs as compared with that received by staff working in LASCHs. YJB's Head of Placements told Miss McMurray that, generally speaking, staff working in LASCHs tended to come from a social work background and be working on NVQ Level 3. Staff in STCs on the other hand tended not to come from social work backgrounds or any field related to care and custody of children. The only training they received was the particular company's initial training course. This lasted several weeks, but tended, the Head of Placements said, to focus

on control and security rather than softer skills. (It is probably also relevant in this respect that there is a higher staff to child ratio in LASCHs than in STCs.)

Miss McMurray also consulted the Commission for Social Care Inspection (CSCI) about training for staff in STCs as compared with those working in LASCHs. They advised:

> "In relation to staff training, STC staff are basically trained to a minimum standard laid down by their contractual obligations. This basic course was designed because most secure training assistants (ie those at the inter-face with the young people) have had little if any previous experience of this sort of work. As part of the inspection process SSI/CSCI ensure that all staff have been through this training and have also been trained and, where necessary re-approved, in restraint techniques according to the contractually approved method. Inspectors take note of training needs, particularly safeguarding, in all inspections and where necessary made recommendations or comment.
>
> "In local authority secure children homes, training is covered in the annual regulatory inspections under the children home regulations as well as the triennial inspections to approve them as a secure facility. This has been a priority for inspectors. Local authority secure units tend to have easier access to training than STCs because they are part of larger organisations who provide in house training programmes and have better staff ratios which make it easier to release staff.
>
> "The YJB has been keen to introduce NVQs to develop the professional body of knowledge for those working in the secure estate and to bring on stream accredited training for staff. However because this took some time to achieve it was difficult for both local councils and private providers to take a strategic approach over several years.
>
> "In relation to safeguarding training, inspectors have been instrumental in ensuring that STCs and LASCHs are involved with their local Area Child Protection Committee and this provides staff development opportunities. Most secure training centres and local authority secure children's homes now have a reasonable understanding and awareness about child protection, usually led by a manager who is a professionally qualified social worker. However because it is likely that many young people in secure establishments have been victims of historic abuse, inspectors consider that there is still a need for more in depth training."

The person specification for the role of care officer at Hassockfield rates experience of working within a secure environment as highly desirable. An "ability to relate to children whose behaviour is difficult and challenging" is also required. In addition, the specification requires "excellent verbal/communication skills" and an ability to "relate to trainees in a way that encourages positive behaviour and builds trainees' self-esteem".

Miss McMurray specifically asked the centre Director about staff training in handling children with emotional/conduct disorders. He advised that:

> "… all our staff undergo a full 9-week training course prior to them working on shift. We also have a 2-day paid dedicated training session every 9 weeks for care staff. On average officers will receive a minimum of 11 paid training days per annum … However, the majority of young people that arrive at Hassockfield have high degrees of anxiety, confusion and vulnerability and … staff become accustomed to working with such young people. We also have 3 Social Workers, 3 Psychologists and 5 Nurses on staff along with 4 other qualified Social Workers, Criminologists and colleagues who have completed the Professional Certificate with the Youth Justice Board. The Director is a member of Durham's ACPC and our working relationship with local Child Protection Agencies is very good and highly transparent."

The Director sent details of the initial training programme, in-service training undertaken by staff, and qualifications held by staff. The initial training programme is comprehensive, comprising over 70 modules. These include introduction to child care, adolescent development, the peer group, rights and care of trainees, assumptions and stereotyping, non-verbal communication, active listening skills, verbal communication, assertiveness, managing aggressive trainees, loss and bereavement and the risk of suicide.

He said five members of staff had completed the Professional Certificate in Effective Practice (PCEP), and eight more were working towards it with a further eight due to start in September/October 2005. In addition, 11 staff had completed the Effective Practice Unit Award (EPUA) and a further six were working towards it. These are both Youth Justice Board effective practice qualifications, aimed primarily at giving people the skills to prevent young people (re-)offending. In addition, a handful of staff had social work qualifications of some sort.

Given my concerns about an over-reliance on PCC to gain compliance from trainees, and in line with the former Head of the Juvenile Group in the Prison Service's comments on the matter, I consider that more attention should be given to inter-personal skills and child psychology during initial and in-service training. Staff should be closely monitored on the way they carry out their work, and both positive and negative feedback should be provided by managers on a continual basis on the way they interact with trainees. CCTV footage should be used to enforce learning.

I welcome the publication on 7 February 2006 of "Managing Children and Young People's Behaviour in the Secure Estate: A Code of Practice". This encourages a "holistic" approach, which is intended to lessen the need to intervene physically, by promoting a more preventive way of dealing with challenging behaviour. Nevertheless, I wholly endorse the former Head of the Juvenile Group in the Prison Service's recommendations on this matter. These are that:

"PCC is used too frequently and in many cases too soon. There is an urgent need for improved methods of behaviour management, ideally supported by better staff training at all levels, primarily in dealing with adolescents and their challenging behaviour.

PCC is regularly used to gain compliance … We need to develop more options and flexible but effective methods of control."

Monitoring

More generally, in reviewing such contract monitoring reports as were available for the period leading to the boy's death, I was struck by how process driven and quantitative they were. There is little evidence of regular or frequent engagement by the contract monitor with trainees and no reference to qualitative issues concerning, for example, the environment, regime and staff trainee relationships

Commenting on a draft of this report, however, the YJB advised that the monitoring regime changed shortly before the boy's death. They said they had developed an Effective Regimes Monitoring Framework which emphasises the qualitative dimensions to which the report makes reference. I welcome this news.

Training for management roles

The duty manager was critical during his interview of staff training and promotion. He said:

> "People get positions in here and they get no training. The duty managers, the team leaders – they are not care managers or officers as they used to be, they are just team leaders. They get promoted to team leader and they expect you to do a couple of night shifts where you shadow another duty manager and that's it, they have to get on with it … I did work for HMP [the Prison Service] years ago and their training and questions means it's a lot harder to get on than it is in a place like this. They do address things whenever in here but it's always after something had happened."[51]

The Assistant Director said during interview that they tagged training on emergency response procedures to security meetings about every three months. She said lots of people were involved:

> "The emergency response plans are all laid out and they identify people so that you have a gold commander, a silver commander, a bronze commander, somebody identified to take notes."

[51] LuptonFawcett commented: "This is entirely untrue. Full training schedules for all staff are available."

She said others, apart from senior managers, were involved.

During interview, the team leader on duty on the night of the boy's death said that, when she first took on the duty manager role, she had another manager do a few shifts with her to begin with to show her all the routines, emergency responses and paperwork. She said, "There's no end to the training, it's however long you need. I think I had three nights with another manager and then I felt comfortable." Later, she said, "There's a file kept in Comms and it's got procedures in for emergencies, fire and things like that. It's all there – what to do and who to call. It was just a case of knowing where that was and for me to read through it." The boy's death was her first emergency situation. She said she felt in control of the situation and dealt with it to the best of her ability. She said she was panicking inside but liked to think she maintained exterior calm.

It is worrying that it may be left to duty managers to find out for themselves what they should do in the case of any given emergency. Uncertainty can lead to delays which could mean the difference between life and death. I consider shadowing to be a useful part in anybody's training, but there is a need for it to be structured to ensure all relevant areas are covered – not those that happen to come up during the shift in which shadowing takes place.

I recommend that Hassockfield introduces a checklist of areas to be covered prior to a new duty manager taking up post. I also recommend that some form of assessment be introduced to ensure this has taken place and that the duty manager fully understands his/her responsibilities.

Responding to self-harm

It is also worrying that both the care officers on duty on the boy's unit on the night of his death reported that they did not know what they were supposed to do if they found a trainee who had apparently killed himself. In the event, the officer who found the boy did exactly the right thing by supporting his body and calling for help. He is to be commended for his quick thinking.

I recommend that all staff receive regular refresher training in what to do when they find a trainee has self-harmed.

