Investigation into the circumstances surrounding the death of a boy at HMYOI Lancaster Farms in November 2007

Report by the Prisons and Probation Ombudsman for England and Wales

August 2009

This is the report of an investigation into the circumstances surrounding the death of a young boy at HMYOI Lancaster Farms in November 2007. The boy was found hanged in his cell. The pathologist who conducted the post mortem examination confirmed that the cause of death was hanging.

The boy was 15 years and eight months old when he died. During his short life he suffered much unhappiness. His father died when he was three. His mother, having become addicted to drugs, drifted away from him. I find it particularly distressing that the boy's uncle and aunt, who were his legal guardians and who had cared for him as surrogate parents for half his life, have had to suffer the agony of his loss. That the boy died in a prison, and at such a young age, must be especially shocking and difficult to come to terms with. I offer my heartfelt sympathy and condolences to the boy's uncle and aunt, and to their daughters who have in effect lost a brother. My sympathy also goes to all those affected by the boy's loss, including his mother and sister, and those who knew and cared about him, including staff at Lancaster Farms and at St Helens Youth Offending Service.

The investigation was a complex one as is the report that now follows. They have taken many months to complete. I am very conscious that the first anniversary of the boy's death has now passed. I apologise for the added distress that the time needed to conclude the investigation will inevitably have caused his family.

I appointed a team of four investigators to examine the circumstances surrounding the boy's death. The team was led by my investigator. He was ably assisted by 3 other investigators. My Senior Family Liaison Officer was the contact point with the boy's family.

I also commissioned a clinical review of the management of the boy's health needs while he was in custody at Lancaster Farms. This was initially conducted by a panel of specialists led by the Assistant Director, Commissioning and Performance, at the North Lancashire Teaching Primary Care Trust (PCT). The final signed version of that review was not despatched to my office until 28 October 2008. The review was, in my view, inadequate. Its brevity did not reflect the complexities that arose during the investigation. At consultation stage, the Chief Executive of the PCT expressed his surprise at the delay in the submission of the report by the clinical reviewer and at its inadequacies. The Chief Executive of the PCT subsequently decided to commission a review of the evidence and statements collected by the initial panel and to provide me with a revised clinical review. I am grateful to the Chief Executive of the PCT for his personal intervention. The revised version is appended to this report.

My thanks go to the Governor and his staff at Lancaster Farms for their assistance and cooperation during the investigation, particularly the Principal Officers who acted as liaison officers. I also appreciate the help given to my investigation team by the Youth Justice Board, the St Helen's Local Safeguarding Children's Board, the Youth Offending Service and the Head of Young People's Team in the National Offender Management Service (NOMS). I am also indebted to the Lancashire Constabulary for the invaluable help and support they gave to my investigators throughout, despite their own very heavy workload.

The investigation into the boy's death came at a time when the inquest into the death of another young person at Lancaster Farms was in progress. I had also investigated this earlier death. Both cases raise questions about the wisdom of sending vulnerable youngsters to prison. Given resource constraints and operating pressures within NOMS and the Youth Offending Service, there are no easy answers. However, if the practice is to continue, the recommendations I make in this report must be effectively implemented. This is the second time I have made recommendations about the Personal Officer scheme at Lancaster Farms. I am also very troubled by the culture of mental bullying witnessed by my investigation team, and this is something NOMS must not allow to prevail.

Such has been the scale of this investigation that I have made a total of 32 recommendations to the key agencies involved in the boy's management: Lancaster Farms, the Youth Justice Board, NOMS, and the North Lancashire Primary Care Trust. (I have also made a number of other proposals in the text, short of formal recommendations.) The recommendations relate to a range of issues, the most critical of which include a failure in the application of the Personal Officer scheme for the boy, and a failure to arrange a sentence planning meeting for him within prescribed timescales. I am also utterly dismayed by the failure to attempt to revive the boy as soon as he was found hanging, despite the fact that his body was still warm, and by the failure to call an ambulance promptly.

I also note that the boy's death occurred three months after a major disturbance at Lancaster Farms which necessitated the temporary closure of the two juvenile units. Once the damage caused during the disturbance had been repaired and the accommodation became usable once more, there was an influx of new arrivals in a very short period. Although the Youth Justice Board attempted to control the pace at which the numbers built up, there is no doubt that some aspects of the establishment's regime for juveniles, including the induction process, were placed under considerable strain.

I understand that a decision has recently been made to change the role of Lancaster Farms into a single site for young offenders and that of HMYOI Hindley into a single site for juveniles, and that the change of role for each institution will have been completed by April 2009. I welcome that decision. But I urge NOMS and the Youth Justice Board to work together to ensure that the lessons learned from both my investigations at Lancaster Farms are given urgent consideration in all sectors of the secure estate for children and young people. Many of the recommendations in this report relate specifically to the management of young people at Lancaster Farms. Although, from April 2009, juveniles will no longer be sent there, I have chosen to retain the recommendations as they stand because I believe they might assist the Coroner's inquest into the boy's death. I also believe they have a wider application across the juvenile estate. The recommendations should be read in that light, therefore.

In line with my normal procedure and good practice, a copy of this draft report was issued to NOMS in the first instance because named individuals have been criticised. This was to enable representations to be made and considered.

