

**Circumstances surrounding the death of a trainee
at HMP and YOI Hindley, in September 2005**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

April 2008

This is the report of an investigation into the circumstances surrounding the death in September 2005 of a trainee, apparently by his own hand.

The trainee had been the sole occupant of a double cell at HMP and YOI Hindley. A prison officer on night duty found him at 10pm, suspended by a ligature made from a bed sheet attached to a pole supporting the privacy screen of his cell toilet. He had been in Hindley for the six months prior to his death and harmed himself on several occasions during that time.

The account of what happened in the immediate aftermath of the discovery of the trainee's body is particularly harrowing.

One of my investigators and a Family Liaison Officer visited the trainee's mother at her home. I offer my sincere sympathy and condolences to all members of the trainee's family. They have suffered the tragic loss of a much-loved family member. I understand that staff and prisoners at Hindley have shared their feeling of loss.

Three of my colleagues carried out the investigation on my behalf. I am also grateful to the Youth Justice Board (YJB), who supported my investigation. Their expert findings and opinions added breadth and quality to the investigation. The Ashton, Leigh and Wigan PCT carried out a comprehensive clinical review, assisted by a member of my office.

An independent Serious Case Review was carried out for the Manchester Safeguarding Children Board. One of my investigators met the reviewer and members of the review panel, and they shared information. Some of the material within my report, particularly in respect of the trainee's early life, is taken directly from this report, with the reviewer's permission.

I am also grateful to the Detective Inspector of Greater Manchester Police who led their investigation. He and his team shared their information readily with my investigators.

My thanks go too to the Governor and staff at Hindley. I am especially indebted to my team's liaison officer at Hindley, whose work and personal commitment enabled the investigation to be so thorough.

However, I must apologise for the delay in issuing this report. The investigation was time-consuming and involved, amongst other things, meetings and consultations between the Youth Justice Board, Manchester Safeguarding Children Board, Greater Manchester Police, Ashton, Leigh and Wigan Primary Care Trust, Bolton, Salford and Trafford Mental Health NHS Trust and officials and staff from the Prison Service.

At the time of his death, the trainee was serving two Detention and Training Orders, together totalling 22 months, imposed on 6 and 8 July 2005. Additionally, on 26 August 2005, he was charged with robbery and a hearing date had been set for 22 September. Although this information came to light during my investigation, it appears the prison authorities did not know of the trainee's further charge and impending court hearing.

This is a long and detailed report, reflecting the utmost seriousness of the death of a child in the care of the state. I make 29 recommendations, of which eight are from the report of the clinical review.

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Prisons and Probation Ombudsman

April 2008

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SUMMARY

The trainee, a prisoner at HMP and YOI Hindley, died during the evening of 15 September 2005. He was found hanging from a ligature fashioned into a noose, attached to his neck and to a rail supporting the privacy screen of his cell toilet. He was discovered at about 10pm. He was alone in the double cell.

The trainee was first remanded in custody at Hindley on 17 March 2005. He was sentenced on 6 July to an 18 month Detention and Training Order for an offence of robbery, and on 8 July to a further four months for an offence of affray. The trainee was due to appear in court again on 22 September. It appears likely that prison staff and the Youth Offending Team were unaware of this further charge.

The trainee had a difficult time during the few months he was in custody at Hindley. However, there were times when he appeared settled. Sometimes he did well in his education classes and, although his attendance was patchy and his conduct in class sometimes disruptive, he was well liked by his teachers who from time to time gave good reports of his efforts. He also made efforts to live peacefully within the prison community. Nevertheless, a detailed examination of the trainee's time at Hindley, both within the accommodation set aside for young people and during the periods when he was admitted to the healthcare centre, shows a troubled young man. It seems he struggled to control his emotions and presented as unable to set and steer a steady course to guide him through his stay in custody. Significantly, although the trainee had friends in the wing where he lived, on several occasions he reported formally to staff that other prisoners (whom he named) were bullying him.

The trainee's mother told my family liaison officer that she believed that he was the victim of bullying. She said she had seen the trainee with bruising on his face and a cut lip. She had also seen him with red marks around his neck, but when she asked him about his injuries he would not say how they had been caused. Neither the trainee nor his mother reported his injuries to prison staff - who possibly did not notice them.

The trainee cut his arms twice, on 15 July and 31 August. On those occasions and one other, 14 September, he also made nooses from bed sheets, some of which he tied around window bars and a rail supporting the toilet privacy screen in his cell. On all three occasions, the Prison Service's standard process was put in train and the trainee was given special care and the intensive supervision laid down in Prison Service Order (PSO) 2700, Suicide and Self Harm Prevention. A significant part of these procedures is the opening and maintenance of a log, identifying the level of care and its frequency. (The log is known as an F2052SH.) The trainee was admitted to the prison's healthcare centre on a number of occasions. At the time of his death, special suicide and self-harm arrangements were in place.

On one occasion, a prisoner wrote to his friend saying the trainee was being bullied and made reference to 'stringing himself up' and that he was 'in the infirmary'. A second prisoner told police and my investigator that he protected the trainee from bullying, and that the trainee borrowed tobacco regularly from other prisoners and was unable to pay it back. A third prisoner, the trainee's co-defendant, said that he had heard from other prisoners that he tried to hang himself every Thursday so that

he could be admitted to the healthcare centre to avoid being bullied. This trainee said that Thursday was significant, as pay back day was Friday and the trainee who died would be unable to repay his debts. A fourth prisoner who had known the trainee for about four years said that he was 'one of the boys' outside prison, but inside was much quieter.

The trainee had told his education worker that he had harmed himself in order to gain admission to the healthcare centre, a popular location relatively free from the competitive and aggressive culture amongst young prisoners within the general population. Another prisoner, as part of an internal enquiry at Hindley into a different matter, said that the trainee had told him that he had pretended to self-harm to get to healthcare, in order to avoid 'trouble' that he was in on the wing.

Staff described a 'noose culture' at Hindley, where young prisoners would sometimes fashion nooses in order to gain special consideration, for example, to be given back privileges, which had been removed on disciplinary grounds. As a result, staff experienced difficulty in determining which incidents of self-harm were genuine and which were not.

Two of the prisoners interviewed volunteered that from their perspective Hindley ran better than another juvenile prison of which they had experience. Both agreed that staff were better and one of them said there was not much bullying on F wing, but 'E wing is worse'. One of the prisoners interviewed, who lived on the same prison wing as the trainee, said that when they were locked in their cells on the evening the trainee died he was 'normal and everything seemed ok'. The trainee said he would see his fellow prisoner in the morning, seemed 'quite happy' and showed no concerns.

A girlfriend told Greater Manchester Police that she wrote 'three or four times' to the trainee from July onwards and received letters in return. She described the trainee's letters as 'upbeat' and said he never mentioned problems or seemed depressed. They also spoke twice by telephone.

The night before the trainee died, he was found to have fashioned two nooses from bed sheets in his cell. The nurse who went to see him that night did not admit him to the healthcare centre. She told my investigators that the trainee had not seemed as upset or distressed as he had been at the end of August (when she had admitted him to the healthcare centre). She thought he had seemed more angry and annoyed. The following morning, when he saw a doctor the trainee said he was still 'pissed off'. When asked if he wanted to kill himself he told the doctor, 'Just watch me tonight.' The doctor did not consider that the trainee was at imminent risk of suicide, but felt that a mental health assessment was needed and duly referred him for. The doctor recorded the trainee's comment in his F2052SH record and referred him for a mental health assessment.

The trainee's mother said that the friend of another juvenile prisoner had told her that the trainee who died had activated his cell alarm bell three times on the night he died, and on the third occasion staff ignored the alarm for 30 minutes. She said that she had been told that a female member of staff was responsible for keeping a record of alarm calls. Officers told my investigators that they had visited the trainee's

cell and given him a toilet roll and, a little later during the evening, lent him a pen. It is probable therefore that the trainee activated his cell call alarm on at least two occasions for these routine requests on the evening he died. Although modern cell call systems leave an audit trail of their activation and intervention, this is not the case at Hindley. A visual and audible alarm sounds in the wing office when a prisoner presses the button in his cell. A member of staff must attend the cell in order to cancel the alarm. The technology does not allow for the system to register the call electronically, so producing a record, which can be checked. On the night the trainee died, the officer who found him hanging did so as a result of a routine check, not in response to an activated cell alarm.

Prison Service Orders, and the Youth Justice Board's service level agreement with Hindley, require that the Governor seeks to contact and involve a prisoner's family, supervising officer and outside agencies in important matters which concern him, particularly if he has harmed himself. The trainee's mother was not informed of either his self-harming or of his deteriorating and violent behaviour, nor was the Youth Offending Team. This is a particularly worrying feature and mirrors what I found in a previous investigation at HMYOI Lancaster Farms.

At the time the trainee died, the night staffing arrangements at Hindley meant that prison officers on duty were not fully occupied. The number of staff on duty should have enabled them to visit more frequently those prisoners at risk of suicide or self-harm. The process laid down under Prison Service Order 2700 guidelines was followed. But having regard to the high staffing levels, it should have been possible to have visited each prisoner on an open F2052SH more frequently than the minimum two-hourly checks which were made.

I criticise the initial response to the finding of the trainee. The officer concerned should have been carrying an emergency pack, issued to him for such an event and attached by a special belt. (The pack would have included a device for cutting ligatures and a radio for contacting colleagues through the communications centre.) However, the officer had left the emergency pack on a table in the wing office. This meant that he could not cut the ligature, nor could he summon assistance by radio. His only method of communicating immediately was through the cell call alarm. But when the officer activated the alarm, nobody responded and he had no option but to lower the trainee back onto the ligature and run to the office for help.

Not only did the trainee inflict, or threaten to inflict, harm upon himself, there were also times when he destroyed equipment in his cell and he was often abusive to staff. He was admitted several times to Hindley's healthcare centre and seen by specialists, including a clinical psychologist and registered mental nurses. On the occasions when the trainee was subject to special suicide and self harm precautions, review meetings were timely and well-attended (the trainee himself attended) and they came to conclusions which appear balanced.

Planning meetings and case reviews are an important part of comprehensive care in prison. In the trainee's case, the need was paramount to ensure that all plans and decisions were communicated and coordinated across the many agencies having an interest in his care before he came to prison, during his time there and after release. Although meetings and reviews were held regularly, staff attendance was poor and it

was not unusual for the trainee and the internal Youth Offending Team worker to be the only members. Meetings were assisted by reports from others who knew the trainee, but written reports cannot take the place of face-to-face discussions.

There are just two areas of accommodation set aside for juveniles at Hindley. This makes it difficult to separate all the prisoners who do not get on with each other. The two wings are large and unwieldy and do not lend themselves to the close care and supervision of young people. All the cells have readily accessible ligature points.

INVESTIGATION METHODOLOGY

1. The investigation opened on 19 September 2005 when one of my investigators met with the then Governor of Hindley. My investigator visited all parts of the prison and familiarised himself with the layout of the wing and cell in which the trainee was found hanging. The full investigation team arrived at Hindley on 22 September 2005 and they were briefed by the Governor and the Safer Custody Manager. A meeting was also held for staff who had worked with the trainee during his time at Hindley or who had been involved following his death. Police attended the meeting, as did the Chair of the Independent Monitoring Board (IMB), the Clinical Manager, and officials of the local branch of the Prison Officers' Association (POA).
2. My investigators issued notices to staff and prisoners advising them of the investigation and inviting anyone with information relevant to the trainee's death to make themselves known to the team. After the draft report was issued, it became apparent that not all of those involved in the trainee's care had been made aware of the investigation. I have amended my procedures to ensure that in future all service providers are made aware of any investigations.
3. In three visits, my investigators interviewed a number of staff including the Safer Custody Team, the incoming and outgoing Governor, the chaplain, a member of the Independent Monitoring Board, a doctor, the Healthcare Centre Manager, and several officers, nurses and prisoners. The Hindley branch of the POA lent their ready support and facilitated the work of the investigation. My investigators also received copies of all police statements.
4. A clinical review of the trainee's care was commissioned. This was completed by Health and Social Care in Criminal Justice Lead from the North West Area Regional Development Team. I am grateful for her contribution to the investigation process.
5. Following the issue of the draft report, it became apparent that there were other healthcare providers who had additional important information about the trainee's clinical care. They have since been invited to contribute to the investigation and I am grateful for the information they have provided.
6. One of my investigator's, together with one of my Family Liaison Officers, visited the trainee's mother on 31 October 2005. They explained the nature and scope of the investigation. In turn, the concerns and questions that the trainee's mother wanted the investigation team to address were noted.
7. The trainee's mother's main concerns were that she was not informed of any of her son's self-harming, she felt that Social Services had not supported him properly when he left care, and she thought prison was not the right place for the trainee as he did not do well with large numbers of other people. She had seen him with a cut lip and a mark on his neck, although the trainee would not tell her how the injuries had been caused. The trainee's mother had not brought her concerns to the attention of staff at Hindley. On one occasion a member of staff told her on a visit that her son was not eating properly and

encouraged her to tell him to eat his meals. She also said that staff response to her was variable. Sometimes, they could be friendly and helpful. However, this was not always the case. Although the trainee had permission to have new training shoes, she was told she could not hand them in when she brought them on a visit in spite of prior authorisation.

8. My investigator advised the trainee's mother that her concerns would be addressed during my investigation. Those in relation to Social Services would be addressed in an independent review commissioned by Manchester Social Services Department.
9. The report was issued in draft to the Prison Service, Ashton, Leigh and Wigan Primary Care Trust, Bolton, Salford and Trafford Mental Health Trust, Manchester Safeguarding Children Board, the Youth Justice Board, North Manchester and prison based Youth Offending Teams, and the Greater Manchester Police. Comments received from these organisations have been incorporated into my final report and an additional annex has been added to include the response to the recommendations.
10. My draft report was also issued to the trainee's mother. She declined to comment on the draft, as she did not wish to delay the production of the final report or listing of the inquest.