Section 10: Handovers

Although the two duty managers had a handover during which the incident with the boy was mentioned (and the incoming duty manager followed this up by reading the relevant paperwork), this does not appear to have happened between other staff – apparently because there was no clear break between shifts. As a result, once the earlier staff went off duty, those who remained knew nothing of the boy's PCC. (Although, given the frequency of PCC at the centre and that neither of them knew the boy well, it is perhaps unlikely that

they would have read any particular significance into it if they had.) The female officer made an entry in the handover log, but there is nothing to suggest that the incoming staff read it. In any case, nothing she wrote would have struck staff as in any way unusual. What was more significant than the PCC itself was the change in the boy's behaviour – and especially his extreme reaction to the PCC and his sense of grievance against staff afterwards. The significance of the PCC in the circumstances leading to the boy's death is necessarily speculative, but I find the lack of a handover extremely worrying. It is all the more regrettable given that there was plenty of time for such a handover, given the overlap in the shifts.

I recommend that the system of handovers is reviewed to ensure that each member of staff coming on duty is briefed about significant occurrences and about each trainee's behaviour during the shift.

I recommend that the handover book is used systematically to record any events of note.

I also recommend that staff coming on duty be instructed to read and initial the handover book at the start of their shift.

Section 11: Staff deployment

The duty manager from the day-shift suggested that staffing during the night was insufficient, particularly if a trainee was on two-minute watch which effectively meant an officer sitting outside his room for 13 hours. He said that, with other tasks officers were expected to do - such as cleaning the kitchen and taking items to the laundry - there simply was not sufficient cover. There was also a lack of flexibility - especially if something happened and staff were drawn to another unit.

It is certainly a matter of concern that one of the care officers was absent from his unit for such a long time on the night of the boy's death – and particularly that he was not in the unit when the boy's death was discovered. Although the Acting Team Leader and the nurse arrived very quickly, seconds might have been saved in getting the cut down knife if someone else had been present in the unit. In this instance, it seems highly unlikely that seconds would have made any difference. In another case, they might.

I have considered carefully the question of staffing. On balance, I think the numbers are sufficient – two officers to 14 trainees should be ample. In addition, I understand that, where a trainee is on a higher level of watch, healthcare staff will support residential staff in carrying out the checks (it is not clear, however, what happens if there are a number of trainees on two minute watch spread across the three houseblocks). It is also not unreasonable to expect staff to carry out other tasks during their shift. However, this must be done in a structured way to ensure there is adequate cover. In this instance, the officer's absence was unplanned, unstructured and open-ended. His tour took in houseblock 1, healthcare and the gatehouse (twice). There was no sense of urgency for him to get back to his unit. (I accept that on almost any

other night this would not have mattered and would have gone totally unremarked.)

I recommend that staff be instructed to stay as near their posts as possible and to communicate regularly with one another via the communications office while they are absent.

The nurse was also away from her 'post' when she was summoned to houseblock 2. I have considered what the repercussions of this might have been in terms of the equipment she took with her. I note that she and the Acting Team Leader carried out their resuscitation attempt without the help of any equipment other than the cut down knife and the equipment they carried on their belts. In particular, I note that no oxygen was administered. The Assistant Director was asked about this at interview but said there was nothing in the healthcare first aid bag that was not in the first aid kit on the unit apart from a suction tool. In the circumstances, and notwithstanding that the suction equipment could have been relevant in this case, I do not consider that the fact that the nurse did not bring with her the healthcare first aid bag made any material difference.

I recommend that an oxygen supply be kept in healthcare.

I recommend that all front-line staff carry cut-down knives on their belts.

I recommend that the contents of the healthcare first aid bag be reviewed to ensure it carries sufficient equipment to cope with serious incidents.

I recommend that the centre considers the costs and benefits of a defibrillator.

Section 12: Morse Watchman

The facilities manager, explained the Morse Watchman system to the police. He said it was used between 9:30 pm and 7:00 am each night to record what checks of trainees had been carried out. He said the handsets were issued to staff at the beginning of the shift by the team leader, who collected them from the duty manager's office. There was one dedicated handset for each houseblock, but a minimum of four handsets should be on site at any one time. At the end of each shift, the handsets are returned to the duty manager who downloads the data on to a PC where it is stored for audit purposes.

The facilities manager explained that any faults would normally be discovered by the care officers. In such a case, the care officer should complete a 'Job Request Log' sheet which was kept on each houseblock. These were collected and the faults should be addressed immediately. The facilities manager said he was aware that the procedure was not always followed strictly and faults were sometimes reported verbally or via e-mail.

He said there had been a fault with the houseblock 2 handset at the end of July in that it could not be downloaded. It was therefore swapped for another handset on 1 August. He said there were no faults with the Morse Watchman handsets documented at the time of the boy's death, but he was "aware that there were concerns regarding one of the handsets on [the boy's] houseblock". The facilities manager said he understood that the handset was not beeping when applied to the pegging unit and that the digital display did not work (later in his statement, he said the beeps were not working but the LED display was). As a result, a care officer had sent an e-mail to the Head of Security. The facilities manager thought this happened on 3 August. (This is correct. In fact, the e-mail stated, "The night Morse Watchman don't seem to be working I've mentioned this last week but they still seem faulty according to staff. Whats happening about tapes for blocks? There are 7 in the safe that I believe to be used but no blanks in the tray." [sic]) He said he was verbally informed by the Head of Security of the fault and checked all the handsets in stock at that time. He said all the handsets were still registering on contact. Some of the handsets had minor faults, but none of these affected their ability properly to record checks. The facilities manager said the handsets should therefore still have been in use. He said his examination suggested that a more deliberate action was needed in order to register the contact.

He said once he had checked the handset he told one of the residential care managers that the handsets were still working sufficiently for use on the houseblocks. He could not remember whom he had told. The facilities manager said the handset that should have been used on the night of the boy's death had been allocated to houseblock 2 since 1 August.

At interview, the facilities manager said the replacement handset had not been used in the week before the boy's death. He said he did not know why staff were not using it. He said again that he had told a member of staff that the handset was now working, but could not recall to whom he had spoken. He did not know whether there was a hand-over or incident book in which something like that might be recorded.

During interview, female duty manager said the system for handing over Morse Watchman handsets varied. She said a member of staff would normally go to collect them, but that sometimes she would take them down. She said the procedure at the time of the interview (January 2005) was that the duty manager actually took the handsets down.

The pathologist was unable to say how long the boy had been hanging. The upshot of failure to use the Morse Watchman is that there is no objective assurance that staff carried out the required checks. Unfortunately, the CCTV cameras in houseblock 2 were not recording either. Whilst the evidence of the other trainees tends to suggest that the required checks were carried out on the night of the boy's death (although not necessarily on other nights), and I have no reason to doubt the care officer when he says he carried out the required checks, the lack of absolute certainty is unhelpful – to staff as much as anything else.

Where equipment fails during the night, it is important that there is a fall back position for such contingencies.

I recommend that staff be instructed to inform the communications office whenever they are operating without the Morse Watchman system. The communications officer should be instructed to keep a closer watch on the relevant houseblock where that situation arises.

Section 13: CCTV

The failure to use the Morse Watchman system on the night of the boy's death was compounded by the failure of the CCTV to record events on the unit. (The boy's mother's original suspicions in this connection have largely been allayed, but the matter is nevertheless a cause for concern.)

The communications officer, a care officer predominantly deployed to the gatehouse, explained to the police that there were about 40 CCTV cameras throughout the centre. There were four monitors in the communications room which were used to monitor what was going on. The fourth screen remained blank and came into operation only when a general alarm was pressed. At this time, the screen showed the area in which the alarm was activated. There were also six video recorders which were on permanent record. It was the communications officer's responsibility to change the tapes in the video machines at 11:59 pm each night.

The communications officer explained that, ordinarily, the video machines and the monitors would be co-located in the communications room. This was accessible to all members of staff but the office was never left unoccupied. (Separately, he said there was a restriction on who should be in the communications office, but did not expand on this.)

However, at the time of the boy's death the communications office was being re-located to a site next to the gatehouse. During the move, the communications office was temporarily located inside the gatehouse itself. This was for about 1½ weeks. During the weekend of 7 August, the four monitors were placed in the gatehouse with the keyboard and the 'Safety Net' (that is, radio) monitor. The six video recorders remained in their original site. This was left unlocked during this time for maintenance.

The communications officer said that, once the ambulance had left the centre, he realised that he had not changed the video tapes due to the timing of the discovery of the boy's death. He said he therefore went upstairs to check they were all running and there was sufficient tape left, as he did not have time then to change them. However, on checking one machine, he found the tape had stopped. There was no error code and no bleeping/alarm. He said he immediately pressed 'Record' and returned to the gatehouse. He thought this was probably at about 12:50 am. He said he did not realise that the machine in question should have been recording events on houseblock 2 until he went to change the tapes about an hour later.

The police commissioned Sanyo's Technical Support Department (TSD) to investigate why the video had stopped. From a maintenance menu not available to end users, the Engineering Liaison Manager found that the machine had not experienced any electrical or mechanical errors to cause loss of recording operation for the period in question. He also established that the maintenance functions and menu were working correctly. In further tests, the manager found that the gap in recordings produced as a result of a loss of power was 12.6 seconds, that produced following a stop and eject procedures was 6.28 seconds, and that following record stop was 2.6 seconds. This last matched the 2.6 black portion seen on the incident tape. This confirmed that the video stopped as a result of the record mode being turned off and not because of any loss of power.

The video tape stopped at 10:20 am on 8 August. CCTV footage showed the duty manager coming out of the communications room at 10:19 am and 56 seconds and then going back in again at 10:22 am for six seconds before coming back out. The duty manager said in his police statement that he sometimes went into the old communications office if he was working in the administration corridor at the weekend to watch the sport on the TV or check the betting prices on Teletext. He said that, whilst he was in there on 8 August, he

> "… did not stop or even touch any of the video recorders that were in the room recording from the CCTV system. I did not remove or touch any of the plugs connected to any of the equipment in the room … I agree I appear to be leaving the room containing the video recorder at the time but I did not stop the recorder and cannot explain how it stopped."

During interview, he said he did not turn the machine off. The interviewers explained to him that experts had determined that the only reason the video would have stopped would have been if someone had turned it off. They asked again if he had turned it off. The duty manager said he "wouldn't even know what camera 1 or video 1 was. I haven't a clue. I have no idea." He said he had borrowed a television to put in the communications room so that he could watch Teletext whilst he was having a break. He was asked whether he had to unplug anything to install the television, but said, "I'm sure there was just a socket in the wall." He said it was "just a mess in [the communications room]. It was just like a jungle. There were things laid everywhere, all over the place." He agreed that, ordinarily, someone would have been with the machines all the time and been able to monitor them to check they were working. He did not think there had been any system of checks during the changeover period. The only point at which anybody would have become aware that any of the machines were not working was when the tapes were changed at midnight.

The duty manager explained that, on the occasion when he went into the room and came back out after just six seconds, "The telephone could have rung. The telephone never stops. I could have just literally got up and walked

in and the telephone could have rung in the office and I would turn straight back round and come out." The duty manager also said that, because of the relative positions of the television and the videos, it would not have been possible for him accidentally to have brushed the switch.

I have not been able to reach any conclusion on how the recorder came to be switched off. However, given the time at which it occurred, I am absolutely satisfied there was no conspiracy by staff to conceal anything relating to the boy's death. Nevertheless, it is a matter for concern that the machine could have been switched off and that no-one would notice that it had been for several hours.

I recommend that access to the video recorders be strictly limited and that their proper functioning be checked on a regular basis. (Any future refurbishments should take account of this requirement.)

Section 14: Equipment

More generally, I am concerned about the overall inefficiency and lack of equipment:

- A care officer went in search of torches that had not been provided at the beginning of the shift, but met with little success. Those he did find needed batteries and he could not find any. The facilities manager said batteries had to be collected from stores by 5:00 pm – but those most likely to need them would not start their shift until after this time.

- The duty manager had to phone the communications room to call an ambulance because her radio was not working.

- There were no surgical gloves in the first aid box.

- The magnetic lock on the doors was not working but staff had not been told.

- The other duty manager also revealed that it was not uncommon for the CCTV system to fail. He said, "The video can be broken down here for a while and it's not recording anything. Cameras and videos break in here – it could be for days sometimes."

- Finally, a Sanyo Technical Support Department report commissioned by the police identified that, during 43,796 hours during which the video machine they tested was switched on, it was not in record mode for 11,658 hours.[52]

[52] LuptonFawcett commented: "The machine in question has not always been used as a constant surveillance recorder but used to be used as an "alarm camera recorder". This means that it was switched on at the mains but only went into record mode if an alarm within the Houseblock was activated. It would then record the area where the alarm was activated until the alarm was re-set, often a matter of minutes. This means that for the majority of the time the record mode would be dormant."

There appears to have been a lack of attention to detail in ensuring that necessary equipment was available and capable of doing the job for which it was intended.

LuptonFawcett advised that the system for charging and changing batteries had been reviewed and managers were satisfied that the system, which was in operation at the time, was efficient and no improvements were necessary. Nevertheless,

I recommend that the centre Director introduces robust systems to ensure that all necessary equipment is in good working order and available to staff at all times.

Section 15: Systems

Camcorder

The purpose of filming incidents is to make it possible to establish after the event who exactly did and said what. This provides protection to trainees and staff alike. I am concerned, therefore, that almost none of the PCC carried out on the boy was captured. There had been plenty of time in the build up to the PCC to collect the camcorder, but no-one thought to do so until the incident was well under way. The procedure seems improperly haphazard.

In commenting on a draft of this report, however, the YJB suggested that instructing staff to bring the camera whenever an incident appeared to be brewing might be problematic. They advised that such events are often difficult to predict and the action of bringing the camera might itself cause an incident to escalate, which might otherwise have been managed. I therefore make no recommendation in this respect.

In addition, there was no system for recording when the camcorder was used and preserving the footage. Staff simply 'highlighted' when it had been used. As a result, it was necessary to go through hours of tape to find the footage of the boy's PCC. The police report on the PCC also referred to the difficulty in tracing the video footage. They noted that, "From the subsequent investigation and interviews it appears that the care staff were not given any training on the use of the handheld camera or the preserving of evidence/tape storage after its use." In the event, the relevant section was identified only because the officer who operated the camera recognised on the footage something she said. This is equally and unacceptably hit and miss. Each use of the camcorder should be recorded and a note made of the position of the footage on the tape.

I am grateful for the clarification as to why the machine was not in record mode for so many hours. The fact remains, however, that it was not switched on during the night of the boy's death.

I recommend that a system is introduced to ensure camcorder footage is saved and easily retrievable.

Morse Watchman

There was a system for reporting faults, but not everybody followed it resulting in some faults being reported verbally and some by e-mail. Perhaps as a consequence, there was no system for recording that faults had been addressed. (In the case of the Morse Watchman, a fault with one of the units had been reported to the security manager via e-mail.)

There was no set system for distributing Morse Watchman equipment – sometimes the duty manager delivered them and sometimes staff went to collect them. As a result, and because of the absence of any system recording that the equipment was in working order, there was a misunderstanding about whether it was fit for use.

I recommend that, wherever a fault with equipment is reported, the fact it has been rectified should be recorded in the handover book.

Perhaps even more worrying than that the equipment was not used on 8 August was the fact that it had not been used since the end of July, apparently without anybody picking up on the fact. There is little point in having an expensive and sophisticated system for monitoring staff actions if the resulting data is not checked, let alone analysed. It is simply unacceptable that the duty managers failed to notice that the systems had not been used for an entire week.

I note that a check sheet is now filled in every morning. This records how many 'tours' have been done and what stations have been missed. Any omissions are addressed. The sheet is completed by the duty manager each morning and handed to the duty director who signs it off. The facilities manager said during his interview that no such form existed in August 2004.