BACKGROUND

11. The trainee attended four primary schools, moving twice because his family moved and once because of his mother's dissatisfaction with the school. He received one-to-one teaching at one primary school, although this did not continue at future schools. There are references to serious truancy and to poor behaviour, including fighting, during the trainee's primary years.
12. The trainee would not talk very much to those in authority. His mother said he came home without mentioning injuries and, even when she questioned him, gave little away. She says he could not talk about his feelings and recalled his taciturn response to efforts by the Family Intervention Team to engage him. Much later, at Hindley, the pattern appears to have repeated itself when sentence plans urged the trainee to talk to staff about his problems.
13. During the trainee's secondary school life there were periods of disruptive behaviour, such as fighting, damage to property, lack of engagement with lessons, unauthorised absences, a five-day exclusion, detentions, serious wrist and hand injuries and failure to attend follow-up appointments. The report prepared for the Local Safeguarding Children Board states that the trainee barely attended school for all of his secondary education, and that action to reintroduce him to regular attendance failed entirely. His mother made several requests for help and at one school her son was provided with two to three hour's tuition each day from a special needs teacher.
14. Actions were taken early in the first year at one secondary school to involve Children's Services, their Family Intervention Team, the community paediatrician and the School Attendance Improvement Service. A referral to a consultant psychiatrist does not appear to have been pursued after the trainee failed to attend his appointment. This was the first recorded occasion when he should have seen a psychiatrist and did not.
15. The trainee began to commit criminal offences. Youth Justice Services encountered problems because there were proceedings, some confusingly happening at the same time, in several courts involving several Youth Offending Teams (YOTs). Although Manchester carried the main responsibility, other YOTs were writing court reports.
16. As the trainee got older, he would be missing from home for days at a time, often living rough and using cannabis. His drinking habits were also seemingly beyond his control. His first Supervision Order proceeded intermittently as social workers were either absent or sick and on occasions the trainee failed to attend appointments. His failures to attend were tolerated for some time before his social workers took breach proceedings.
17. However, a stay in residential care appears to have been a success. Simply staying there, attending school and complying with the conditions of a Reparation Order were real achievements for all concerned, including the trainee. Staff at the home reported that anger management and other challenging behaviour was no longer an issue. The trainee was gardening as

part of his Reparation Order and is said to have gone to school and liked it. In contrast, the prospects for a return home were not overly encouraging:

- The trainee sustained further injuries to his wrist while missing, and caused concern by removing the plaster and fixings twice.
 - During home leave, he stayed out and took drugs. It was the opinion of a psychologist that stricter discipline was necessary and that his mother needed help with boundary-setting.
 - Staff at the residential care home said that highly structured timetabling would be necessary if rehabilitation was to work.
 - Barnardo's said that the trainee was not ready for independent living and required 24 hour supervision.
18. There were efforts at coordination with Barnardo's taking the lead. However, there is a record only of two joint planning meetings. These meetings did not involve the trainee, his mother or the YOT, and resulted in no formal assessment nor, Pathway Plan apart, any kind of plan. The trainee returned home and stayed for about three months, but things deteriorated and he was placed in foster care. This started well, but ended badly although he stayed for nearly six months. The trainee was referred to Barnardo's too late to meet the requirement for a Pathway Plan to be in place by his 16th birthday. Barnardo's came to challenge the basis of the plan, taking the view that independent living was inappropriate for him.
19. There were six months between the trainee leaving foster care and being remanded to Hindley. As far as can be ascertained, he:
- was in and out of adult bed and breakfast accommodation in hotels on about seven occasions;
 - was placed in, and disrupted, specialist emergency accommodation for young people on about three occasions;
 - lived at home for a brief period;
 - lived rough for an indeterminate period;
 - was arrested on a number of occasions, sometimes in connection with alleged offences, and sometimes because of breach of bail conditions;
 - was detained in police custody, mostly overnight, on about five occasions;
 - appeared in at least four courts on twelve occasions, including remand appearances, trials, and sentencing hearings.
20. Children's Services had terminated the trainee's 'looked after' status and appeared to be relying on the provisions of section 24 of the Leaving Care Act, closing the case to Children's Services and resorting to bed and breakfast accommodation intended for homeless adults. Several attempts were made to place the trainee in various forms of specialist emergency accommodation but he appeared to have little interest in making them work. Efforts to place him in longer term supported accommodation failed. A lack of suitable

accommodation, together with his mother's feeling that it was not appropriate for the trainee to live at home, meant there was no option for the court in March 2005 but to remand him to custody.

21. By then, the trainee had been before courts on many occasions. He had also spent time in police cells. (His first criminal conviction was in 2001 when he was 13, but his remand in custody in March 2005 was his first time in prison.)
22. The trainee's mother visited him regularly at Hindley, and she had made it clear that he would be welcome to move permanently back into the family home upon his release. She said that, together with a YOT worker, she had visited the trainee on 15 August 2005. He told them that the police had visited him. They apparently had told him they had evidence of his involvement in a burglary which might lead to a further two-year sentence.

A copy of this report should be sent to the Chief Constable of Greater Manchester police to ask him to consider whether police officers should routinely notify prison Governors when prisoners are to be interviewed or charged in connection with further offences that might affect their behaviour or mental health.

HMP AND YOI HINDLEY

23. Hindley opened in 1961 as a Borstal for 15 to 21 year-old young men. In 1983, the Borstal system was abolished and Hindley was reclassified as a Youth Custody Centre.
24. Staff at Hindley have considerable experience in managing the security and care of young people as the prison has spent nearly all its 45 years of operation dealing with young people. At the time of my investigation, Hindley held 455 young adults and juveniles, both unconvicted and convicted.
25. Two wings of equal size are set aside for juvenile prisoners, usually referred to as young people, aged between 15 and 17. The wings, which have a total of 144 cells, provide 192 places in a discrete location away from older prisoners. The young people's wings operate under the Prison Rules, augmented by a Service Level Agreement (SLA) between the Youth Justice Board (YJB), who provide funding, and the Prison Service. A monitor appointed by the YJB oversees the SLA and reports on performance.
26. The trainee was located initially in F wing, which with E wing makes up the juvenile part of the prison.
27. All prisoners at Hindley should have a personal officer to advise and to some extent befriend those in their care. The personal officer can give advice and guidance on many things, from the prison's rules and dos and don'ts, through to information in respect of courts and the wider legal process. When the scheme works at its best, personal officers can be a 'friendly ear' or a 'shoulder to cry on.' Some prisons allocate named officers to named prisoners. Others allocate officers to the prisoners who occupy particular cells (for example, an officer might be responsible for prisoners in, say, cells 1-10, another for those in cells 11-20, and so on). This is the way Hindley organises the work of personal officers. It is particularly relevant in the trainee's case, as he occupied no fewer than 17 different cells during his six months at the establishment.
28. A learning and skills centre opened in 1996. It is now used exclusively by young people and is open five days a week. The curriculum ranges from basic literacy and numeracy to GCSE.
29. Hindley has a 13-bed in-patient healthcare centre. All its cells are used for single occupancy. Nurses and Healthcare Officers staff the healthcare centre, with primary care undertaken in partnership with the Ashton, Leigh and Wigan Primary Care Trust.
30. A Mental Health Day Care Centre opened in 2004. Bolton, Salford and Trafford Mental Health Partnership via a Service Level Agreement provide mental Health In-reach Services. The service is structured in a similar way to a community mental health team. The registered mental health nurses are a constant presence within Hindley and are a point of referral. They can refer prisoner patients onto the consultant psychiatrist or consultant psychologist if they feel a further assessment is required. The mental health nurses manage

the health needs of the young people and will liaise with other professionals both inside and outside Hindley as required. The other staff within the team are two Consultant Psychiatrists, two Clinical Psychologists, a Senior Occupational Therapist, an Art Therapist and a Clinical Nurse Specialist.

31. The in-reach team are focused on trying to provide easily accessible mental health services for the young people. All young people identified by the registered mental health nurses as requiring to see a psychiatrist will generally do so within a week of the referral. The Mental Health Trust have trained eight prison officers to provide support for the young people who struggle greatly with the custodial regime and are not amenable to conventional therapeutic inputs.
32. The cells at Hindley are typical of many in the prison estate. They are of adequate size, have integral sanitation and are appropriately furnished. However, they fall short of the best standard in one important respect: they have readily accessible ligature points, to which makeshift ropes can be easily fastened. Upgrading and refurbishing them all would be a substantial and expensive process. But they are particularly unsuitable for vulnerable young people in custody.

A programme should be drawn up to refurbish the cells at Hindley, particularly those set aside for juvenile prisoners, to 'safer cell' standards in order to minimise the availability of ligature points.

33. A full announced inspection by HM Chief Inspector of Prisons in November 2003 concluded that Hindley provided a safe environment for the young people in its care. Suicide and self-harm procedures were described as a model of good practice. However, measures to detect and prevent bullying among young people were criticised as being deficient, with insufficient emphasis on confronting bullying behaviour.
34. I understand Hindley has implemented all the recommendations made by the Chief Inspector and the programmes to deal with bullying are supportive, challenging and thorough. Regular meetings of, and actions arising from, the Violence Reduction Committee demonstrate the degree of attention to this problem. Minutes from meetings in July, August and September 2005 show that while one of the juvenile wings, E wing, remained unpopular, F wing (the wing where the trainee lived) appeared to be going through a trouble-free period.
35. However, the trainee made allegations on three separate occasions he was being bullied. A fourth report, known at Hindley as 'Bullying Alert Reports' was submitted by a prison officer on the day after the trainee's death.
36. I shall consider later in this report the extent to which the trainee was a victim of bullying. However, I should also record that my investigators found that the Governor and staff at Hindley had responded energetically to the Chief Inspector's report. They had initiated, and continued to maintain, both a comprehensive policy and practical monitoring and regulatory arrangements to

deal robustly with bullying. The investigators judged that, although bullying persisted, significant progress had been made.

37. There is also evidence that personal officers tried to form a relationship with the trainee. One says in the wing record, 'I went to introduce myself to the trainee'. Another says, 'I am a bit disappointed with the trainee at the moment.' The many entries in wing records show a good level of care and a wish to get acquainted, and to advise and support the trainee.
38. However, the system works best when a prisoner remains in the same cell. In the trainee's case, this was impossible to achieve. Not only did he move frequently between E wing, F wing and the healthcare centre, each time he moved to a different cell from the one he had previously occupied, with a consequent change of personal officer. Table 1 below shows that during his time at Hindley, the trainee occupied six different cells in F wing, five different cells in E wing, four cells in the healthcare centre (one of them twice, on different occasions) and one cell in the segregation unit.

Date (2005)	From	To
17 March	Court	F1 – 13
18 March	F1 – 13	F2 – 39
24 March	F2 – 39	E1 – 11
10 May	E1 – 11	E2 – 14
15 June	E2 – 14	E2 – 32
4 July	E2 – 32	E2 – 29
13 July	E2 – 29	E1 – 18
13 July	E1 – 18	E2 – 33
16 July	E2 – 33	H1 – 02
19 July	H1 – 02	H1 – 03
27 July	H1 – 03	F2 – 37
30 August	F2 – 37	F2 – 16
1 September	F2 – 16	H1 – 07
3 September	H1 – 07	H1 - 03
11 September	H1 - 03	G1 - 02
11 September	G1 - 02	F1 – 02
15 September	F1 - 02	F1 - 07

Table 1

Figures 1 or 2 following a letter identify the wing's landing. F1 indicates F wing ground level landing and F2 indicates F wing 1st floor landing. 'H' denotes health care centre and 'G' Segregation unit.

39. As a consequence, the trainee would have been unable to form an in-depth relationship with any one personal officer. Indeed, given the number and frequency of his moves, it would have been difficult for him to build solid relationships with either staff or his peers. It would also have been virtually impossible for him to have personalised his own cell with photographs, posters and mementos from family and friends. Nevertheless, as a result of his frequent cell moves, many staff knew the trainee and his moods and habits.

Incentives and earned privileges scheme

40. It is a requirement in all prisons that an Incentives and Earned Privileges scheme is in place. Prisoners are generally allocated to one of three grades: 'basic', 'standard' or 'enhanced'. Typically, when first received into prison, they will be allocated to 'standard' regime. If they perform well and work hard in classes or at work, are deemed good members of the prison community, and if they follow their training plans, they will attain 'enhanced' status. Prisoners will be on 'basic' privileges if they are disruptive, if they behave badly towards their peers and staff, or if they refuse to work. 'Enhanced' may mean more recreation, extra visits, access to better quality and higher paid work and the like. 'Basic' will mean withdrawal of most privileges, often including that of having a television in the cell.
41. Hindley's system follows closely that prescribed by the Prison Service, the single difference being that of terminology. At Hindley, the three tiers of privilege are known as 'bronze', 'silver' and 'gold'. The trainee never reached gold level.

Safeguarding juveniles at Hindley

42. The Safeguards Manager at Hindley, started work at the establishment in April 2004, initially as Child Protection Coordinator. She was interviewed for this investigation in November 2005, at which time she had been Safeguards Manager for about a year. She has a social work background. In November 2004, she took over line management responsibilities for the Suicide Prevention Co-ordinator and for the holder of a newly created post of Violence Reduction Co-ordinator. She estimated that her team received approximately 23 child protection referrals a month (these often overlapped with bullying in the establishment). Child protection referrals came straight to her (or to the duty governor during evenings or weekend). She informed the wing manager, Deputy Governor, local Social Services, local YOT, police liaison officer and family. Whilst she kept a detailed log of events, it was the responsibility of Social Services to investigate.
43. The Safeguards Manager trained staff of all grades and seniority in child protection and adolescence awareness. She also conducted a session for newly-appointed prison officers regarding child protection. She trained the young people too, and issued leaflets explaining how they can make informed decisions.
44. The Safeguards Manager said that the Area Child Protection Committee (ACPC) [now Local Safeguarding Children Board] had approved the procedures at Hindley. They are reviewed every year and would be reviewed in the next few months as a result of changes in legislation.
45. The local Child Protection Committee meets monthly and the Safeguards Manager presents a detailed log of all new cases and what is being done. She

details the outcomes, and demonstrates how the young person has been involved in the process. She said that suicide prevention, anti bullying and child protection should be everyone's concern and that her department should monitor, promote and support management and progress. Although there were some training issues she felt very supported, particularly by the Governor.

46. The Deputy Safeguards Manager told my investigators that the notes of the safeguards meeting in September 2005 identified 325 bully alerts in the year to date. There were 45 in September alone. This was the highest number on Hindley's records. Safeguards training, including violence reduction and anti bullying, was given to all staff who joined for duty at Hindley. Furthermore, notice board presentations were often put at staff briefing points and on wings. Roadshows were held. The Deputy Safeguards Manager had also produced a 'Safeguards' booklet which outlined staff responsibility and procedures for various safeguards issues e.g. how to complete a Bully Alert Form. (These are in the staff information rooms.) He felt that, by and large, staff knew how to respond to bullying, and they knew the procedures. If he had any criticism, he felt wing staff could be more proactive in challenging bullying behaviour at the time of its occurrence.