Enhanced observations of trainees

The Morse Watchman is not sophisticated enough to capture non-routine observations of trainees – for example, where the trainee is on 5 or 10 minute HRAT observations. Neither is there any requirement for staff manually to record that they have carried out their checks. Instead, they make one or two entries on each shift to indicate that checks have taken place. There is thus very little oversight that the checks are actually carried out. The duty manager was required to sign during each span of duty to verify that HRAT observations had been completed and recorded appropriately. Given the lack of contemporary monitoring, it is not clear how meaningful this verification is. In any case, I am concerned to note that, for the period 11 - 29 July, there were 20 occasions on which the duty manager did not sign the boy's HRAT book to verify that observations had been correctly completed.

I conclude that the systems and structures underpinning the efficient running of Hassockfield were wholly unsatisfactory. If Premier was not monitoring itself effectively, it is equally true that they were not being monitored effectively by the YJB either.

I recommend that the centre Director and the YJB reviews the systems and procedures governing all aspects of operations in the centre to ensure nothing is left to chance and introduce robust audit procedures to monitor their effective implementation.

Section 16: Physical safety and design

Curtain rails

The boy hanged himself by securing a shoe lace over the end of a curtain rail. The lace would ordinarily have slipped off due to the angle at which it would have needed to be placed, but the boy held it in place with a plaster which held the lace until the tension was able to do the job instead.

A report by a Quality, Environment and Safety Officer (QESO) at HMP and YOI Doncaster on the curtain rails in use at the time of the boy's death notes that one of the requirements for the centre was to avoid an austere prison appearance. Hence a homely environment was provided wherever possible, including provision of curtains, carpets, wallpaper, quilts and covers etc. The QESO noted that finding a suitable means of suspending curtains had proved to be a challenge: "the curtain rails have caused problems from the outset". A frangible rail that was easy to remove had been used, but trainees took these down to use as weapons. Velcro also proved to be unsuitable. Eventually, a curtain rail from a load release system ("Safe Trak") was used. However, instead of the coupling system provided, the rail was secured to a wooden batten and attached to the wall. The batten extended beyond the end of the rail to reduce the effective thickness of the structure, thereby making it more difficult to secure a ligature.

I was shown one of Hassockfield's curtain rails (not in use) when I visited. I noted that there was a very small gap between the rail itself and the baton to which it had been attached. Given enough patience and intelligence (which the boy clearly had), this could have been exploited to thread through a very thin ligature. The report by the QESO also noted it would have been possible to attach a ligature to a slot in the top side of the rail intended for multi purpose fixings. A ligature could also be attached to an individual curtain runner. A test carried out after the boy's death showed that the runner broke only after considerable weight had been applied.

The means by which the boy attached the ligature to the curtain rail was ingenious and painstaking. There can be little doubt of his intention. It is also relevant to note that, without the sticking plaster, he would not have been able to secure the ligature. I do not consider that this eventuality could or should have been foreseen. Nevertheless, the mechanism for securing the curtain was clearly unsafe in a number of respects.

The QESO's report noted that the Health and Safety Officer had not been consulted at the time the curtain rails were changed. He recommended that health and safety professionals should be consulted in relation to building and equipment modifications. He also recommended that a full review should be undertaken to determine whether any other changes introduced into the fixtures and fittings at the centre heightened the risk of their being used in any suicide or self-harm attempt. I agree.

I recommend that the health and safety officer be consulted before any changes are made to fixtures and fittings at any secure training centre.

Until such time as a suitable replacement is found, the windows at Hassockfield have no permanent coverings. This is uncongenial and unpleasant, and unacceptable in an institution holding vulnerable children.

I recommend that safe curtains be identified and put up as soon as possible.

Building design

More generally, Miss McMurray pursued the boy's mother's concern about comparative physical safety standards at STCs and LASCHs. CSCI advised:

> "In relation to buildings, the specification for STCs was laid down by the Home Office and it is they and the YJB who approve and certificate them as fit for purpose. SSI [Social Services Inspectorate, the predecessor to CSCI] was involved in a process of testing the Hassockfield building during and after construction but prior to its opening and was able to get a number of potentially dangerous design issues changed. However, we had no influence over the major design issues.
>
> "The position in relation to secure children's homes is different. These establishments are approved by the S of S [Secretary of State] with DH/DfES officials, including an architect who specialises in secure settings, and SSI/CSCI inspectors act as advisors. Design guidance has been produced to ensure that buildings were both safe and secure. All approvals of new builds or refurbishments have been fully inspected and tested at the pre-opening stage. This has involved inspectors from SSI/CSCI and OFSTED. I believe that professionals in the field considered this to be a very comprehensive and thorough process."

When I visited Hassockfield, I found work was in hand to lower ceilings to provide a more congenial environment. But generally speaking, I was surprised at how austere and prison-like the centre was. Furnishings were sparse and unattractive and movement was impeded by an oppressive number of locked doors.

I recommend that, in commissioning future STCs, the YJB follows the model for designing and constructing LASCHs, particularly as it relates to obtaining professional advice from experts in child care in secure settings.

Section 17: Debrief/support for staff

One of the care officers from the boy's unit said in his interview that he had continued to work after the boy's death, carrying out all the normal checks until 8:30 am. At about 8:00 am, the Director came to the unit and gathered the trainees together to tell them what had happened. After that, he said they went upstairs for a talk with the social workers and the psychologists in the board room to discuss how they were feeling. He said the support initially was very good.

Other staff agreed. One said she and others continued working to the end of their shifts. The following morning, she gave statements. She said they had a service with the trainees in the gym for about 20 minutes. She left the centre at about 11:00 am. She said there was a debrief at about 4:00 or 5:00 that afternoon which a psychologist attended. She said she thought the support they had been given was "excellent". Counsellors came in on a number of occasions, and were available for staff to speak to if they wished, but there was no compulsion.

The female duty manager said during interview that she considered the support she had received had been "fantastic. I couldn't have asked for any more. It's been excellent. Everybody's been really supportive. There's been counselling organised for us. No pushing us back into coming down here, nothing like that."

The officer who discovered the boy's death said during his interview that there was a support meeting but that he did not find it very helpful, although he thought a lot of people did. He said, "they were just repeating what had happened and getting it out of their systems. But the support was there at that time and there were counsellors and anybody you wanted to see."

The male duty manager's view was different. He acknowledged during his interview that he had spoken to someone from ICAS [the counselling service contracted by Premier] but said that, although he "supposed" the support was there if he had wanted it, he felt "that a lot of people were pushed back to work and I thought they shouldn't have come back." He continued:

> "But just because they are not trained enough to tell people … 'Come up. We will look after you' and I just thought that was worse to do that … All those people were just back to work – they were told to come back to work but they are not trained enough, in my opinion, to deal with people who are suffering stress like that … People are trying to do good possibly but they are not trained to tell people to come back to work two days later after they'd just tried to give mouth to mouth to keep him going. In my personal opinion I thought that was absolutely

> ridiculous. I don't think that would have happened in other professional places."

The duty manager's view aside (and I cannot judge whether people were pushed back to work), the support offered to staff following the boy's death is to be commended.

PART VI - Conclusion

The death of a 14 year old while in the charge of the state necessarily raises concerns about the appropriateness of custody for all but the most serious juvenile offenders. I do not enter that debate here. Indeed, it may be noted that in some respects the boy appears to have settled well at Hassockfield. He scored well on the incentives scheme and received positive reports from education. (Clearly a bright boy, it was to be welcomed that custody at least ensured he attended education on a regular basis.)

However, my investigation has revealed other major causes of concern. First, the fact that the boy was located so far from home, and from a family to whom he was clearly close, was lamentable. Equally lamentable was the fact that, given the correlation between his location and his suicidal ideation, a transfer nearer home was not pursued with greater vigour.

Second, I consider that the incident with the cigarettes was managed in a very heavy-handed manner, and that insufficient account was taken of the boy's age, previous good behaviour and the limited extent of his own culpability in possessing the cigarettes. By many accounts, this had a detrimental effect on his behaviour (though this is not documented prior to the PCC incident). Logic suggests that the incident therefore also played on his mind.

Third, I have serious concerns about the PCC itself – that is, whether it was warranted and whether it was carried out correctly. Fourth, I deprecate the fact that none of the events of that weekend – the demotion on the incentives scheme (and the boy's reaction to it), the knock-back with regard to bail and the PCC (which the boy clearly considered to have been an injustice, to the extent that he was said to have "lost it") – triggered an assessment of the boy's vulnerability to self-harm.

These concerns, which are directly relevant to the course of action the boy chose, are compounded by more general worries about management and control at Hassockfield. The boy's key worker was not replaced; the footage of his PCC was almost lost and was in any case worthless; there was confusion over whether or not the Morse Watchman was working; a member of staff absented himself for a considerable time from the houseblock; the CCTV video was switched off; there were equipment failures and the curtain rails had been modified in a makeshift way which left them susceptible to ligatures being attached.

Tragedy is not a word to be used lightly and perhaps especially so when I have the mournful duty of reporting on so many wasted lives. However, I have found this a uniquely troubling story. At its centre is an intelligent but damaged and vulnerable 14 year old boy who took his life while in the care of the state, having planned the details of his own funeral. If this does not constitute a tragedy, the word has lost all meaning.

PART - VII

Recommendations

1. I recommend that, notwithstanding any request to the contrary by solicitors, in circumstances where communication has been abruptly terminated immediately after the death, the centre should write directly to the family within 10 days, offering condolences and setting out as much information as possible. The form of any subsequent communication should be determined by the particular circumstances.

2. I recommend that the YJB apologises for the lack of meaningful and timely engagement with the boy's mum following her son's death.

3. I formally recommend that the Prisons and Probation Ombudsman should investigate all deaths in STCs and that this function should be enshrined in legislation at the earliest opportunity.

4. I recommend that, immediately following a death, an officer and a manager should assemble the trainee's property, record each item on a discrete form, check the property against the property records and place it carefully in a sealed container. Both members of staff should sign the form and the property record. (If the family member collecting the property then wants personally to check the property on the spot, this should of course be allowed.)

5. I recommend that YOT workers be reminded of the need to be alert at remand stage to changes that might impact on the suitability of a particular court order and advise the court accordingly.

6. I recommend that a copy of this report be sent to HM Courts Service for their consideration.

7. I recommend that the YJB revises the Placement Alert form to give much greater prominence to vulnerability.

8. I recommend that the guidance document be amended to direct YOTs to consider specific areas of the young person's history, behaviour and current demeanour as well as their likely response to custody when assessing vulnerability.

9. I recommend that the STC advises the YOT when a trainee is considered to be at risk of self-harm or suicide.

10. I recommend that a member of the YOT attend all HRAT reviews. If this is not possible, copies of the record of each HRAT Review should be routinely faxed to the relevant YOT member.

11. I recommend that the Transfer Request form be amended to include specific reference to risk of self-harm with a further space to indicate the nature and immediacy of the risk.

12. I recommend that the transfer Request form be amended to enable the urgency of the request to be highlighted.

13. I also recommend that the YJB be required to respond to Transfer Requests with a likely timescale for transfer, so that the responsible local authority can be asked to find appropriate alternative accommodation (at least in the case of COSRs) instead.

14. I recommend that the centre Director takes steps to raise the profile of the keyworker system and ensures it is properly implemented and monitored.

15. I also recommend that staff are given specific training for this role, which should include information about agencies to whom they can refer trainees when they identify particular issues or problems.

16. I recommend that the trainee's keyworker be required to take part in all HRAT reviews.

17. I also recommend that, as far as possible, the same members of staff form the two other members of the team with regard to a particular trainee.

18. Finally, I recommend that the centre be required to invite the next of kin or carer to take part in HRAT reviews.

19. I recommend that potential triggers to self-harm are explicitly explored with the trainee (and his/her carer) and flagged up for all staff to see.

20. I recommend that an entitlement to daily visits for those on remand be incorporated in the STC Rules at the next opportunity.

21. I recommend that all STCs are required to facilitate daily visits to trainees on remand.

22. I recommend that Hassockfield reviews its visiting arrangements to ensure that everything possible is done to ensure that visits take place in a relaxed, natural and congenial environment.

23. I recommend that it is made clear that all incentives decisions are made on the particular merits of the case, referring to guidelines only to determine what the maximum penalty may be.

24. I recommend that the YJB conducts a review of the nose distraction technique and of the way it is taught.

25. I also recommend that, where a trainee is injured during the course of PCC, photographic evidence is taken immediately afterwards.

26. I recommend that the specific conditions under which PCC may be used are strongly impressed upon staff and that this message is constantly reinforced by managers and through training.

27. I recommend that the use of PCC (including the reason for it and any resulting injuries) be rigorously monitored by both centre managers and contract monitors and that investigations be carried out where:

    - the number of incidents in a particular month is high; or
    - where one member of staff is involved in a high number of PCCs as compared with his/her colleagues; or
    - where an injury has resulted.

28. I also recommend that staff should be de-briefed following each instance of PCC and encouraged to consider what alternatives were open to them. Wherever possible, the trainee should be involved in this process.

29. "PCC is used too frequently and in many cases too soon. There is an urgent need for improved methods of behaviour management, ideally supported by better staff training at all levels, primarily in dealing with adolescents and their challenging behaviour.

30. PCC is regularly used to gain compliance … We need to develop more options and flexible but effective methods of control."

31. I recommend that Hassockfield introduces a checklist of areas to be covered prior to a new duty manager taking up post. I also recommend that some form of assessment be introduced to ensure this has taken place and that the duty manager fully understands his/her responsibilities.

32. I recommend that all staff receive regular refresher training in what to do when they find a trainee has self-harmed.

33. I recommend that the system of handovers is reviewed to ensure that each member of staff coming on duty is briefed about significant occurrences and about each trainee's behaviour during the shift.

34. I recommend that the handover book is used systematically to record any events of note.

35. I also recommend that staff coming on duty be instructed to read and initial the handover book at the start of their shift.

36. I recommend that staff be instructed to stay as near their posts as possible and to communicate regularly with one another via the communications office while they are absent.

37. I recommend that an oxygen supply be kept in healthcare.

38. I recommend that all front-line staff carry cut-down knives on their belts.

39. I recommend that the contents of the healthcare first aid bag be reviewed to ensure it carries sufficient equipment to cope with serious incidents.

40. I recommend that the centre considers the costs and benefits of a defibrillator.

41. I recommend that staff be instructed to inform the communications office whenever they are operating without the Morse Watchman system. The communications officer should be instructed to keep a closer watch on the relevant houseblock where that situation arises.

42. I recommend that access to the video recorders be strictly limited and that their proper functioning be checked on a regular basis. (Any future refurbishments should take account of this requirement.)

43. I recommend that the centre Director introduces robust systems to ensure that all necessary equipment is in good working order and available to staff at all times.

44. I recommend that a system is introduced to ensure camcorder footage is saved and easily retrievable.

45. I recommend that, wherever a fault with equipment is reported, the fact it has been rectified should be recorded in the handover book.

46. I recommend that the centre Director and the YJB review the systems and procedures governing all aspects of operations in the centre to ensure nothing is left to chance and introduce robust audit procedures to monitor their effective implementation.

47. I recommend that the health and safety officer be consulted before any changes are made to fixtures and fittings at any secure training centres.

48. I recommend that safe curtains be identified and put up as soon as possible.

49. I recommend that, in commissioning future STCs, the YJB follows the model for designing and constructing LASCHs, particularly as it relates to obtaining professional advice from experts in child care in secure settings.

Part VIII - Annexes

Section 1: Investigation

The boy's death occurred a few months after I took over responsibility for investigating all deaths in prisons, and amongst the residents of probation hostels and detainees in immigration removal centres. My remit did not at that time extend to secure training centres.

At the time of the boy's death, the Youth Justice Board took the view that it was not appropriate for my office to undertake the investigation due in part to concerns about a blurring of the distinction between prisons and secure training centres. It was agreed instead that, in light of my office's growing experience in investigating deaths in custody, we would act in an advisory capacity to the Youth Justice Board which was to carry out the investigation itself.