YOUTH JUSTICE BOARD: SERVICE LEVEL AGREEMENT AND MONITORING ARRANGEMENTS

47. The YJB Chief Executive and the Director General of HM Prison Service are jointly responsible for agreeing the Service Level Agreement (SLA) between the Board and the Service.
48. The YJB sets out annual performance indicators for its facilities within the secure estate. These relate to standards of regimes, and include minimum time out of rooms for young people and their involvement in education and training. The standards include key measures relating to safety and ensuring that appropriate information is accessed. Assessments for vulnerability and substance misuse must be made when a young person is first received into custody
49. The Youth Justice Board's Effective Regimes Monitoring Framework is designed to focus performance monitoring on the individual treatment and care of young people, based around each stage of the custodial process. The monitoring programme, and the intensity of the monitoring of individual establishments, are intended to be risk and intelligence led in the sense that judgements will be made by performance monitors appointed by the YJB at each facility. The monitor will decide which performance indicators are to be monitored and the depth of examination that is required. This monitoring is designed to provide the YJB with the ability to monitor regularly and intensively any establishments indicating high risk or under-performing. The overall aim of the framework is to ensure that performance monitoring contributes effectively to continuous and measurable performance improvement across the secure estate.
50. According to the YJB Regional Manager:

‘As with other secure establishments Hindley is subject to monthly monitoring visits and reporting via the Effective Regimes Monitoring Framework. The Performance Monitor for this establishment spent three days there during August 2005 in order to develop her knowledge of the establishment and working practices. Her monitoring report covering this period indicates an ‘amber’ (on a ‘traffic’ light system) rating for safety, order and control and regime delivery.’
51. From January 2005 until the time of the trainee's death in September 2005, the monitor completed five Effective Regimes Monitoring Framework forms (covering visits made in January, February, March and two in August). In addition to those reports, there was an undated summary report covering April to September and a report dated 10 May covering Education Attainment.
52. The Effective Regimes Monitoring Framework gathers information and highlights areas of concern for management information and action. Should an area be of grave concern, it is highlighted in red in the report and the matter is discussed by the Regional Manager, Performance Monitor and senior management at the Young Offender Institution to agree a way forward. If the

concern is ongoing, the matter should be escalated in importance in accordance with the Service Level Agreement.

53. It is important to identify the extent to which the Youth Justice Board (YJB) monitors the SLA with Hindley. I reproduce below the perspective of the YJB monitor, as described in interview with my investigators.
54. The YJB monitor said that Hindley deals with high levels of juvenile vulnerability and a high incidence of mental health problems. Bullying was at a high level, but positive action was being taken by the Governor and her staff. The prison provided substance misuse course work, but no programmes for anger management or offending behaviour and, in the view of the YJB monitor, almost always operated on minimum staffing levels on the wings.
55. Important documentation often did not accompany juveniles when they arrived at Hindley. The principal document is known as ASSET. This is a structured assessment tool used by Youth Offending Teams throughout England on all young offenders. ASSET looks at the factors which may have contributed to the young person's offences and highlights any particular needs or difficulties that the young person has. ASSET is also the main document which addresses issues of risk. At Hindley, all trainees arriving from court without an ASSET were treated as though they were vulnerable to suicide or self-harm and a suicide and self-harm document was raised. Also, as a precaution, juveniles whose documents did not arrive with them would be located in a single cell as their risk to others could not be fully assessed. There were times when this lack of information was an internal issue. On such occasions, the information had been faxed through to the prison after 'office hours', but had not made its way from the fax machine to the wing. In the main, however, the problem arose because documents were not sent from court. The YJB monitor was pursuing this with YOT managers.

Staff receiving and assessing young people at Hindley should liaise with all relevant agencies in order to ensure that vital information arrives at the prison on the day the young people are received into custody.

56. The YJB monitor said there were problems over good order with some of the young people. She particularly mentioned healthcare, where she thought they would benefit from having discipline staff on duty at weekends.
57. The YJB monitor felt that the safeguarding systems were excellent, and largely followed. There had, however, been many management changes, which was unsettling. As a means of strengthening the prison's team at senior level, a governor had been newly appointed as head of young people. The YJB monitor described him as firm but full of ideas, and felt she could work well with him and the deputy head of young people. The YJB monitor said that communication between her and the prison team was good.
58. The YJB monitor said she generally visited Hindley monthly, and following these visits she wrote a report for the YJB and the Governor. (I note, however, that between January and September 2005 Effective Regimes Monitoring forms

were completed only for the months of January, February, March and August.) The report required a response from Hindley. The YJB monitor also examined wider issues and got involved in individual cases, where she felt she could advise or offer support. She visited the Care and Separation Unit [segregation unit] if a young person was located there, but Hindley rarely used the unit to hold such prisoners. The YJB monitor felt she had good access to the Governor if she felt she needed it, and could speak openly and would get an honest and helpful response. If for any reason she could not attend for a visit, a colleague from the YJB visited in her stead.

59. In August 2005, the YJB monitor conducted a three-day audit and assessed the Safety, Order and Control and Regime Delivery as 'Amber', on a 'traffic light' system. She noted some good work, but was concerned particularly about bullying. In October 2005, she noted, 'Bullying remains at a level of concern despite the introduction of targeted measures to reduce incidents.' She added, 'Bullying remains a feature. Despite decline of incidents in E wing, which is subject to partial closure, incidents on F wing have increased. Stringent monitoring is highlighting hotspots and key perpetrators.'
60. My investigators asked the YJB monitor for her opinion of the use of cells known as 'cool down' rooms, where juveniles might be taken for a short period to allow them to settle following an outburst. She said that the YJB had no rules on their usage. It was thought of as 'time out' rather than segregation, but there was no formal classification. She also said that records had not formerly been kept of the occasions when the rooms were used, but this had changed and a report was now made each time a young person was held in one. The rooms did not have CCTV but were to be so equipped in the near future. Generally, young people were not in the cells for long: usually only half an hour, though they could be held for two hours. The YJB monitor did not feel the cool down cells were over-used. I have been unable to discover under what rule the rooms are legitimised.

Use of so-called 'cool-down rooms' should be legitimised or discontinued. At present, they appear to have no legitimacy under either Prison Rules or within the Service Level Agreement between Hindley and the YJB

61. The YJB monitor felt relationships between staff and trainees at Hindley were good, although there were one or two 'old school' officers. She felt that there was ample evidence of effective communication and intervention. So far as her own duties were concerned, she frequently had to attend the prison for several days at a time, owing to the workload. She felt that there was more than enough work at the prison to justify a full-time monitor. I agree.

Bullying, Gangs and Self-Harm

62. The regime reports repeatedly pick up on gang-related bullying, and link it to a high level of self harm at Hindley. Despite this, neither gangs nor bullying are mentioned in the YJB Regional Manager Summary from April 2005.

63. In her Effective Regimes Monitoring report from late August, the YJB monitor records:

‘Bullying remains a feature in Child Protection reports. It was evident through discussion on the wings with young people that the fear of bullying remains high. A concerted effort to tackle bullying is on-going with managers taking a harder stance on punishment of identified bullies. The number of assaults has risen significantly this month.’

64. This matter is again raised in the YJB monitor’s Effective Regimes Monitoring report for October, the month following the trainee’s death:

‘Bullying remains at a level of concern despite introduction of targeted measures to reduce incidents.

‘Bullying remains a feature. Despite decline in incidents on E wing which is subject to partial closure, incidents on F wing have increased. Stringent monitoring is highlighting hotspots and key perpetrators.’

65. In the months before the trainee’s death, there is no record that the issues of bullying, gangs or self-harm were brought to the attention of the YJB service delivery team who manage the SLA, or were subject to joint discussion between the YJB and the Prison Service. It is also of note that, prior to the trainee’s death in September, the YJB service delivery team had seen only the Effective Regimes Monitoring reports for March and August.

Staffing levels

66. The Youth Justice Board does not set minimum staffing levels but the operational specification says:

‘Governors shall insist that there are sufficient numbers of experienced, trained and qualified staff in order to develop the regime requirements. The monitor should raise with the establishment, in accordance with the escalation procedure at section 13 of the service level agreement, any fears that young people may be at risk through inadequate staffing levels.’

67. In November 2005, the YJB set out in its strategy for children and young people within the secure estate:

‘The Youth Justice Board believes that all institutions within the secure estate for children and young people should ... be run by staff committed to working with children and young people, who are adequately trained in this work ...’

68. Elsewhere in the document, the YJB proposes working closely with the Prison Service, ‘in particular, to reduce the numbers held on split sites.’ The SLA at section 4.3.2 also requires that governors, ‘endeavour to ensure that Juvenile Awareness Staff Programme (JASP) trained staff are detailed onto accommodation for juveniles only.’ The commitment of the YJB to a juvenile

focussed workforce is clear, but there are no current measures to ensure that all staff, including those working in healthcare and education, work solely with juveniles. Neither the YJB nor the Prison Service requires that staff who work on split sites (young offenders and juveniles) should work with the juveniles alone. In theory, staff working with juveniles could be interchangeable with those in the young offender wings.

Offending Behaviour Programmes

69. According to the YJB Key Element of Effective Practice (KEEP) guidance document for offending behaviour programmes:

‘Offending Behaviour Programmes are designed to have an impact on reducing re-offending by young people. Some programmes do this by directly focussing on offences themselves so young people can think about the offences they have committed and attempt to change factors associated with the offending.’

70. The YJB national standards for youth justice services (2004) require:

‘Appropriate offending behaviour programmes should be provided for all convicted young offenders in secure establishments.’

‘Offending behaviour work should constitute part of the individual training plan.’

71. For the financial year 2005-2006, the Youth Justice Board withdrew funding for Offending Behaviour Programmes at Hindley. However, the operational specification in the SLA requires that offence related work is delivered where there is an assessed need. Hindley continues to run offence related programmes, notable examples being in drug awareness, citizenship and anger management.

Assessment

72. An ASSET (the structured assessment tool used by Youth Offending Teams) was completed for the trainee in December 2004. YOTs complete ASSETs on all young offenders who come into contact with the criminal justice system. The process looks at the young person’s offence or offences and identifies factors or circumstances, ranging from lack of educational attainment to mental health problems, which have contributed to their behaviour. The information gathered from an ASSET can be used to inform court reports so that appropriate intervention programmes can be recommended. The information will also highlight particular needs or difficulties a young person has in order that these may be addressed.
73. According to the YJB guidance for remand management in young offender institutions, ‘Working practice guidance for YOI remand services (December 2003):

'The remand worker should review the information provided on ASSET and the Post Court Report (PCR) to develop an assessment of the remandee's needs and issues and the objections to bail - the vulnerability sections are of particular importance at this early stage. This information should be used to inform discussion with the remandee.'

'If an ASSET is not received, the remand worker must contact the home YOT to request that one is prepared and sent. Information on ASSET receipt should be recorded and included in quarterly feedback to the regional manager.'

74. According to YJB national standards, the trainee's ASSET should have been updated prior to his remand, again following his sentence and revisited as a result of any significant event. In their local management report, North Manchester YOT say:

'In relation to the YOT case files there are some shortfalls in that there are some recording issues. The trainee's Detention and Training Order ASSETs are missing (following conviction), although one was completed the day before sentence and the previous four ASSETs are virtually the same.'

75. The investigation team was not able to see the trainee's Detention and Training Order ASSET. It was not available in his file at Hindley and, therefore, could not have informed his remand or sentence planning.

Remand Planning

76. The YJB outlines guidance for YOTs in respect of remand management planning within the KEEP (Key Elements of Effective Practice) documents and other relevant training materials. However, the YJB is aware that many YOTs are unable to prioritise remand management and provision varies widely. Within their annual youth justice plan, YOTs outline to the YJB the focus that their local authority intends to give to remand management services.
77. I understand that Hindley has a service level agreement with Wigan YOT and that a YOT worker is seconded to assist in the remand management of young people. However, my investigators were unable to access a copy of the agreement as the YOT remand worker had not seen the document. This led to a general lack of clarity in the requirements of the role. The YOT remand worker said that he spent a lot of time at case conferences which could be complex and time-consuming, taking him away from what he considered to be his core business, remand planning.
78. The national standard for youth justice services (2004) stipulates that a remand planning meeting should be organised within five days of young people being remanded into custody. It is expected that either a YOT officer from the supervising team or an officer seconded to the establishment should attend the meeting. The YOT remand worker recalled that he undertook an initial interview with the trainee the day after his arrival. (This is standard procedure.) He could not recall details of the meeting, but outlined that in such interviews

he confirms routinely with a young person what has happened in court and why he has been remanded into custody. He then establishes their bail address and notes details of family and expected contact.

79. Before the first formal remand planning meeting takes place, YJB national standard 2.57 says:
- ‘YOT and secure establishment staff must collate detailed information from all relevant sources, including the remandee and his family, about the young person’s health, welfare, education, current circumstances and risk to self and others. The planning meeting must be informed by an ASSET’.
80. The planning meeting should determine whether a programme could be offered in support of a bail application at the next court appearance, and prepare a remand plan setting out what programme of work will be offered by the establishment and the YOT during the remand period.
81. The trainee who died was at Hindley on remand from 17 March 2005 until the date of his first sentence hearing on 6 July 2005. The YOT remand worker’s records showed that he conducted a remand meeting, within the timescale laid down, on 24 March. A further meeting was programmed for 21 April. That meeting was postponed as the YOT remand worker attended a training course that day. The meeting was held eventually on 19 May. A worker from Manchester YOT attended along with the trainee and the YOT remand worker. A further meeting on 16 June.
82. The YOT remand worker recalled that initially the trainee’s behaviour was not very good, and he had reminded him that behaviour is often commented upon in a pre-sentence report and can have some bearing on any eventual sentence. He said that he considered the trainee to be eligible for an Intensive Supervision and Surveillance Programme (ISSP), and that his view was shared by Manchester YOT. He reflected his view in the pre-sentence report he completed following the June planning meeting.
83. According to the YJB guidance for remand management in young offenders’ establishments, Working practice guidance for remand services, December 2003, ‘The (YOT) remand worker should seek to involve the personal officer who should, where possible, attend the remand meeting.’ Other people who may be involved in planning review meetings include: YOI (prison) representatives, other prison staff involved in providing services, eg (drugs workers, career advisors, family/carer, Connexions worker. The meetings should be organised by the remand (prison) service, although the YOT might be better placed to encourage family attendance.
84. The YJB strategy for the secure estate for children and young people (November 2005) states clearly a commitment to the principle of ‘end-to-end’ sentence planning:

‘Remand planning cannot occur in isolation from prison service staff because the remand plan must be reflected in the daily activities for that young person.’

85. Wing or education staff should be present at remand planning meetings to ensure that the plan can be effectively delivered. For example, anger management was identified as a key area for the trainee, yet there is no evidence that he undertook any work in this area.
86. The YOT remand worker estimated that personal officers are present at just one per cent of remand planning meetings. There is no record of any Prison Service staff attending the trainee’s remand planning meetings.

Sentence and training planning meetings

87. According to YJB national standard 11.4, a sentence planning meeting must be convened within 10 working days of sentence. On 19 July, nine days after the trainee was sentenced, a meeting was held between him and a worker on secondment to Hindley from Manchester YOT. The YOT secondee’s role is to co-ordinate sentence planning for young people who are sentenced to Detention and Training Orders. He and the trainee were the only people at the meeting. Although invited, the trainee’s family could not attend.
88. The same national standard provides: ‘Secure Establishment staff must deliver the training plan with the active support of the supervising officer from the YOT.’ My investigators were unable to establish why key members did not attend the meeting. I understand that there is no formal mechanism for feeding back to the YJB the results of either remand or sentence planning meetings and therefore no way to monitor attendance.
89. The YOT secondee said he was unclear about the role he was required to perform at Hindley. He was frustrated at the lack of co-ordination between seconded YOT staff and prison staff. He said that he was often required to chair decision boards, rather than being allowed to do what he considered core Detention and Training Order planning business. The YOT secondee felt that the contribution of personal officers was key to ensuring the effective delivery of a sentence plan and he echoed the YOT remand worker’s concerns that they did not attend planning meetings.

Personal Officer Scheme at Hindley

90. The service level agreement between the YJB and the Prison Service, 2005-2008, sets out the role of the personal officer/caseworker in the Operational specification. It includes:

‘The assigned individual must keep in contact with the YOT supervising officer, and will be the point of contact within the establishment for outside agencies and families in relation to the young person.’

‘... ensure the following is achieved ... that each young person’s sentence plan is formally reviewed...’

‘The personal officer/caseworker should act as a ‘significant adult’ and role model to young people and should work proactively with young people who are choosing not to engage in the regime.’

91. These requirements are also reflected in PSO 4950 and in YJB national standards for youth justice services (2004). The requirements demand a proactive approach to the role of personal officer:

‘The personal officer should actively seek the engagement of the young person in the prison regime and oversee the effective function of the sentence planning process.’

92. The service level agreement also states that:

‘The personal officer should fulfil the role of a significant adult or role model to the young person. If a young person had the same personal officer allocated to him for the entirety of his remand period/sentence, there would be an opportunity to establish a stronger relationship between the personal officer and young person. This may enable the personal officer to determine more easily if the young person’s behaviour has altered in any way and take appropriate measures to ensure his wellbeing.’

93. The experience of the YOT workers at Hindley suggests that this is not happening, at least not in the important area of remand and sentence planning and management. If personal officers were to attend planning meetings, they would provide the essential link between the planning process and the effective delivery of the remand/sentence plan.

94. In her report of 12 August, the YJB monitor notes: ‘Efforts to improve attendance of personal officers at Sentence Planning Meetings should be maintained in order to achieve 100% compliance.’ She records that efforts to achieve this target have been made and personal officer attendance at sentence planning meeting has improved, but that it should be explored further on the next site visit. Her next monitoring report, written following her visit of 23-26 August, does not mention this issue.

Availability of documents to staff making assessments of young people on reception

95. The YOT is responsible for ensuring that the secure establishment receives a core ASSET, a pre-sentence report (where relevant), and post-court report, within one working day of a sentenced young person leaving court (national standard 11.2), or as soon as possible when a young person is remanded into custody (national standard 2.53). If a secure establishment requests missing documentation, this should be provided within one working day of the YOT receiving the request. If there are specific risk factors associated with the young person, they should be communicated immediately.

96. The YJB has put into place an email system, known as 'NoDocs', intended to track and monitor requests for missing documentation. The intention is that if a young person arrives without documentation, the establishment must alert the YOT using the 'NoDocs' email system.
97. According to YJB's national standards for youth justice services (2004), paragraph 10.11, secure establishments who do not receive the relevant documentation on the reception of the young person should contact the YOT within one hour and treat the young person as vulnerable until the documents are received. If the documents are not received within 24 hours, the YJB regional team should be notified, presumably (although this is not explicitly stated) via the 'NoDocs' email system. Standard 10.13 requires that all young people must be assessed for risk of self-harm and suicide on arrival.
98. The YJB monitor outlined the approach that Hindley takes when a young person arrives without documentation. The establishment immediately contacts the home YOT (i.e. the team from the area in which the young person normally resides). Hindley asks for the relevant documentation to be faxed without delay. A member of staff will email the 'NoDocs' system after 24 hours if the young person's documentation has still not been received.
99. The YJB monitor is notified once an email has been sent to the 'NoDocs' account. She notifies the YOT and investigates where the transfer of information has broken down - whether at the YOT, court, or escort service - or if the documents have been received but misplaced at Hindley. She contacts the relevant agency to ensure, as far as possible, that the documents are sent without further delay.
100. Hindley's Deputy Suicide Prevention Co-ordinator, said that in the month of August, 22 young people arrived without documentation. This led to a F2052SH file being opened on all of them. (As noted, in accordance with national standards, these young people had to be treated as being at risk of self harm pending determination which could only be made once documentation was complete.) The Youth Justice Board's 'NoDocs' Report (December 2004 – September 2005) records that only seven emails were sent to the NoDocs email account from Hindley in August. In light of the above, it can be concluded that the documentation was received within 24 hours in the cases of 15 of the 22 young people who arrived without documentation. Even so, the work required to secure what should be there when a young person arrives, not to mention the added pressures on trying to keep safe those young people at risk, places an unnecessary burden on prison staff. Moreover, there is a risk that the quality of the work will be diluted as staff know that some young people are subject to suicide and self harm procedures for no other reason than that their documents are not to hand.

Hindley should undertake an analysis of where transfer of documents has broken down and develop protocols to strengthen the system.

Manchester YOT should review their process for transmission of documents, and develop an audit system to ensure compliance with national standards

The YJB should review the 'NoDocs' system to ensure that it makes an effective contribution to procedures for transferring assessment information between the community and the secure estate.

The YJB should clarify the procedures in relation to a young person arriving at a unit without all of the relevant paperwork.

PRISON SERVICE NATIONAL STANDARDS AND APPLICATION IN THE CASE OF THE TRAINEE WHO DIED

Parental involvement

101. Prison Service Order 4950, 'Regimes for prisoners under 18 years old', is especially significant in the trainee's case. Paragraph 5.43 states:

'Governors must make arrangements, having regard to the YJB's KEEP processes, which promote the positive contact and involvement of the families of the young people where appropriate, particularly in the sentence planning process, and ensure that relevant information is passed to families or other appropriate adult on each of the following occasions:

- on first reception
- at the conclusion of the initial sentence planning process
- after each important review
- prior to release within the purpose of encouraging their contribution
- other significant events such as illness, self harm or transfer.'

102. However, the trainee's parents took no part in his sentence planning. My investigators saw one document in respect of the first meeting, which said they were unable to attend. Hindley did not subsequently notify the trainee's family of their concern about his self-harming or of his violent and deteriorating behaviour.

National standards for prisoners at risk of suicide and self-harm and how they were applied in the trainee's case

103. Suicide and self-harm provisions are directed by Prison Service Order 2700. Chapter 1 says safety is a shared responsibility for all who live and work in prison. Chapter 2 identifies the vulnerability of and procedures for prisoners during their early days in custody. Chapters 3 and 4 concern the actions to be taken following incidents of self harm, and the management of prisoners identified at risk of self harm.

104. Chapter 4 paragraph 4.2.1 says:

'The case review for each prisoner on an open F2052SH must decide on the level of supervision required and must specify this in the support plan, including:

- the level of observation for those prisoners in single cells
- the level of observation for those prisoners in shared accommodation at times when they are left alone
- whether the prisoner requires intermittent supervision. This [intermittent supervision] can only be authorised by a doctor or nurse (in consultation with the duty governor) or the duty governor (in consultation with a doctor or a nurse).'

105. The trainee's reviews were held on time and they were thorough. However, they did not set minimum observation levels
106. PSO 2700 also says that supervision should be proactive and dynamic, engaging those subject to F2052SH in conversation rather than just observing their behaviour. On the whole this was a satisfactory feature of care at Hindley. A Senior Officer counselled the trainee, as did a nurse. Another Senior Officer spent time with him and it is obvious all three members of staff knew the trainee well.
107. Annex B of PSO 2700 also deals with fundamental procedures. It stipulates that anyone noting changes in mood or behaviour must: 'Report any further observations (including at night) and contacts with the prisoner and subsequent follow up action in the daily supervision and support record, including any change in mood or behaviour ... Bring any concerns to the attention of the manager of the unit where the prisoner resides.' This was done by nurses, wing staff and night patrols on each occasion the trainee either harmed himself or threatened that he would.

Guidelines for doctors working in prisons

108. There are specific guidelines for doctors working in prisons. Prison Service Instruction 5/2003 introduced a Department of Health (DH) publication, Good Medical Practice for Doctors Providing Primary Care Services in Prison, (January 2003). The publication is a comprehensive guide for doctors working in prisons as full-time or part time practitioners.
109. I list here some extracts from the Department of Health publication:
 - the term 'doctors providing primary care services in prison' covers clinical generalists in secure environments including doctors in the prison medical service, general practitioners visiting prisons, general practitioners with a special interest who work in prisons etc.
 - work with colleagues in the ways that best serve patients' interests.
 - you should undertake appropriate investigations and referral with attention to timing and pacing. Both under-investigation and over-investigation, and under-referral and over-referral, can expose patients to risk.
 - keeping good records of the clinical encounter ... provide[s] the basis for future care and are the main way to share information with other members of the practice team who may be providing care for a patient.
 - records of consultation [are] an indication of a management plan.
 - patient care is enhanced when there is good team working, so you should monitor and, where necessary, try to improve the way in which your practice team functions.
 - additional observations to doctors working in prisons. Doctors working in prison should be aware of the important role they have to play as part of the wider health care teams that reach across the NHS/Prison Service boundary. The development of good working relationships between members of this wider health care team can lead to better patient care.

Medical treatment on the morning of 15 September

110. At interview, the doctor who saw the trainee on 15 September 2005 said he had been a General Practitioner for 20 years. As a partner in a general community practice, he visited Hindley about six times each year. He said he had some knowledge of prison suicide and self-harm procedures. When asked how he interpreted the trainee's comment, 'just watch me tonight' the doctor said it had sounded flippant but since he was not a child psychiatrist he was not confident to judge whether it was flippant or not. The trainee said he would have marked his mental health referral as 'urgent ASAP' had 'more alarm bells been ringing.' However, the doctor had assessed there was no suicidal risk at the time of this consultation and that the trainee was fit to return to the wing. He said he did not give particular thought to the frequency of suicide watch to be applied to the trainee when he left the consultation on the morning of 15 September, as he was aware that the F2052SH regime was still in place for the trainee.
111. The Department of Health booklet makes clear that doctors working in prison, either in a full or part-time capacity, must work closely with all colleagues, and share appropriate information with them.

Using the Department of Health booklet as a template, a comprehensive training plan should be devised for doctors to remind them of their roles and responsibilities of working in prisons.

KEY EVENTS

Events between 17 March 2005 and 30 June 2005

112. The trainee was remanded into custody on 17 March 2005. When he arrived at Hindley, a Healthcare Officer (HCO) examined him as part of a Reception Health Screening. The trainee showed injuries to the knuckles of both hands, which he said had happened on 15 March, volunteering at the same time that the injuries were caused when he punched a wall. The HCO arranged for the trainee to see a doctor the next day. The doctor decided that no further treatment was necessary. Details of the screening and of the doctor's subsequent assessment appear in the trainee's medical record. The trainee was also asked at his reception screening if he might consider harming himself. (This is a standard question on the screening form.) He said that he would not.
113. A Cell Sharing Risk Assessment (CSRA) was completed on the same day. The purpose of this assessment was to establish if the trainee could cope alone in a cell and whether he might pose a risk to another trainee if he were in shared accommodation. In part 2 of the CSRA, the Senior Officer who completed it noted that a 'vulnerability alert' had been received from the YJB. This vulnerability alert, dated 17 March, was part of the Bail Profile, one of the ASSET range of documents. (The Bail Profile is designed to help YOTs provide information to courts when they consider remanding a young person on bail or to a secure facility.) The Bail Profile said that the trainee would be vulnerable as this was his first time in custody. In part 3 of the CSRA, the HCO who carried out the Reception Health Screen marked the risk box 'medium risk' – 'no immediate risk, but situation will need to be reviewed regularly'. The locating officer noted at section 4 of the CSRA (the final part) that the trainee 'appears to have a good positive attitude towards being in prison and would be ok on his own in a single cell.' The trainee was therefore located in a single cell in F wing.
114. On 18 March, the day after his arrival at Hindley, the trainee was interviewed by YOT remand worker seconded to Hindley from Wigan YOT. The trainee said that he understood the reasons for his imprisonment and gave details of family contacts. The YOT remand worker told my investigator that young people are often very anxious when they arrive, and he uses the initial meeting to explain that custody probably will not be as bad as they fear. He arranges a meeting between the young person and his solicitor to discuss the possibility of further bail applications. As a matter of course, he will speak to the home YOT worker following the initial meeting.
115. On 24 March, the trainee told an officer that following evening association on 21 March a prisoner had urinated through his cell door, and that two others had entered his cell at lunchtime and 'thrown his possessions all over his room.' This was the first of three occasions between March and August when the trainee complained of being bullied. The officer raised a form, 'HMP/YOI Hindley Bullying Alert Report', number 110/05. The purpose of the form is to register details of an alleged bullying incident, investigate it, report findings and

action taken by the investigating officer and refer it for the wider consideration of the overall policy and monitoring meetings at Hindley. The form is well-devised. It is a single two-sided sheet. On the front, details are required of the alleged incident, investigation and action. On the reverse is a comprehensive set of notes for the guidance of staff dealing with any part of a bullying incident. A Senior Officer (SO) signed the form and in a brief conclusion wrote, 'the trainee after this incident requested a move to E wing and this happened.' There is no information on the form that the incident was investigated. I can only speculate that the trainee felt a new start, in a different environment, would be the best thing for him. I am unable to say what happened to the alleged bullies, as this is not recorded. The SO did not complete the 'Action Taken' column of the form, which asks for specific information on interview dates and who interviewed the alleged bully.