My office's involvement in the YJB's investigation was that one of my Assistant Ombudsmen:

- shared with the YJB the PPO Terms of Reference for investigating deaths in custody and described the form our investigations took;
- visited Hassockfield with YJB staff and met the investigating police officer at Durham police station;
- visited Lancashire Youth Offending Team with YJB staff and met the boy's supervising officer. The Assistant Ombudsman had earlier talked to YJB staff about the sort of things they might want to ask the YOT staff;
- visited the C&R National Centre at Kidlington with YJB staff;
- advised the YJB that they should consider commissioning a clinical review (as per PPO normal practice);
- advised on preparing for interviews with Hassockfield staff. She suggested questions they could ask to clarify various issues raised by the police statements. She also agreed to write the section of the report about the evening the boy died;
- Attended for the first two of three days of interviews and led on about three or four of the interviews.

The involvement of my office ceased to all intents and purposes from January 2005.

However, as its draft report neared completion, the YJB became anxious about the appropriateness of its role as investigating body. It was also concerned that the ensuing report's independence:

> "… would be compromised by our contractual relationship with Premier Custodial Services which runs Hassockfield Secure Training Centre. Our relationship with Lancashire Youth Offending Team differs from the direct contractual relationship with Hassockfield and yet the investigation made it necessary to comment with the same authority on

> practice at YOT and custodial level, despite these differing relationships. The report may not have been considered fairly balanced by those upon whose practice we were commenting.
>
> "It was with the robustness of the report in mind that we approached the Prisons and Probation Ombudsman to complete this investigation on our behalf at the point that new information became available."

I agreed to take on the investigation on the understanding that I should start afresh.

I took possession of all the documentation held by the YJB. This included YOT records, ASSET forms, court reports, custodial documents, statements by staff, documents obtained or commissioned by the police and transcripts of interviews carried out with staff by the YJB investigators (occasionally supported by this office). Given the long passage of time since the boy's death and having reviewed the transcripts of interviews, I decided there was no added value in re-interviewing staff. Where this report refers to "interviews" therefore, it is the YJB interviews that are meant.

Miss McMurray and I visited Hassockfield Secure Training Centre to familiarise ourselves with the lay-out and ethos of the centre and to learn something of its operation. During this visit, I spoke at length to the centre Director about the progress of the investigation to date. Miss McMurray and I subsequently accepted an invitation to visit Rainsbrook Secure Training Centre near Rugby to provide us with greater familiarity with the secure estate for children and young people and to provide a point of comparison with Hassockfield.

I met the boy's mother early in my investigation at the office of her solicitors, Bhatt Murphy, and heard directly her principal concerns and questions about her son's custody and death. I agreed to as full a disclosure of contemporaneous and other documents as possible, subject to the views of the Coroner.

Once the Coroner had indicated that he had no objections, Miss McMurray forwarded to Bhatt Murphy copies of all documents in our possession that were relevant to the investigation. She subsequently disclosed to Bhatt Murphy, the STC manager and the YJB a working draft of this report (I was especially keen to ensure that the boy's mother was able fully to engage in the investigation). Miss McMurray afterwards liaised regularly with Bhatt Murphy to ensure the boy's mother's concerns were addressed by the investigation. Further to this, she made enquiries of Hassockfield about items of the boy's clothing that had not been returned and looked into the training and experience of centre staff in dealing with young people with behavioural and emotional disorders.

Miss McMurray obtained a copy of Premier Custodial Service's own investigation report on the boy's death and secured their agreement to this being disclosed to his mother.

Miss McMurray liaised with both the Coroner and the police to obtain copies of notes the boy left, transcripts of interviews with other trainees on the unit at the time of the boy's death, and a copy of the boy's medical record. She also commissioned a clinical review by Ms Yvonne Francis, MSt (Cantab) BA Hons, Cert Ed, RN, RM, RHV, DN Cert, of the medical care provided for the boy during his stay at Hassockfield.

Bhatt Murphy suggested that a specialist review of the boy's general care at Hassockfield would be appropriate. I have considered this carefully. It is quite possible that, had I been responsible for this investigation from the outset, I might have commissioned such a review. However, given the amount of time that has passed (together with changes in personnel at the centre), I am not persuaded there would be sufficient value to such a review to warrant the added delay or cost. In addition, the centre is regularly inspected by the Commission for Social Care Inspection (CSCI), a specialist body that employs inspectors with expertise in the field of childcare and psychology. CSCI carried out an unannounced inspection immediately after the boy's death. My view is that that inspection fulfilled the need identified by Bhatt Murphy.

More generally, it is worth bearing in mind that this is one of several investigations into the boy's care and death, each of which brings its own particular expertise to bear. Apart from the CSCI inspection, the Area Child Protection Committee (ACPC)[53] has carried out a lengthy and detailed investigation of the interventions that were provided by a range of agencies during the boy's lifetime, and the YJB has conducted a Serious Incident Review which examines management and procedural issues concerning the boy's supervision and care. Taken together, but particularly in light of CSCI's existence and involvement, I am not persuaded that at this stage a specialist review is warranted.

Miss McMurray reviewed the report of the unannounced CSCI inspection of Hassockfield immediately after the boy's death and obtained information from the CSCI Chief Inspector relating to the dissemination of the CSCI findings. She sought advice from the YJB on the same subject.

She visited the YJB's London headquarters to learn about the allocation, placement and transfer process and obtained information relating to the availability of alternative places during the boy's period in custody. Miss McMurray also contacted the YOT officer of the Lancashire Youth Offending Team and obtained information from him about the boy's placement at Hassockfield, the YOT's officer's advice to the court and the boy's request for a transfer.

Miss McMurray also obtained from the YJB copies of monitoring reports for Hassockfield for the period to February 2004. She was told that there was no monitor in situ for the first part of 2004, so no further reports were completed.

[53] Now the Local Safeguarding Children Board (LSCB).

Finally, she reviewed copies of transcripts of evidence to an inquest into the death of another young prisoner that were provided by Bhatt Murphy.

I issued a draft of this report to the boy's mother, the YJB, Hassockfield and the Lancashire YOT. I also copied extracts of the draft to CSCI. This final version takes account of their comments.

Section 2: Clinical Review

Introduction

A boy died while in the custody of Hassockfield Secure Training Centre (STC) in County Durham on 9 August 2004. On 3 February 2006, I[54] was asked by Ms Emma Bradley, Deputy Ombudsman and Head of the Fatal Incidents Investigation Unit, to undertake a clinical review of the health care records forwarded to the Ombudsman by the Coroner. These were the only documents relating to the boy which came into my possession for the purpose of the review.

The boy arrived at Hassockfield at 10.30 pm on 10 July 2004, having previously been accommodated at a Children's Home. According to the notes made by the nurse who assessed the boy at 10.30 pm on 10 July 2004, she had available to him/her documents which were not included in the healthcare record. In the initial mental health assessment, the nurse noted that the boy was uncommunicative. The admission sheet and initial physical and mental health nursing risk assessments appear, therefore, to be based on those documents which accompanied the boy to Hassockfield from the Children's Home.

Outline medical history

The boy was born on 14 November 1989. At the time of his death he was 14 years old. His next of kin was his mother. He had a history of absconding from the family home and from a Children's Home.

The boy had a history of deliberate self-harm and attempted suicide. The evidence presented in the notes was that, one year previously, he had taken an overdose of ecstasy, necessitating a hospital admission. He also had superficial scratches on his arms dating from about three weeks before his arrival at Hassockfield. The boy also had scarring to both hands. This was reported as dating from injuries caused by an aerosol when he was three years old.

The boy was recorded as having a history of physical aggression, making threats to kill and damage to property. He was described as a heavy user of

[54] Ms Yvonne Frances, MSt (Cantab) BA Hons, Cert Ed, RN, RM, RHV, DN Cert.

alcohol and tobacco. He also used cannabis and had recently tried heroin. He was described as misusing substances on a daily basis.

The boy had received psychiatric services in the past. He was reported to have a diagnosis of severe emotional and conduct disorder. He was described as likely to develop mental health problems in the future, such as depression. However, he was deemed currently to be 'untreatable'. Another reference to treatment elsewhere in the record leads to the conclusion that the term untreatable was ambiguous. It may have meant that at the time there was no treatment available to him rather than his condition being impossible to treat.