116. On 15 April, a teacher asked the trainee why he was not regularly attending education. His record (F2052A - a running narrative used by staff to record information of importance) showed that he had been warned by wing staff for not attending education previously on 5, 8 and 11 April. The trainee said that a prisoner, whom he named as the one who had allegedly urinated in his cell on 21 March, had threatened to hit him. The teacher raised a Bullying Alert Report, number 150/05, and submitted it on 15 April. It seems it was not dealt with until 28 April when it was endorsed as being investigated and completed. It is not clear why such a lengthy delay occurred. The violence reduction coordinator investigated and wrote, '[Prisoner's name] has denied all claims at him bullying others. I have advised him about any further action and staff need to maintain supervision.' He recorded, in the 'action' section of the report, that on the same day (28 April) he had interviewed and advised the alleged bully of the behaviour expected of him. The violence reduction co-ordinator signed the form in the space marked 'Unit Manager'.
117. The arrangement for the trainee's education changed so that he could be taught in a small group on the wing and he seemed to progress. His regular teacher reported that he had good relationships with the other young people in the class, and he talked openly with her. She recalled that there was one trainee with whom the trainee who died did not get on well initially, but that their relationship developed over time and they were 'ok' in the end.
118. On 18 April, the trainee's status under the Incentives and Earned Privileges scheme was reduced to bronze, when he again refused to attend education. On this occasion, he said that he 'just didn't want to', but later said that he was being 'hassled' by a trainee whom he refused to name. The reduction to bronze status meant that the trainee was no longer allowed a television in his cell and a restriction was placed on the amount of his own money he could spend each week. Instead of a television, he was allowed a small radio.
119. A review of the trainee's cell-sharing risk assessment was carried out on 20 April. A worker from the Manchester YOT was consulted and a number of documents were considered during this process, including the ASSET and pre-sentence report. It was again concluded that the trainee was medium risk and that he should stay in a single cell.

120. On 23 April, the trainee's privilege status was returned to silver. This was an attempt to encourage him to change his behaviour and a note was made in his record that he was being given 'a chance to prove himself'.
121. On 5 May, a member of Barnardo's staff and a Manchester YOT worker visited the trainee at Hindley. His family did not attend this meeting. I have no information in respect of the purpose of the visit or its outcome.
122. On 18 May, the trainee's privilege status was again reduced to bronze. This followed four warnings over the previous three weeks for disruptive behaviour or not attending education.
123. On 19 May, the trainee attended a Remand Planning meeting, a formal process looking at his background, the present and the future beyond either sentence (should he be convicted of the offences for which he was to face charges) or discharge to the community. The meeting was attended by a worker from Manchester YOT and the YOT remand worker, together with the trainee. Parents are invited to remand planning meetings, but the trainee's family did not attend this meeting (his mother had visited the previous day). At the meeting, the trainee agreed to present a positive attitude towards staff and fellow trainees, and to try to achieve silver privilege status by 25 May. He also agreed to attend education regularly and to maintain contact with his family through visits and telephone calls.
124. On 23 May, an SO conducted a further cell sharing risk assessment. He wrote that he had considered the trainee's alleged offence of robbery, his wing file and violence reduction documents, and concluded that there was no change in risk in relation to cell sharing. The SO assessed the trainee as medium risk and decided he should remain in a single cell.
125. A further Remand Meeting was held on 16 June (the notes of the meeting mistakenly record the date as 16 May). The trainee attended along with those who had attended the earlier meeting, plus a seconded YOT officer from Manchester. It is apparent that many agencies or different sections of the same agency had an interest in the trainee. This may have been inevitable, having regard to his complicated lifestyle but did not help in focusing the trainee's needs on a single YOT or a dedicated worker.

In order to prevent fragmentation of care for young people in prison, the YJB may wish to consider how to ensure that continuity and accountability are established and maintained between all the community agencies who have an interest.

126. The YOT remand worker said that he considered the trainee to be eligible for an Intensive Supervision and Surveillance Programme (ISSP), a sentiment shared by Manchester YOT. This was reflected in the pre-sentence report completed at the June remand planning meeting. The YOT remand worker reminded the trainee that his behaviour gave cause for concern on the prison wing, and from an early stage he had been subject to adjudication (disciplinary

action) for misdemeanours, usually swearing and shouting at staff. He also reminded the trainee that behaviour is often commented upon in a pre-sentence report and could have some bearing on an eventual sentence. The trainee agreed to the same objectives regarding his education and family contact as at the previous meeting. He also agreed to try to regain silver privilege status by 22 June and to avoid any further warnings. He succeeded with this, and was once more returned to silver status on 19 June, after having 'improved in behaviour and attitude'.

Events between 1 July 2005 and 9 September 2005

127. On 1 July, the officer who was the trainee's personal officer at the time, noted in the wing file that he was currently 'a bit disappointed' with him. This was due to the trainee's 'unacceptable' attitude towards other officers and the regime in general. The trainee was warned three times on 4 and 5 July for refusing education and disrupting the class when he attended. He was verbally abusive to another officer, who later issued one of the warnings.
128. On 6 July, at Crown Court, the trainee was sentenced to 18 months custody under a Detention and Training Order (DTO) for an offence of robbery. On 8 July, at Manchester Youth Court, the trainee was sentenced to four months DTO for an offence of affray, to run consecutively to his earlier sentence. On his return from court to Hindley, an officer reviewed the trainee's cell sharing risk assessment (CSRA). The reason for the review is given as 'sentenced to 18 months DTO – states ok'. The 'medium' risk box is ticked.
129. There is no record of anyone discussing further the implications of this sentence with the trainee or his feelings about it. Given the YOT remand worker's opinion that the trainee was suitable for ISSP, it is possible that he was not expecting a custodial sentence and one with a nominal length of 22 months might have come as a considerable shock. It is also possible that the officer who completed the CSRA discussed this with the trainee and his comment 'Seems ok' summarised a discussion. Nevertheless, in the absence of full comments, I cannot conclude that the trainee was asked in detail about his reactions to the sentence.

Young people should be interviewed in depth when they return from court, particularly where their status and circumstances have changed.

130. On 6 July and again on 8 July, entries in the trainee's medical record in the section marked 'Further Reception Health Checks', read 'fit and well' on each occasion. However, his behaviour continued to deteriorate and give cause for concern. On 7 July, he was warned twice for refusing education, and on 9 July he was warned again for the same reason. He was warned additionally for being in the cell of another trainee.
131. At about 10.50pm on 12 July, the trainee smashed his toilet. Earlier that day he had been warned for refusing education and had been reduced to bronze privilege status on account of what was described in his wing file as 'appalling behaviour'. Incident reports in the same file show that the trainee was taken to

a 'cooling down' cell at about 12.45am on 13 July. Although staff were prepared to take the trainee under physical restraint and applied handcuffs, he offered no resistance once they had entered his cell. He walked to the 'cool down' cell where he was examined by an HCO who noted small cuts to his hands, sustained when the trainee smashed his toilet. The injuries required no treatment. The trainee was charged under the Prison Rules and on 15 July the Governor heard the charge. The trainee said he had smashed his toilet as he was upset at the death of his grandmother and that he was sorry. His wing report, provided for the hearing, was poor and referred to 'numerous warnings'. The punishment was a five-day loss of privileges, mainly in respect of association and classes. The Governor suspended the punishment for one month. This meant that, if the trainee committed no further offences within the month, the punishment would not be activated.

132. At about 9.55pm that evening, the trainee rang his cell bell. An officer visited the cell and saw that he had made a noose from a bed sheet. He had also cut his arms using a piece of porcelain. The same HCO who had seen the trainee in the early hours of the morning again attended to him. The trainee repeated that his 92 year-old grandmother had died two days earlier, that he had initially felt angry and was now low in mood. He was tearful and also fed up with being teased. The officer opened a suicide and self harm form, F2052SH. This was the first of three occasions when F2052SH forms were opened as a result of concerns about the trainee's perceived risk of suicide or self-harm.
133. The HCO made an urgent referral to the chaplaincy and mental health team and he noted the document to this effect. In the section of the F2052SH which asks 'What do you think would help the prisoner?' the officer wrote, 'Treatment to injuries, close watch overnight, follow up from chaplaincy team in the morning.' The F2052SH was passed to the deputy suicide prevention co-ordinator to complete the section entitled 'Initial action by residential unit manager'. She decided that it was appropriate to manage the trainee on the wing. She wrote that the chaplain would see him as soon as possible and that wing staff should also offer support. The deputy suicide prevention co-ordinator completed the form at 10.30pm. There is no record of instructions in respect of frequency of checks to be made on the trainee, other than the officer's initial assessment of 'Close watch overnight.' At 11.30pm, the trainee asked if he could be moved off the wing. The record does not show that he gave specific reasons. In the event, he was taken to the healthcare centre soon after midnight.
134. On the morning of 16 July, the trainee saw a doctor and again said that his grandmother had died. He was admitted as a patient to Hindley's healthcare centre. Staff writing at different times in the ongoing record of the F2052SH, noted: 'in good humour', 'went on exercise', 'mood appears stable', 'chatting freely with staff', 'saw chaplaincy and said that helped him considerably'. Next day (17 July) passed without incident, but about midnight the trainee rang his cell bell and an HCO answered. He noted, 'can't stop thinking about his nana, making him want to kill himself.' He talked to the trainee for about 20 minutes and recorded 'seems settled.'

135. On the morning of 18 July, the trainee saw the doctor who recorded that he was 'feeling low again but no active self harm ideation present.' The doctor noted that the trainee was to see the mental health team and was now fit for ordinary location.
136. The same morning a Registered Mental Nurse (RMN) met the trainee and conducted a mental health assessment. The trainee said that he was hearing male voices telling him to hurt himself, and had done so for a few years. He said that in the past he had hurt someone as the voices had told him to 'Kick his head in'. The trainee described himself as paranoid. He said he had harmed himself many times both in prison and outside. He said again that his grandmother had died recently. The nurse noted in the trainee's medical record that he told her he was, 'Sleeping and eating ok. Hallucinations would appear to coincide with cannabis use on the outside, but unclear as he describes this becoming worse.' The trainee said that he was being bullied on the wings. He was reluctant to give names as he said 'nothing gets done.' The nurse noted a two-point action plan:
- to see psychologist within the next two weeks
 - to continue support from the mental health team.
137. The nurse wrote in the trainee's medical record that she, 'Spoke to the outside YOTS who will be sending more information about the trainee, also to speak with visiting psychologist re whether she feels further input with her is appropriate.' The nurse noted in his F2052H review form that the trainee said he wanted to go to Lancaster Farms (another YOI). She advised him to complete a transfer application. My investigators have found no evidence that the trainee made an application for a transfer, although from time to time he made routine applications in respect of other matters.
138. In accordance with the requirements of the F2052SH process, a review meeting was held during the afternoon of 18 July. The trainee attended, as did the chaplain, the RMN who had conducted the earlier mental health assessment, and another nurse. The trainee told the meeting that he did not want to return to F wing where he was being bullied. He said he was still upset about his grandmother's death. He had been to the chapel and said prayers. The review concluded that the F2052SH should remain open, that the trainee should receive continued support from the mental health team, and should attend the chapel. There are no comments as to the frequency of observation for the trainee.
139. Prison Service Order 2700 identifies, at Section 4.2, that each case review must decide on the level of supervision and specify this in the support plan. At Hindley, rather than specify the level of supervision in each prisoner's support plan, it is customary to stick a white label on the front of each F2052SH. The label reads: 'Level of Supervision. This prisoner must be observed a minimum of once during the morning, afternoon and evening period and once every two hours during the night unless more frequent level of supervision is detailed in the Care Plan.'

140. Thus, instead of identifying intervals in each plan, the prison uses a blanket approach unless the narrative of the form provides for more frequent supervision. Page 3 of the F2052SH is headed 'Record of Case Review.' This page is adequate and, although it has a section marked 'Support Plan', it does not require the reviewers to make a specific direction in respect of frequency of supervision.

Review teams must follow the instructions in Section 4.2 of Prison Service Order 2700 by determining and recording, on each occasion a review is held, the frequency of supervision required for those subject to suicide and self harm monitoring procedures.

141. On 18 July, a formal meeting, known as a DTO meeting (held when a prisoner is convicted and sentenced), was held. It was chaired by a YOT worker seconded to Hindley. The YOT worker told my investigator that he is one of a team of three YOT workers whose role is to deliver offending behaviour programmes for juvenile prisoners. He said in practice, however, the YOT officers are largely used for chairing decision boards, training plan meetings and conducting risk assessments. The YOT worker felt that there was no support for offending behaviour programmes, and said that none had taken place for some time. Funding was withdrawn by the YJB but, although formal accredited programmes are no longer in place, some work is done with young people in respect of offending behaviour.
142. Although an 'establishment representative', ideally the trainee's personal officer, together with the trainee's 'outside' YOT member were designated to attend the meeting, only the YOT secondee and the trainee were present. They were assisted by written reports from a tutor on substance misuse programmes and by a six-page report completed by the trainee's personal officer.

The Governor should ensure that planning and case meetings have the highest possible multi-disciplinary attendance from inside and outside the prison. Families should be involved where possible in such meetings.

143. The tutor reported good progress in the two courses the trainee was attending: alcohol awareness and cannabis awareness. This did not represent an 'offending behaviour programme' in the sense described by the YOT secondee, but it showed that he was attending, and doing well in, the courses he had started. However, his personal officer's report described the trainee's behaviour as 'pretty appalling' and identified that he was on bronze privileges. His personal officer said that the trainee had been the subject of reports for breaking furniture and fittings in his cell and did not listen to advice. He recommended that he should attend full time education and that he should enrol for offending behaviour programmes in Anger Management and Consideration of Crime and Consequence. A first review date of the training plan was set for 14 November.

144. The trainee mentioned during the meeting that he was being threatened by a group of juvenile prisoners who were part of a gang outside prison. He said possessions had been stolen from his cell. He said he was a member of a particular gang and those who had stolen from him were members of a rival gang. The YOT secondee submitted a security information report.
145. As a result of the security incident report the trainee's wing senior officer raised a 'Bullying Alert Form', number 267/05. This was the third time a form had been raised and investigated. The form does not carry the date when it was raised, but the SO investigated the trainee's allegation, came to a conclusion and signed the form as completed on 24 July. The SO concluded that, although the alleged bullies were well-known and currently on Hindley's anti-bullying programme, it was unlikely they had bullied the trainee on this occasion as he had spent the previous week in the healthcare centre. The 'findings' section of the form reads, 'The trainee has been on healthcare for over one week after a self-harm incident. He had not been on Spruce Unit for a number of months which puts the cell theft by these two as unlikely. These two are well-known by staff as bullies already on bully form.' I am unable to say whether the SO interviewed the alleged bullies as he left uncompleted the 'action' part of the form.

Staff should be advised, and quality checks should be made, on the completeness and appropriateness of documentation and action in respect of incidents dealt with through Bullying Alert Forms.

146. On 19 July, a note in the trainee's medical record reads, 'To remain on HCC (healthcare centre) until s/b (seen by) psychiatrist. No change to given care.' On 20 July a GP in a local practice contracted to provide medical services to Hindley, saw the trainee as part of the F2052SH review process. The doctor made an entry in the F2052SH: 'Fit O.L. Due to see psychiatrist Monday'. There is no entry in the medical record to support this and an entry written in this way does not constitute a referral. The clinical reviewer told my investigator she thought that healthcare staff may have mistaken 'psychiatrist' for 'psychologist' as the trainee saw a psychologist two days later, as per the referral made by the RMN on 18 July. The doctor may merely have noted what the nurse had recorded on 19 July. This can be no more than speculation.
147. The following day (21 July) staff made notes in the trainee's wing history sheet and in the daily supervision and support record of the F2052SH. These record that he was boisterous when at education. They note also that, 'he is fit to return to the wing but there is no space on the wing.' The notes do not show that anyone asked the trainee how he felt about returning to either E or F wings.
148. The visiting psychologist saw the trainee on 22 July. She saw him on two further occasions (29 July and 12 August). The trainee told her during his consultation on 22 July that he had heard voices from a very early age telling him to kill himself. He said the voices also told him to destroy property, every two or three days. The trainee also said he thought he had seen a psychiatrist in the past. He was aware that people might think he was making it all up, but

he definitely heard a male voice which was not his own. He said that he could deflect the voice when he was outside prison but not inside. He said he had thoughts of self-harm and threatened that he would kill himself if he was returned to the wing, owing to mental health problems and gang related threats. The psychologist wrote in a conclusion to her assessment, 'No evidence of abnormal perceptions during interview. The trainee's account of the voice he hears is not particularly convincing. He appears open to the idea of learning to cope with the voice/his worries at night time. Did not request medication. Will arrange to see next week.'

149. Over the following few days, healthcare centre staff comment that, 'The trainee has a very poor attitude and is only just about compliant. He is adamant he will not return to the wing.' Most of the comments in the record relate to the trainee's compliance with the healthcare regime and to very little else. His family visited him on 24 July.
150. The trainee's behaviour continued to deteriorate. On 25 July, his record shows that he used abusive language to a teacher during a class in the healthcare centre. This led to a disciplinary hearing conducted by a governor. The trainee admitted the charge and said he was 'in a mood', as normally he was allowed to listen to music in class but, on the occasion which led to the abusive language, this was not allowed. He apologised for his language.
151. Later the same day, the trainee attended a review of his F2052SH along with the RMN who had attended his previous review, another nurse, a probation officer and a chaplain. The trainee was adamant that he did not want to return to the wing, as another young person was going to 'get him'. He would not tell staff who this young person was. The review team decided that the trainee should continue with education and that he should again receive help from the mental health team. Significantly, they decided that he should return to normal location when space became available and that he should contact the deputy head of young people about a possible transfer to Lancaster Farms.
152. The following day (26 July), the trainee refused to return to E wing. This led to a further adjudication being opened and adjourned so that the officer who had reported the trainee could be present. In the event, the hearing was not pursued. Seven weeks later, on 3 September, a governor wrote the charge off, as it had not been 'reopened in reasonable time.' The trainee moved to F wing on 27 July.
153. For the next few days, the trainee was described in the F2052SH log variously as 'being in good spirits', 'No problems', 'talking to other lads' and 'refusing to attend education'. The trainee refused to attend education during this period.
154. The visiting psychologist saw the trainee again on 29 July. She noted that he said he was finding being on normal location difficult but 'he's unable to describe exactly how.' The trainee repeated that he was hearing a male voice in his head, mainly telling him to destroy property or hurt people. He acknowledged that he had a choice whether or not to listen to the voice, but he did not accept the voice might be his own thoughts. The trainee also said that the previous evening the voice had told him to hang himself, but he had not

thought about how he would do this. He was able to think of things that would stop him killing himself, for example, his family and friends. The psychologist informed the trainee that it was his decision whether or not he wanted to see her again, and he replied that he would like to continue. The psychologist noted that she was unsure as to the impact of the appointments and advised the trainee of the relaxation classes available within the healthcare centre. Although the psychologist concludes, 'I remain unsure what impact this [contact with psychology] is having,' she arranged to see the trainee in a fortnight's time.

155. On 1 August, the trainee F2052SH was again reviewed. Three members of staff attended the meeting, together with the trainee. He said that he felt better and that he would speak to staff if he felt 'down'. He had seen his family during the week and knew he would receive letters from them and see them again soon. He also said that he had found out that his grandmother had not died after all. The F2052SH was closed by an SO.
156. The same day, the trainee flooded his cell. This led to a further disciplinary charge, to which he pleaded guilty. He told the adjudicating governor that he had been on bronze privilege level for three weeks, his review had not taken place, and 'it isn't fair.' The trainee's wing report, by the SO who had closed his F2052SH, said that he was 'due a privilege review shortly but because it's not done when he wants it doing he reacts poorly by kicking his door and flooding his landing. He is immature and needs to accept responsibility for his actions.' The then Head of Custody heard the report and banned the trainee from associating with other prisoners and from entertainment and classes for ten days. He also fined the trainee 14 days earnings.
157. Throughout August, the trainee was up and down. He attended education fairly regularly, and appeared to have good days and bad days. On 9 August, he was given silver status and on 11 August his education report said he had 'worked very hard'. On other occasions, he was warned for misconduct. He verbally abused teachers and one time he was removed from his class. The story was much the same on the wing. His then personal officer reported that he was: 'a bit disappointed with the trainee at the moment. Although his behaviour towards myself is acceptable, his attitude towards other officers and the regime in general is unacceptable. Will continue to monitor.'
158. The visiting psychologist saw the trainee at a third and final interview on 12 August. A second psychologist, under training, attended as an observer. The trainee said that he was feeling considerably better on the wing, and that both the voices and his desire to self harm were less frequent. He said he was feeling less distressed and that he tended to use exercise and his television to distract him. He mentioned that the television had only recently been returned to him after a period of forfeiting it for bad behaviour. The trainee felt he had more control and was coping better than before. He said he now had, 'No intention of harming himself at present. We agreed together that further appointments were no longer necessary.'
159. However, the wing record around that time shows that the trainee continued to verbally abuse staff and on one occasion refused to leave an exercise yard. He

swore at one member of staff who tried to reason with him, and on 14 August threatened to throw hot water on another. The month of August, at least in the eyes of staff, was characterised by a phrase in his record, 'the trainee lets himself down.'

160. On 31 August at 11pm, the trainee made a ligature from his bed sheet and tied it around the window. He also cut his wrists using broken glass. A nurse was called. The trainee reported hearing voices telling him to kill himself. The nurse said in interview with my investigators that the night patrol had called her to the trainee's cell. She saw that he had superficial cuts to his arms and was distressed and crying. He said his girlfriend had lost their unborn baby. He said he was upset about the loss of his baby and about not being able to speak to his girlfriend. He said she was in hospital in Manchester. The nurse offered to telephone her., but the trainee said, 'No, leave it till morning.' He said that if he had to stay on the wing he would kill himself. The nurse admitted the trainee to the healthcare centre and located him in the 'safer cell' (cell number 7) which has CCTV monitored from the nursing station. She also opened a new F2052SH. This was the second time the trainee was subject to suicide and self-harm monitoring.
161. The trainee appeared more upbeat in the healthcare centre and settled well with his peers, talking and playing pool, although he was also reported as being particularly noisy and demanding at times. He resumed his education classes. His teacher told my investigators that on 2 September he told her that he had planned the situation along with another young person who was also taken to the healthcare centre so that they would gain admission. Another prisoner, as part of an internal enquiry at Hindley into a different matter, said that the trainee had told him that he had pretended to self-harm to get to healthcare, in order to avoid 'trouble' that he was in on the wing. The prisoner did not reveal this information until several months after the trainee's death.
162. On 3 September, the trainee's case was reviewed in accordance with the F2052SH process. Four members of staff, a mental health nurse, a general nurse and a member of the chaplaincy attended, as did the trainee. Notes of that meeting, (Record of Case review) say, 'States girlfriend [name] has lost baby and is in hospital. States he is 'wounded'. Feels upset at night when has time to think. All family on holiday in Turkey.' The support plan record reads, 'Chaplaincy will ring hospital and check situation. Healthcare staff will continue to give support. Mental Health Team to give support when back on wing.'
163. The following day, an officer completed a scheduled review of the trainee's cell sharing risk assessment. The officer noted that the trainee had self-harmed on 31 August, and that he had 'exhibited anti social behaviour.' His risk was considered to remain at 'medium'. A governor agreed the assessment and countersigned the form on the same day.
164. On 5 September, a further F2052SH review was held. Four members of staff, including the chaplain and a member of the mental health team, were present at the meeting, as was the trainee. Notes of the meeting say, 'Feeling better – happy to return to wing when a space is available. No thoughts of self-harm at

present.’ The support plan section of the review notes said, ‘2052SH to remain open. To continue with support from mental health team and chaplaincy. To access support from healthcare centre staff on wing.’

165. On 6 September, the trainee was due to leave the healthcare centre and return to mainstream accommodation in E wing. He refused and was once more charged under the Prison Rules. That evening, whilst in the exercise yard, his behaviour and attitude were described as ‘unacceptable’ and he refused to leave the yard. The trainee eventually returned to the wing without the need for staff intervention, and was warned under the incentives scheme. On 8 September, an adjudication governor heard the charge of refusing to go to E wing. The trainee admitted the charge and said he did not want to return. He said, ‘I have trouble there.’ His general behaviour report from the healthcare centre described his behaviour as ‘disruptive, challenging and verbally abusive’, and said he had been ‘issued with warnings ... and is headed for the basic regime.’ The outcome was that the trainee was banned for seven days from watching TV in his cell. He immediately again refused to locate in E wing and was therefore readmitted to the healthcare centre.
166. Entries in the clinical record and F2052SH over the following few days show that the trainee complied broadly with the regime and apparently had no thoughts of self-harm. The following morning, staff reported his attitude was poor and this was discussed with him. He went to education in the morning, but refused in the afternoon. Again, he was reported as being abusive to staff.

Events during the five days leading up to the trainee’s death

167. On 10 September, an entry made at 7.10pm in the trainee’s healthcare record says, ‘Shouting abuse at [prisoner], refused a direct order to put his hands back inside his cell so that his flap could be closed. F254 (charge sheet) completed.’ A registered general nurse (RGN) signed the entry. The trainee was placed on disciplinary report for the alleged offence of disobeying a lawful order (to allow his cell-door hatch to be closed).
168. The following day, 11 September, the trainee’s F2052SH was reviewed in the healthcare centre. The meeting was attended by three members of staff, a governor, nurse and prison officer. The trainee also attended. The closure review on the form notes, ‘States he is over the original trauma of his girlfriend losing her baby. Happy to return to normal location. Would like a transfer to L/Farms [Lancaster Farms YOI], will be making application on F wing. To return to F wing – standard (Silver) regime. TV restriction lifted. All agreed to close F2052SH.’ The trainee was discharged from the healthcare centre, initially to the segregation unit to answer the disciplinary charge of not allowing his door hatch to be closed, and then on to F wing. The adjudicating governor (the same governor who had attended the F2052SH review a day earlier) recognised the futility of subjecting the trainee to further punishment. Instead, he had a talk with him and said he was prepared to keep him on silver status. The governor hoped to give him the motivation to keep his silver status which, amongst other things, meant he could have a TV in his cell.

169. The trainee went to F wing. The wing record entry made on 11 September by an SO says 'Gov's instruction. The trainee is to go back to 'silver' but the slightest slip and he will be on loss of association. Within 20 mins of the above being written, the trainee was found hiding in another cell. Governor informed who said 'lock him up' and back on loss.' Significantly, the trainee's TV was not taken from him.
170. On 12 September and again on 13 September, the trainee refused to go to education. The wing record says on each occasion, 'Warning under IEP' (Incentives and Earned Privileges scheme). If the trainee gave a reason for not going to education, it is not recorded. On 13 September, the trainee destroyed furniture and other items including his television in his cell and armed himself with a table leg to prevent staff entering. The situation was resolved when an officer talked him into handing over the table leg. The wing diary note says, 'Good work in resolving the situation peacefully.' The trainee was once more placed on disciplinary report.
171. On 14 September, the trainee was again placed on bronze regime. An entry at 3.05pm for that day in his wing file (F2050A) shows the reasons as, 'Refusing education, hiding in another cell and generally being abusive to staff.'
172. At 10pm on 14 September, the trainee activated his cell alarm system. The night patrol officer wrote in the wing diary, 'Pressed his cell [alarm]. Checking, saw some nooses on window and pole. Orderly Officer and Nurse attended. F2052SH opened.' The trainee had two nooses, one tied to his cell window bars and a second tied to the pole supporting the privacy screen to the toilet. The night manager and a nurse (the same nurse who had seen the trainee on 31 August) came to see him. The night manager was in the cell talking to the trainee when the nurse arrived. Although there were pieces of sheeting attached to the bars and the vanity pole, in the nurse's opinion they were not realistic nooses. In an entry in the healthcare Observation Book, she described them as 'just short pieces of sheeting not long enough to use as nooses.' The trainee was apparently angry and using abusive language because he had no electricity as he had broken the sockets off the wall. There was water on the floor. The TV was smashed and the pillow and bedding were damaged. The nurse recalled that the trainee said, 'I might as well be dead' referring to having no TV and no 'smokes'. He said he had 'got mad and smashed up' his cell. The nurse talked to him. He calmed down and said it was his own fault.
173. The nurse felt that transfer to healthcare was inappropriate. As there was no vacant accommodation on F wing and it was impracticable to repair the damage at that time in the evening, she decided, in consultation with the Orderly Officer, to leave the trainee in his own cell for the remainder of the night.
174. In her own words, the nurse felt that the trainee was 'No longer really going to kill himself.' She decided that he would be all right in F wing until the next morning. She opened a F2052SH for the third time. The nurse wrote on the form that night staff should observe the trainee intermittently (five times an hour) until he slept. She made an appointment for him to see a doctor next

morning. At interview, she said, 'He was not as upset or distressed as he had been on 31 August. He was angry and annoyed, totally different from then. In my judgement, a move to the healthcare centre was not necessary.' She told the trainee that if he needed to see her he only had to ask the officers to telephone. She stayed on the wing for a while after talking to the trainee. Before leaving, she handed the F2052SH to the night patrol officer. The trainee spent the remainder of the night in his own cell.