Admission health assessment

On the admission sheet, it was noted that the boy had a fractured metacarpal in his right hand. There was to be a follow-up appointment at Burnley General Hospital in early August. He was not on any medication.

The boy was described as very low in mood. He was morose and uncommunicative. He did not want to phone his mother. He said he had smoked cannabis earlier that day. He was described as evasive when questioned as to why he preferred to be detained rather than receive a supervision order.

The rest of the admission nursing risk assessment, both mental and physical, comprised the information cited in paragraphs 3 – 6 above.

The nurse wrote that the boy was to be "on five minute observations", *but no records of any observations were found in the file provided.*[55] The boy was to be transferred to Houseblock B2 (HB2B) and see the doctor in the morning.

The nurse added before the doctor saw him the next morning that a referral had been made to the Substance Misuse Co-ordinator. She had also found the boy's hospital appointment card in his possessions. He was due to attend at 9 am on 2 August.

Medical assessment

The doctor assessed the boy on 11 July. He found that he had a fractured right fifth metacarpal caused by punching a wall a week previously. The doctor noted he required a follow up X-ray.

The doctor noted that the boy had in the past been in hospital following an overdose of ecstasy. He recorded that he was on no medication. He also noted the old burns on his hands.

[55] In fact, observations were recorded on the High Risk Assessment Team file. They should, however, have been replicated on his healthcare file.

The doctor found the boy fit and well although he described him as quiet and introverted.

Chronology of healthcare and health-related events

Nursing staff recorded later on 11 July that University Hospital of North Durham was to be contacted regarding following up the boy's hospital appointment. On 13 July the boy saw the dentist. On the same date his mother signed a consent form authorising treatment, vaccinations and access to past medical records. *There were no past medical records in the file nor any reference to them being applied for.*

On 15 July at 10.45 pm, the boy complained of abdominal pain and nausea. The nurse who saw him recorded that he did not have diarrhoea or constipation and had not vomited. He was described as having general discomfort and given soluble paracetamol 200mg. (In light of the boy's reported heavy drug use prior to admission at Hassockfield, it is possible he was suffering from withdrawal symptoms.)

On 20 July, nurses arranged for the boy's appointment at Burnley to be cancelled and his notes sent to Durham Hospital, where a replacement appointment had been made. Later that day, the boy reported that his injury was painful because he had fallen on his right hand. On examination, it was seen to be very swollen and difficult to mobilise. He was sent out to Accident and Emergency and his mother was informed. He returned a few hours later with his hand strapped and bandaged. He had been X-rayed and was to return the next day. The nurse making the entry noted that his vulnerability had been reviewed and there were no problems.

On 21 July, the boy attended the fracture clinic at 10.30 am. He returned at 12.45 pm with a back slab on his hand and wrist and a four week follow up appointment. Later an entry was made in his medical record which stated that he had been involved in an incident at 4.35 pm. He had fallen on his hand. The entry continued 'Please read report'. *This was the first of three similar references to an incident and a report. There were no reports in the medical file.*

At 5.25 pm, the boy was "seen in Healthcare prior to transfer to hospital". *There was no further reference to that visit to hospital or the incident which precipitated it.*

On 23 July, the boy was stopped from playing football because of his injured wrist. He appears to have tried to get permission to play by taking off the back slab, but permission was still denied because of the risk of injury if he fell during the game.

On 26 July, there are two entries by different authors which may refer to one episode or two. The first said: 'Seen today. Full report to follow.' The second said 'S/B [meaning seen by] CPN [meaning community psychiatric nurse]. Report to follow.' *There were no reports in the file.*

On 31 July, the doctor saw the boy, noted his fracture clinic appointment and recorded that he had a cough but his chest was clear, therefore no treatment at present. On the same day, it was recorded in another hand that the boy had been seen by the doctor prior to his coming hospital appointment and was fit to travel.

On 2 August, the boy was seen in Healthcare prior to his hospital appointment. When he returned, it was noted that the hospital had been unaware of his appointment. It was also noted that a review of vulnerability had been completed.

The next day, the record contains the entry '14.30 Involved in incident. Please read report.' *This is the second of three similar entries, but no reports were found in the file.* At 3:30 pm, the boy was reported to have been seen immediately prior to leaving for the Accident and Emergency department at UHND. He returned in less than two hours, with a report that there was no new injury. Strapping had been applied and he was to attend his next booked appointment.

Between 3 and 7 August, the boy went to court and was remanded until 18 August. The photocopying had obscured the dates on the relevant entries.

On 7 August, a note records that information had been received from East Lancashire NHS Hospital about the boy's previous fractured metacarpal. The information was to be taken to the boy's next appointment at UHND.

At 6 pm on 8 August, the record contains the entry 'Involved in incident. Please read report.' *This is the third of the three similar entries where no reports were found in the file.* At 7.45 pm, the nurse who had originally admitted the boy (name not decipherable) made a long entry in his record. She wrote that she had been asked to see him after the earlier incident. She continued, describing how he:

> "initially refused to wash blood from around nose saying he would after a photograph had been taken. I informed him I would not examine him until he did so."

She noted the boy had a slight swelling over the bridge of his nose but there was no disfigurement apparent. He was able to breathe through both nostrils. She noted three scratches over left collar (sic). The boy was recorded to have demanded to go to hospital for an X-ray. The nurse continued:

> "I refused stating it was my decision as a duty nurse and I did not think it was needed."

The nurse then wrote that the boy would be seen by the doctor in the morning "as a precaution".

Events of 9 August 2004

At approximately midnight on 8/9 August, the nurse who had seen the boy earlier in the evening was called to HB2B. She found that he had been found suspended by a ligature made from a shoelace. Custody officers had supported his body and they cut him free with a cut-down knife supplied by the nurse. Emergency services were called. The nurse found the boy unresponsive, with no pulse. He was cyanosed (bluish skin discolouration caused by lack of oxygen circulation) and had been incontinent of urine. Cardio-pulmonary resuscitation was initiated and continued until paramedics arrived at about 12.25am and took over before removing the boy to UHND.

Findings, conclusions and recommendations from the clinical review

On admission to Hassockfield on 10 July, a nurse wrote that the boy was to be "on five minute observations". No records of any observations were found in the file provided and no reason was given for the initiation of such observations. (It is likely, however, that the boy's low mood and previous history of self-harm might have been reasons to commence suicide and self-harm monitoring.)

The boy had received psychiatric services in the past. He was reported to have a diagnosis of severe emotional and conduct disorder. He was described as likely to develop mental health problems in the future, such as depression. He was exhibiting low mood on admission. There was no reference to a referral for a mental health assessment. However, on 26 July there was an entry which said 'S/B CPN. Report to follow.' There were no reports in the file. It is unacceptable for there to have been no report filed within the fourteen days which elapsed before the boy's death.

Recommendation: Visiting health professionals should provide verbal feedback and write an entry for the immediate information of the nursing staff at the time of their consultation.

On 11 July, a nurse wrote that a referral had been made to the Substance Misuse Co-ordinator. There was no entry in the file confirming that any consultation with a substance misuse worker took place. The only possibility was that it was the entry on 26 July which said: "Seen today. Full report to follow." However, this may have been another reference to the visit by the CPN. It is probable that the boy was a candidate for substance misuse assessment and throughcare.

Recommendation: There should be management checks to ensure referrals are followed through.

The boy's mother signed a consent form authorising treatment, vaccinations and access to past medical records. There were no past medical records in the file nor any reference to them being applied for. It was therefore unclear whether the form the boy's mother signed was part of routine practice or whether there was an intention to apply for the records for all trainees. In this

case, there was an amount of past medical history including a serious mental health prognosis. There might have been benefits to his management and wellbeing if the previous records had been acquired.

Recommendation: The purpose of obtaining parental consent to the acquisition of past medical records should be reviewed and a policy formulated to produce an effective policy on this matter.

On 20 July, a nurse noted that the boy's vulnerability had been reviewed and there were no problems. Again on 2 August, it was noted that a review of vulnerability had been completed. These entries make no contribution to the record in the absence of a copy of the vulnerability assessments themselves.

Recommendation: The role of health care staff in the reviewing of vulnerability and the timing and purpose of such reviews should be considered and explained in policy and procedures.

The boy was reported to have been involved in three incidents, on 21 July, 3 August and 8 August. After the first, he went to hospital but there was no record of his return or the findings of the hospital. After the second, he went to hospital again and returned with a report that there was no new injury. Strapping had been applied and he was to attend his next booked appointment. On the third, he had clearly received a blow to the face causing swelling and a nose bleed, but he was not taken to hospital. This was a clinical judgement on the part of the duty nurse. The nurse had planned for him to see the doctor the next morning, but he was found hanging during the night.

On no occasion was the incident explained in the medical record. There were no formal reports of injuries on the file. The nurse described the boy as having blood on his face on 8 August and a swollen nose. She refused his demand for a photograph to be taken and his demand to go to hospital. The boy could reasonably have expected to go to hospital since he had on the previous two occasions. If there was to be an enquiry into the incident, a photograph might have been useful.

Recommendation: All incidents resulting in injury must be formally recorded within the healthcare record, a description of injuries made (or a photograph taken and placed on file), followed by a medical assessment.

Section 3: Youth Justice Board

The Youth Justice Board was created following the Crime and Disorder Act 1998 that came into force on 30 September 1998. The Act outlines the powers and responsibilities of the Youth Justice Board, including:

- To monitor the operation of the youth justice system and the provision of such services;

- To advise the Secretary of State on […] the content of any national standards that he may see fit to set with respect to the provision of accommodation in which children and young people are kept in custody;
- To identify, to make known and promote good practice in the following matters, namely –

    - the operation of the youth justice system and the provision of youth justice services;
    - the prevention of offending by children and young people; and
    - working with children and young persons who are or are at risk of becoming offenders.

The Youth Justice Board is also responsible for the purchasing and allocation of placements in secure facilities for young people in the criminal justice system for whom all community interventions have been exhausted. The Youth Justice Board is responsible for the monitoring of secure facilities to ensure that the welfare of a young person is at the centre of any such establishment regime.

Section 4: The Secure Estate for Children and Young People

The secure estate for juveniles consists of three sectors:

- Secure Children's Homes (SCHs);
- Secure Training Centres (STCs), run by private companies on contract to the YJB; and
- Young Offender Institutions (YOIs), run by the Prison Service.

STCs are distinct from SCHs in that they are larger establishments. The focus of SCHs is to work with vulnerable young people with physical, emotional and behaviour management problems, whereas STCs provide a more structured environment that emphasises education and vocational training together with the addressing of offending behaviour.

STCs are distinct from YOIs in that they have a higher staff to young offender ratio (minimum of three staff members to eight trainees) and are smaller in size, which means that individual needs should be more easily met. STCs are purpose-built centres for young offenders up to the age of 17. They are run by private operators according to Home Office contracts which set out detailed operational requirements.

STCs are governed by Statutory Rules (the Secure Training Centre Rules 1998 (SI 472) and the Amendment Rules 2003 (SI 3005)). The STC Rules 1998 state the aims of the STC are to "accommodate trainees in a safe environment offering high standards of education and training" and a programme "designed to tackle offending behaviour of each trainee and to assist his development".

The bulk of secure estate places is in the YOI sector. On 1 April 2004, there were 235 contracted places in SCHs, 194 places in STCs and 2,965 places in YOIs/female prisons.

Section 5: Commission for Social Care Inspection

In March 2004, the Commission for Social Care Inspection (CSCI) carried out its fifth annual inspection of Hassockfield STC. Overall, the report was satisfied that previous recommendations had been acted upon and there was evidence of "significant improvements" as compared with previous inspections. The report did, however, identify that management, risk assessment and quality assurance systems and processes needed to be developed to underpin safe practice and that Hassockfield would benefit from the appointment of an experienced child care manager.

Following the boy's death, CSCI conducted an unannounced inspection of Hassockfield on 17/18 August 2004 to establish whether sufficient safeguards were in place for other children and young people in the centre.

The (as yet unpublished) report noted that:

- the Inspectors "continued to observe positive relationships during this visit including many examples of staff ensuring that young people were safe from harm, listened to and treated with respect and dignity";
- "many young people were described as being positive about their experience in the STC";
- "staff were confused about the basis on which physical intervention is permitted with young people";
- "There were comprehensive, multi-disciplinary procedures for managing the risk of suicide and self-harm";
- "Systems were in place to ensure that any concerns about the mood or behaviour of young people subject to HRAT procedure were recorded by staff, shared appropriately and acted upon without delay. However in light of the death of the young person, the centre should review its procedures for instigating or re-instigating HRAT status to ensure that any lessons that can be learned are understood and acted upon";
- "neither the video recording system nor the morse watchman monitoring system were operational on the unit in which the young person died … the consequence of the failure was that there were neither morse watchman records nor video recordings to show that a young person had been observed to be safe during the periods when they were locked in their room";
- "Our overall impression of the centre was that relationships between staff and trainees continued to be warm, caring and positive";
- staff were "feeling supported by management and a counselling service was available to them."

The Inspectors concluded:

> "systems, processes, and practices fell short of what is required to ensure the safety and wellbeing of young people. These included staff being away from their workstations for excessive periods of time and the absence of contingency arrangements in the event of systems failure. During and after the inspection visit we received assurances that action was being taken to ensure that adequate safeguarding arrangements were in place."

When I met the centre Director, he said he was extremely angry at what he felt was the failure of the CSCI to engage in any meaningful way with him over their report. Some 13 months later, he said he was no wiser as to what had led CSCI to conclude that his establishment was unsafe.

CSCI refuted this. They said their concerns were discussed with managers from Hassockfield, the contractors and the YJB in the feedback meeting at the end of the inspection fieldwork. As the Director was on leave at that time, the lead inspector telephoned him after he returned to work in the following week and discussed their concerns, including that systems were unsafe. CSCI said the Director agreed that the systems would be repaired and a revised director's rule issued to cover contingency action in the event of further failure. Both the Director and the YJB confirmed to the inspectors within the following week that this action had been taken. The Director was therefore made aware immediately after the inspection of the reasons why CSCI considered the establishment to be unsafe.

CSCI also explained that, under a service level agreement with the Youth Justice Board, they send draft inspection reports to the YJB which then arranges for them to go to the Secure Training Centre. The YJB then provides CSCI with comments from both the STC and the YJB. CSCI said they sent the report to the YJB in November 2004 and communicated with them about it a number of times between then and May 2005. At that point, CSCI asked for confirmation that Hassockfield were content with the report. It then emerged that the report had not been sent there. During a meeting in August 2005 between the CSCI Lead Inspector, the Director and his external Serco Manager, it transpired that they had still not received a copy of the report. CSCI then provided one and wrote to YJB to suggest a meeting. This took place on 19 September 2005. As a result, some changes were made to the report and CSCI understand that the Director is now satisfied with its wording.

CSCI noted that the process of sharing their report with Hassockfield was "clearly extremely unsatisfactory". They were reviewing their service level agreement with the Youth Justice Board, and seeking to improve arrangements for communicating with STCs about inspection reports in the course of that review.

I sought advice from the YJB about this. They advised that it was not true to say that Hassockfield had not had a copy of the inspection report from the YJB. They said that the Director would not acknowledge that he had received the report until it had come directly from CSCI and he had been formally and

directly consulted by CSCI on its contents. The YJB advised that discussions about the report had been going on between the YJB and Hassockfield since the report was shared in November 2004 because the question of young people's safety was a grave concern.

CSCI commented that neither the Youth Justice Board nor the Director contacted them to say that they wanted them to vary the service level agreement and communicate differently on this occasion. They said they would have willingly sent the report directly to the Director if either party had asked them to. CSCI said they were clear throughout this period that all parties had been informed of the issues that led them to suggest that the establishment was not effectively discharging its safeguarding responsibilities at the time of the inspection and that they had been addressed.

This represents a sorry story in itself. I hope urgent steps are taken to ensure this situation can never arise again.