175. On 15 September, at a disciplinary hearing relating to events of the previous night, the trainee pleaded guilty. In explanation he said he wanted a transfer. Although he had mentioned his wish to move to Lancaster Farms and indicated that he would make a formal transfer request, scrutiny of the Applications Book shows that he never formalised his stated intention. For damaging his cell furniture, the trainee was fined 75 per cent of his earnings over 14 days.
176. A doctor saw the trainee at 10.40am. The purpose was to review the risk of the trainee attempting suicide or self-harming in the light of the incident with the nooses on the previous evening. The doctor assessed the trainee and then made an entry in his F2052SH, "Says remains pissed off. Asked if he still wanted to kill himself he said 'just watch me tonight'". The doctor was required to mark one of two 'tick boxes' – to indicate if the trainee was to return to his residential unit or be admitted to the healthcare centre. In discussion with a nurse, the doctor agreed that a mental health referral was appropriate. He therefore ticked 'return to residential unit', fully aware that the trainee was still subject to the F2052SH regime. The doctor made no specific instruction regarding the trainee's immediate care which he should have done on page 6 of the F2052SH record. This page asks the doctor to give recommendations about the person's management within the residential unit and the date of a follow up out-patient appointment. This page has not been completed.
177. In the trainee's clinical record, the doctor wrote 'F2052 completed – still states suicidal ideation. Refer to mental health'. In accordance with good medical practice the doctor requested a referral to the Mental Health Team so that the significance of the ideas and thoughts that the trainee was expressing could be assessed. A nurse completed a mental health referral following this consultation and according to the mental health team diary, the trainee was to be assessed by one of the mental health nurses on 16 September, in line with normal procedure.
178. The trainee returned to F Wing. At 1.55pm, he moved across the landing owing, to the damage in his own cell. He moved to a double cell but was the sole occupant. At 4.30pm, the trainee was unlocked to clean his cell. An entry by an officer at 6.10pm said 'did not go on association but had conversation with the trainee, everything seems fine'. At 7.10pm, the duty governor visited. At 7.35pm, the landing officer gave the trainee some hot water and noted that he said he was 'ok'. At 8.30pm, the same officer passed a toilet roll under the cell door for the trainee.

The trainee is discovered hanging from a ligature in his cell

179. An officer told my investigators that he was doing his rounds on F wing at about 10pm when he approached the trainee's cell. The observation panel was covered from the inside. The officer opened the door and found the trainee hanging by a ligature attached to the rail of his toilet vanity screen.
180. When the officer had arrived at the prison to start his tour of night duty, he had been issued with a special belt. Attached to the belt were various items of emergency equipment, including an anti-ligature knife (a specially fashioned device, having a blade which can be used to get under and cut a tight ligature) and a torch. The belt also had a pouch in which the officer's internal radio for routine and emergency communication was housed. The officer said that he had left his belt and emergency kit on a table in the wing office, some distance from the trainee's cell.
181. The officer went into the trainee's cell and supported his weight, at the same time reaching out and pressing the call button within the cell. The button activates an audible alarm in the wing office. Nobody responded. Other staff on night duty heard the alarm but, knowing that the officer was doing his rounds, assumed that he would respond to it. In interview with my investigator, an officer who was a member of night duty staff, said that he noticed bells ringing but that, 'It is normal for cell bells to be going off at the time and the officer on patrol would deal with it.' He did not therefore take any action when the bell rang as he thought that it was simply a prisoner requesting toilet roll/water and the like.
182. Because no-one responded and because he had no emergency equipment on him, the officer who found the trainee had no alternative but to lower him back onto the noose and run to the office. He collected the anti-ligature knife and ran back to the cell.
183. The officer who found the trainee was supported by three others – the night orderly officer, who was on the wing at the time, the officer who had earlier provided the trainee with hot water and another officer who was on night duty. Together they cut the ligature from around the trainee's neck and started resuscitation procedures. The officer who found the trainee called a night nurse by telephone. She ran to F wing and checked the trainee for signs of life. She found none. The nurse inserted an airway and gave oxygen. Two officers performed chest compressions and the nurse administered oxygen with an ambu bag. In interview with my investigators, she said she was aware that an ambulance had been called but did not recall by whom. The nurse said that in her view it was too late to save the trainee.
184. Paramedics arrived at the prison at 10.26pm and were escorted without delay to F wing. They examined the trainee and found no sign of life. He was taken to a local hospital at 10.50pm. At 11.26pm, the hospital called to say that the trainee had been pronounced dead.

185. The duty governor and other senior members of staff, including the Governor and chaplain, came into the prison, as did the police and the Coroner's Officer. The Governor, mindful not only of her obligations under prison procedures but also wanting to break the news personally to the trainee's family, prepared to visit the trainee's mother. The Governor told my investigators that the police advised her it would be better if they informed the trainee's family of his death and she took their advice.

Notification to families of prisoners who have died should be made in accordance with Prison Service Order 2710.

186. All appropriate contingency plans were activated within the prison. The following morning at 7.15am, the deputy governor held a meeting known as a 'hot debrief'. Night staff and the Safer Custody Manager attended. The debrief enabled staff to examine what had happened while memories were fresh, and what might be learned for the future. It also gave the deputy governor and Staff Care Team an opportunity to support staff who were upset about the trainee's death and their inability to have saved his life.
187. On 16 September, the day after the trainee died, an officer raised the fourth and final Bullying Alert Report (unnumbered) in respect of the trainee. The officer said, 'Overheard various conversations from other trainees that [prisoner] was making the trainee do 'shout outs' [where a prisoner or prisoners shout from their cell window or doors, usually during lock-up periods, with the intention of intimidating or otherwise causing distress to other prisoners] and telling him to kill himself which he later did.' The SO who investigated the allegation subsequently reported, 'I have told [prisoner] that as he only recently came off stage 2 [of the programme to get bullies to change their behaviour] he will go straight back onto stage 2. I have warned him that the next step is possibly citizenship [another stage in the process] or a transfer. Placed on basic regime to be reviewed in the next seven days. His TV was not removed as I have deferred this for PO's (Principal Officer) attention. [Prisoner] is adamant he is innocent of this.' The SO noted in the action column that he interviewed the alleged bully on 17 September and placed him on stage 2.
188. An autopsy on the trainee was carried out on 16 September. The finding was that the trainee died from hanging. A toxicology examination concluded that the death was not influenced by any common drugs.

CLINICAL REVIEW

189. The clinical reviewer found that the trainee received prompt care from healthcare and psychology services at Hindley, in line with primary mental health care requirements. She wrote that, although the trainee did not see a psychiatrist, it was unclear whether or not he would have had a different programme of care. The clinical reviewer noted that Hindley did not appear to have clear protocols for GPs to make psychiatric referrals and that the lack of systems hindered communication and information sharing between services.
190. The clinical reviewer acknowledged that it was not known whether or not admitting the trainee to the healthcare centre on 15 September would have changed the course of events. She commented that the nurse who saw him on the evening of 14 September and who knew him well, thought that he was less upset than he was on 31 August when she had also seen him, and that in-patient care was not indicated.
192. Commenting on the doctor's notes in the trainee's record on 15 September that he was to 'see the psychiatrist on Monday' the clinical reviewer noted that there was no record of a referral having been made. It may be that this entry was made because of the previous entry that the trainee was to remain on healthcare 'until seen by a psychiatrist'. What is known, is that no formal referral for the trainee to see a psychiatrist was ever made during his time in Hindley (he did however see a psychologist on several occasions). Examination of the Mental Health In-reach Team diary shows that a nurse placed the trainee on the list for a nurse led mental health assessment on 16 September, in line with normal procedures.
193. The clinical reviewer makes eight recommendations, which are listed below.

Healthcare staff should receive guidance and information on standards of record keeping which complies with NMC guidelines.

Clinical records should be audited on a weekly basis. This should be introduced immediately.

HMP/YOI Hindley should plan when to move onto the new (ACCT) Assessment, Care in Custody and Teamwork procedure which will link needs in a more holistic way regarding the management of those identified at risk of self-harm or suicide. (Hindley adopted ACCT in June 2006.)

A protocol should be developed to bring together all assessments to ensure information and planned care is located in a central point within the clinical record.

Care Plans should be developed to ensure planned care is understood by all and evaluated on a regular basis, highlighting changes to care.

GPs should be programmed onto prison training events where prison systems link with the health of prisoners/trainees. PSO 8450 – Issue of a model induction framework for healthcare staff must be initiated. This covers induction and necessary information for all healthcare staff, including agency and visiting staff.

An on-call induction/self-harm manual should be developed to assist on call/locum GPs to understand prison systems when attending HMPYOI Hindley.

Healthcare staff should receive training in appropriate standards for correct record writing and keeping. This should be initiated immediately and be included in staff induction.

MATTERS CONSIDERED DURING THE INVESTIGATION

194. This report contains poignant details of the trainee's short life.
195. It is apparent that from his infancy to the day he died, the trainee found coping with life very difficult. He hurt himself, apparently deliberately, from an early age and he behaved in ways that the most patient of parents and the most well-intentioned schools found overwhelming. When he was in the care of state agencies, the pattern did not change very much or for very long.
196. It is possible that a psychiatric referral, much talked about before the trainee went to prison, might have assisted. An independent Serious Case Review for the Manchester Safeguarding Children Board shows the extent to which the trainee might have been helped, had things developed in a different way.

The trainee as a juvenile prisoner

197. The trainee had committed serious criminal offences which attracted a significant custodial sentence, notwithstanding his YOT worker's opinion that he was a candidate for an Intensive Supervision and Surveillance Programme. However, it is clear that the trainee could not cope easily with prison. I am not surprised that prison staff found him troublesome and, in the word of one of them, 'immature'. (The irony of that word attached to a 17 year old will not be lost on any reader of this report.) The trainee was both of those things and more.
198. It strikes me that many staff may have been as much out of their depth in trying to cope with the trainee as he was in trying to cope with prison. The use of the Incentives and Earned Privileges scheme and recourse to prison disciplinary arrangements lacked subtlety or sophistication.
199. I am also concerned by the recurrent references to bullying by other prisoners. This is an ever-present danger in every YOI, but it is apparent that the trainee's problems were not resolved when he reported that he was being bullied. His own words in relation to being asked to name bullies, having done so previously, were 'Nothing gets done.'
200. The trainee offered many reasons for being located off the main wings, where he felt unsafe and frightened. He said his grandmother had died. He said his pregnant girl friend had lost their baby. Neither story was true and it is probable that the trainee knew this. He went further. He caused harm to himself and his behaviour ensured that he could move to the healthcare centre, where he felt safer than he did in either of the two large wings of the prison.
201. But even in the healthcare centre, the trainee could not settle or live anything resembling a normal life. He abused staff and disobeyed orders. It must have been plain to all that he was a very disturbed young man who needed help. I am sure that Hindley tried to help and marshalled resources in order to bring the trainee to a life as productive as it could be.

Bullying at Hindley

202. I am satisfied that the trainee borrowed tobacco and may not have been able to pay his weekly debts. I am satisfied also that he was bullied. He may also have bullied others. There are accounts in witness evidence (the chaplain reported, 'the trainee gave it out to some of the other lads too') and from the 'shouting out', a way of intimidating other prisoners, in which the trainee allegedly took part during his days in the healthcare centre.
203. I have noted earlier in this report the impression of my investigators that Hindley had made progress in combating bullying. The then Governor and her team had both a comprehensive policy, and practical monitoring and regulatory arrangements, to ensure that bullies were dealt with robustly and that staff supported those prisoners being victimised. However, Hindley is a big place. Its accommodation for juveniles is impersonal and the layout is such that staff cannot know all that is happening. In the nine months to September 2005, Hindley staff investigated 325 incidents of alleged bullying. Wings holding 100 prisoners do not lend themselves to the high standard of supervision, care and attention needed to help young people cope with life in the competitive environment of prison.

Consideration should be given to sub-dividing the juvenile accommodation at Hindley, in order to facilitate better care and supervision of young people, particularly in the furtherance of minimising opportunity for bullying.

Personal Officers and other significant members of staff at Hindley

204. Personal officers are often significant figures in the lives of prisoners. In the best schemes, they know their prisoners and understand their temperaments and problems. They have the opportunity to influence them for the better. Personal officers can also see warning signs; they can win the confidence of those in their care and ensure prisoners seek and get help for a variety of needs.
205. Hindley's personal officer scheme is based on officers being allocated to prisoners by cell number. Because of the way the system operates, the trainee had several personal officers during the six months he was at Hindley. However, some officers wrote from a standpoint of obvious knowledge when they made entries in his files and I believe they encouraged him to change his ways. A governor, although not the trainee's personal officer, told my investigators that he had many conversations with him, offering him opportunities to think his life through, sometimes offering incentives to get him to see that it made sense to try to change for the better.
206. Sometimes, other significant people are successful in helping prisoners who might not readily turn to a uniformed member of staff for help. In the trainee's

case, both the chaplain and teachers took an interest although they could not resolve his problems.

207. Education staff came to know the trainee well. He attended classes with some degree of regularity and he had a good deal of quality input from his teachers. At interview, they said that during the summer they were with him for two and a half hours during the mornings and again in the afternoons. They knew the trainee's personal circumstances and he had also told them about his life at Hindley.
208. The Consultant Clinical Psychologist who met the trainee on several occasions outlined her clinical reasons for not referring him for psychiatric assessment. She said that in her view, the trainee's presenting difficulties – periods of low mood and self harming behaviour – could be appropriately assessed and managed by a clinical psychologist, alongside support he received from the registered mental nurses. The psychologist said that the trainee's presentation was not an unusual one within secure settings. She said that he reported hearing voices and that this pre-dated his entry into custody. The psychologist did not think this reflected emerging mental illness ie psychosis. She said that it is not uncommon for young men with backgrounds of chronic adversity to report unusual experiences, such as voice hearing, within the prison setting. The prison environment places young men with few skills for managing difficult thoughts and feelings under considerable stress. They frequently spend periods of two hours during the day (and longer in the evenings) alone with their thoughts and feelings in their cells. Many report 'voices' which may seem more likely to be their own thoughts and occur in the absence of any other psychotic phenomena. The trainee was one such man. He reported voices telling him to hurt himself and others. In the psychologist's opinion, it is likely that he was more comfortable attributing these thoughts externally in the form of voices rather than owning them as his own thoughts. She did not therefore think it necessary or appropriate to refer the trainee to a psychiatrist.

Meetings at Hindley

209. Although the trainee's sentence planning meetings were held, they were not always on time and were not well attended. While the written reports submitted to meetings were of excellent quality, written reports cannot replace face-to-face communication at important events. The seconded Youth Offending Team member told my investigation team that attendance was poor and on one occasion only the trainee and he attended a meeting. The prison is a busy place, but my investigators were satisfied that adequate resources are provided by the YJB in order to ensure good levels of attendance at significant meetings in respect of the lives of young people at Hindley.
210. The YJB monitor wrote on 12 August 2005, 'Efforts to improve the attendance of personal officers at Sentence Planning Meetings should be maintained in order to achieve 100% compliance.' She later wrote that efforts to improve had been made and that 'personal officer attendance at planning meetings has improved.'

Monitoring of the Service Level Agreement between Hindley and the Youth Justice Board

211. At the time of my investigation, there was good information in reports from the YJB monitor in respect of Hindley's performance.
212. The monitor visits infrequently, usually just once each month. Following her visit she writes a report for the information of the Youth Justice Board and the Governor. I believe that young people at Hindley would be well served by the appointment of a full-time monitor and that, in making the appointment, the YJB would realise better value than it does at present for the resources it allocates to the SLA. In order to regulate the work of any institution, and to ensure that it performs at least to the standards laid down, a monitor must have a deep knowledge of the prison and a constant awareness of its day-to-day running. This cannot be achieved by what is, in effect, no more than a monthly 'snapshot'. The ability for them to measure, and to observe the work on the ground is severely limited. Given the large expenditure the YJB already incurs at Hindley, the additional cost of a full-time monitor would be small in overall terms.

The YJB should consider the level of their monitoring of the Service Level Agreement at Hindley with a view to increasing its frequency and intensity.

CONCLUSIONS

213. The trainee was one of a large number of troubled young men at Hindley. By its very nature, the population is difficult to manage, with many young men suffering from mental problems or personality disorders.
214. Hindley has good systems which, on the whole, operated well during the period leading to the trainee's death. Staff tried to give him some incentive to settle his behaviour, they were sensitive at the time he armed himself with a table leg and a nurse took appropriate action when he made the nooses on the night of 14 September. However, the trainee's behaviour, which was never good, deteriorated further during the months he was at Hindley. He saw an experienced psychologist on three separate occasions. Her very full notes of those interviews show that she did not judge the voices the trainee heard to be psychotic in nature. She believed that he heard voices but that they were his own thoughts. The notes also show that the consultations were full and structured, and that the trainee shared in the conclusion that he was coping better than he had been and that further appointments were unnecessary.
215. The trainee had a history of harming himself from an early age. This pattern continued at Hindley and from time to time he was subject to special suicide and self-harm procedures. He had been referred for psychiatric assessment in the community, but does not seem to have seen a psychiatrist. He was not referred to a psychiatrist whilst in Hindley but was seen by a Clinical Psychologist on three occasions.
216. Some prisoners had apparently joined a dangerous 'club'. My investigators heard anecdotal evidence from prison officers, teachers and prisoners, all of whom said that to make nooses and threaten to use them had become an established way of securing safer and more attractive accommodation within the healthcare centre than was to be found within the general prison community. It was also a way to regain possessions, which prisoners had lost through bad behaviour. The trainee's teacher said at interview that he and another prisoner had told her they had put ligatures around their neck so they would be transferred to the healthcare centre. She said they were laughing and joking about it. It must have been very difficult for staff to identify who was genuinely at risk of suicide or self-harm and who was not. Those who were at risk were mixed with those who might not be, either because of the so-called 'noose culture' or because they had arrived at the prison without documents which would enable staff to assess the risk. Not surprisingly, staff took the safe option and on the night the trainee died, 22 prisoners were subject to the provisions of F2052SH. Some would have been genuinely at risk. Others would not. The danger of staff being conditioned to watching people who 'didn't really mean it' or who were on watch for administrative reasons was, in my view, ever-present.
217. But the biggest problem by far at Hindley was the bullying and the sheer volume of work it presented, as evidenced by the reports of the Youth Justice Board Monitor, the information gained in many interviews with staff and prisoners, and in the records of the Anti-Bullying Committee. At Hindley, attention to the

problems of bullying took up much staff time and effort. A comprehensive programme and a dedicated team of staff managed the process. Meetings were regular, staff were trained to spot the signs, victims were supported and bullies were challenged and placed on 'community' programmes. I am satisfied that Hindley was proactive in its approach and had developed a coherent plan to minimise the occurrence of bullying and intimidation.

218. However, I have no doubt that the trainee was bullied. It appears that he also had no faith that anything would change. The chaplain reported he knew that the trainee 'had problems with some heavy boys, but he gave it out to some of the other lads too.' Nevertheless it remains a worry that prisoners in general and this trainee in particular were prepared to go to considerable lengths to gain the relative safety of the healthcare centre.
219. I turn now to the self-harm monitoring process. Page 5 of the F2052SH, section 2, is headed 'Doctor'. Within that section is an instruction to the doctor 'Complete Page 6 now'. This instruction is adjacent to the box which the doctor (who saw the trainee on 15 September) ticked, by (b) (i) Return to Residential Unit. Page 6, at paragraph 2, requires the doctor's 'Recommendations on management within the residential unit.' It also requests that the doctor insert a date for a follow up out-patient appointment. No entries appear on page 6 of the trainee's form and it is unsigned. The doctor should have made a documented judgement and given reasons when he saw him during the morning of 15 September.
220. As the doctor had already referred the trainee to the Mental Health Team, he felt recommendations required for the F2052SH document would follow from that referral. He had judged the trainee not to be suicidal at 10.40am on 15 September 2005. However, the doctor was aware that the trainee was subject to the F2052SH which was still active and returned him to the wing on the understanding and with those instructions still in force. The doctor therefore felt that additional instructions were not required.

The prison/health partnership should ensure that clinical staff cross-reference information which has relevance to both medical records and the suicide and self-harm procedure

Night staff duties and performance on 15 September

221. On the night the trainee died, staff completed their duties in respect of frequency of observation of those prisoners at risk of suicide and self-harm. They visited the trainee's cell within the timescales laid down and they completed their records satisfactorily.
222. The duties of the officers on nights were not onerous. They had to observe prisoners subject to the provisions of F2052SH at two-hourly intervals, unless they were directed to see them more frequently. The trainee who died was on the two-hourly observation schedule and staff did what was required. They told my investigators that there were at least four members of staff on nights in the part of the prison where the trainee was located. By their account, only one of

them took an active part in observation of prisoners at risk. They talked of having a 'one night in four' rota. When asked what they did when they were not on active duty under the rota, one said they read magazines.

223. The officer who discovered the trainee hanging was not wearing his belt which contained his radio, anti-ligature knife and other emergency equipment. Consequently, having found the trainee hanging, he had to press the cell bell designed for prisoners to attract attention. No-one responded. As a result, he had to lower the trainee back onto the noose in order to attract attention. This is simply unspeakable. On his initial visit in September 2005, my investigator drew the attention of the Governor to the safety procedures and to the staff issues.

Night duty staff should be required to wear their emergency packs and radios in the prescribed manner.

224. Over many days at Hindley, my investigators took the opportunity to talk to staff and prisoners. They examined numerous documents, many of them records of meetings and actions taken by the Governor and her staff to make Hindley safe and decent, a place where young men could take opportunities to change their ways in a climate free from fear.
225. In some respects Hindley falls short of its targets. Important prisoner case meetings are not usually well-attended and behaviour offending programmes do not run to the degree laid down in the prison's SLA with the Youth Justice Board. The YJB might well consider the level of their monitoring of Hindley's performance. Many programmes are in place, however, notably citizenship, drug and alcohol awareness and therapeutic courses. Psychological services are good. Mental health team members are well-qualified and committed to their work. Anti-bullying and safeguarding arrangements are in place and administered by an enthusiastic and capable staff. F2052SH procedures (replaced in June 2006 by ACCT) were put in place without delay. Review meetings were well-attended and came to balanced decisions, making good plans for further care of those vulnerable to suicide and self harm.
226. My investigators found the vast majority of Hindley's uniformed prison staff to be committed to their work. Much good is done in education in caring for a troublesome group of young men. But Hindley is first and foremost a prison. It is not able to cope easily with the multitude of behaviour problems experienced by so many disturbed young men. The use of disciplinary hearings under the Prison Rules and recourse to the Incentives and Earned Privileges scheme seems to have had little beneficial effect on the trainee's behaviour. Indeed, it would not be hard to argue that they had a perverse effect.
227. I have commented elsewhere in this report that the size and nature of the accommodation makes it virtually impossible to keep track of everything that happens. The cells also have readily accessible ligature points, easily utilised by someone who feels low for a moment or who has enduring long-term emotional problems.

228. Manifestly, it is not possible to say what was in the trainee's mind when he tied the noose around his neck. It may have been another attempt to ensure he could be moved from the wing, an attempt which went badly wrong. Alternatively, it may have been that the trainee had 'had enough' of trying and failing to survive in prison.

229. I conclude that Hindley did not give sufficient attention to two specific areas of the trainee's care:

The prison should have notified and involved the trainee's family, in accordance with the terms of Prison Service Order 4950, paragraph 4.53, of the circumstances of his violent behaviour and his self-harming.

The Governor must ensure that the provisions of Prison Service Order 4950 are fulfilled, particularly in terms of notifying families and significant others when the behaviour of a young person causes concern.

The officer who found the trainee hanging should have been better prepared than he was to deal with the emergency. He was issued with a radio and a safety (anti-ligature) knife when he started his shift, in order to deal with just such an incident. However, he had left them on an office table some way from the trainee's cell. The only way he could gain assistance, having supported the trainee's weight and tried unsuccessfully to raise the alarm through the cell bell system, was to lower him back on to the noose and run to the office for help. This was a grim and avoidable course of action that he was forced to take because of the situation he found himself in.

RECOMMENDATIONS

For the Prison Service

- 1. A programme should be drawn up to refurbish the cells at Hindley, particularly those set aside for juvenile prisoners, to 'safer cell' standards in order to minimise the availability of ligature points.**
- 2. Consideration should be given to sub-dividing the juvenile accommodation at Hindley, in order to facilitate better care and supervision of young people, particularly in the furtherance of minimising opportunity for bullying.**

For the Governor, Hindley

- 3. Using the Department of Health booklet as a template, a comprehensive training plan should be devised for doctors to remind them of their roles and responsibilities of working in prisons.**
- 4. The Governor should ensure that planning and case meetings have the highest possible multi-disciplinary attendance from inside and outside the prison. Families should be involved where possible in the meetings.**
- 5. Staff receiving and assessing young people at Hindley should liaise with all relevant agencies in order to ensure that vital information arrives at the prison on the day the young people are received into custody.**
- 6. Young people should be interviewed in depth when they return from court, particularly where their status and circumstances have changed.**
- 7. The Governor must ensure that the provisions of Prison Service Order 4950 are fulfilled, particularly in terms of notifying families and significant others when the behaviour of a young person causes concern.**
- 8. The prison/health partnership should ensure that clinical staff cross-reference information which has relevance to both medical records and the suicide and self-harm procedure.**
- 9. Review teams must follow the instructions in Section 4.2 of Prison Service Order 2700 by determining and recording, on each occasion a review is held, the frequency of supervision required for those subject to suicide and self harm monitoring procedures.**
- 10. Notification to families of prisoners who have died should be made in accordance with Prison Service Order 2710.**
- 11. Night duty staff should be required to wear their emergency packs and radios in the prescribed manner.**

12. Staff should be advised, and quality checks should be made, on the completeness and appropriateness of documentation and action in respect of incidents dealt with through Bullying Alert Forms.
13. Use of so-called 'cool-down rooms' should be legitimised or discontinued. At present, they appear to have no legitimacy under either Prison Rules or within the Service Level Agreement between Hindley and the YJB.
14. Hindley should undertake an analysis of where transfer of documents has broken down and develop protocols to strengthen the system.

For Greater Manchester Police

15. A copy of this report should be sent to the Chief Constable of Greater Manchester police to ask him to consider whether police officers should routinely notify prison Governors when prisoners are to be interviewed or charged in connection with further offences that might affect their behaviour or mental health.

For the Youth Justice Board (YJB)

16. The YJB should consider the level of their monitoring of the Service Level Agreement at Hindley with a view to increasing its frequency and intensity.
17. As part of the planned audit of National Standards, the YJB should consider clarifying the procedures in relation to when a young person arrives at a unit without all of the relevant paperwork, taking into account the NoDocs system that was introduced in 2004.
18. The YJB should review the 'NoDocs' system to ensure that it makes an effective contribution to procedures for transferring assessment information between the community and the secure estate.
19. The YJB should clarify the procedures in relation to a young person arriving at a unit without all relevant paperwork.
20. The YJB should consider how to ensure that continuity and accountability are established and maintained between all the community agencies that have an interest in young people in custody.

For Manchester Youth Offending Team (YOT)

21. Manchester YOT should review their process for transmission of documents and develop an audit system to ensure compliance with national standards.

Recommendations from the Clinical Review

- 22. Healthcare staff should receive guidance and information on standards of record keeping which complies with NMC guidelines.**
- 23. Clinical records should be audited on a weekly basis. This should be introduced immediately.**
- 24. HMPYOI Hindley should plan when to move onto the new (ACCT) Assessment, Care in Custody and Teamwork procedure which will link needs in a more holistic way regarding the management of those identified at risk of self-harm or suicide. (In fact, Hindley adopted ACCT in June 2006.)**
- 25. A protocol should be developed to bring together all assessments to ensure information and planned care is located in a central point within the clinical record.**
- 26. Care Plans should be developed to ensure planned care is understood by all and evaluated on a regular basis, highlighting changes to care.**
- 27. GPs should be programmed onto prison training events where prison systems link with the health of prisoners/trainees. PSO 8450 – Issue of a model induction framework for healthcare staff must be initiated. This covers induction and necessary information for all healthcare staff including agency and visiting staff.**
- 28. An on-call induction/self-harm manual should be developed to assist on call/locum GPs to understand prison systems when attending HMPYOI Hindley.**
- 29. Healthcare staff should receive training in appropriate standards for correct record writing and keeping. This should be initiated immediately and be included in staff induction.**