This final version takes into account the responses received from NOMS, Youth Justice Board, St Helens Youth Offending Service, North Lancashire Primary Care Trust and the boy's family solicitor.

It need scarcely be said that this is a painfully sad story.

This version of my report, published on my website, has been amended to remove the names of the boy who died and those of staff and prisoners involved in my investigation.

Stephen Shaw CBE
Prisons and Probation Ombudsman **August 2009**

CONTENTS

SUMMARY

The boy's tragically short life began in Liverpool in March 1992. Three years after his birth he lost his father. As his mother had severe problems of her own, the boy had to live thereafter with his grandmother. After her death not long afterwards, the boy was taken into foster care. In 1999, at the age of seven, the boy's aunt and uncle became his legal guardians. Although he tried to maintain contact with his mother, the boy looked upon his aunt and uncle as his parents.

The boy's education was interrupted by frequent truanting. Whilst still very young, he took to drugs and drank alcohol excessively, often returning home drunk. He soon began to break the law. On one occasion he had to be admitted to hospital after taking an overdose of drugs. The boy's family told my investigator that he went out of his way to please his peers at any cost. They also said they believed that much of his reckless behaviour was due to the influence of two girls who lived nearby, and who they thought coaxed the boy into committing crimes. The boy thus became known to the Youth Offending Service from 2006.

In May 2007, the boy committed four separate acts of theft from a shop and one of assault. On each occasion he had been drinking alcohol. After appearing in court, the boy was remanded to Local Authority Care in Liverpool. On 5 June, his case was heard by St Helens Youth Court where he was given a Supervision Order. Three days later, he subjected a shopkeeper to a torrent of abuse for which he was arrested the same day. The boy again appeared at St Helens Youth Court and was given a four month Detention and Training Order (DTO) which required him to spend the first half of his sentence in custody and the remainder under supervision in the community. Whilst in police custody prior to his court appearance, the boy used a spoon to inflict minor cuts on his arms and other parts of his body. He was placed at HMYOI Thorn Cross on 11 June. This was the boy's first experience of custody. An ACCT (Assessment, Care in Custody and Teamwork) form was opened the following day because staff were concerned about his recent history of self-harm. (ACCT procedures are a process used by the Prison Service to monitor and support those prisoners who are thought to be at risk of self-harm.) Although the boy did not harm himself at Thorn Cross, the ACCT form remained open throughout his brief time there. As the boy was subject to further charges, he was considered to be unsuitable for the open unit at Thorn Cross. His ability to cope in a prison environment was also questioned. As a result, the boy was transferred to Red Bank Secure Children's Home near Warrington. In the initial stages of his time at Red Bank, the boy's risk of self-harm was closely monitored, although not by means of the ACCT form which is only used by the Prison Service. The boy remained at Red Bank until 10 August 2007, when he was released to serve the remainder of his DTO in the community. However, three weeks later, he appeared at Liverpool Crown Court on an outstanding charge of affray. The boy was given another four month DTO and returned to Red Bank where he remained until 22 October.

The boy failed to comply with the curfew element of the supervised phase of the DTO. Consequently his YOT (Youth Offending Team) worker recommended to the courts that he had formally breached his licence conditions. Just two weeks after leaving Red Bank, the boy therefore returned to court on 7 November and was ordered to complete the remainder of his DTO in custody. In spite of his

vulnerabilities and his known fear of being sent to prison, the boy was placed at Lancaster Farms the following day (8 November). On 28 November, the boy was transferred from Buttermere Unit to Windermere Unit upon completion of his induction period. At 7.10am the following day, the boy was found hanging in his single cell. He had been due for release on 22 December.

I am critical of some individual members of staff at Lancaster Farms and I draw attention to systemic failures that, in my view, impaired the quality of care given to the boy. The investigation found that the decision to place the boy at Lancaster Farms was not informed by any current assessment of his ability to cope with the macho environment of a prison establishment. Detailed information about the boy's experiences at Red Bank was not passed to Lancaster Farms. During the reception process, little attention was paid to the information available in the boy's Asset form (a standard assessment document used throughout the Youth Justice System to measure young people's risks and vulnerabilities).

In my opinion, the boy's induction process was mechanistic and more suited to the establishment's needs than to those of the individual young person. His first night interview was conducted in an open area within earshot of other young people. During his time in the induction unit, the boy hardly left his cell. Although he told his family he was frightened by the possibility of being bullied, he did not bring this to the attention of staff. The boy did not complete all the induction modules, but nevertheless was deemed ready to transfer out of the induction unit on 28 November. That day, despite the fact that all young people had to be locked in their cells to enable staff to attend a training programme, the boy transferred to Windermere Unit.

There was a significant systemic failure regarding the allocation of a Personal Officer for the boy. The member of staff assigned to him in this role on 9 November was on leave followed by night duty when allocated, and could not therefore engage with the boy until his return to daytime duty on 25 November. No alternative Personal Officer was allocated in the meantime. This is the second time I have had cause to criticise the Personal Officer scheme at Lancaster Farms in the course of investigating a death.

Lancaster Farms failed to organise a sentence planning meeting within the required target of ten working days of the boy's arrival. Instead, a meeting was scheduled for 4 December 2007. Sadly, by this time, the boy had died. Had the meeting taken place on time, arrangements might have been made to involve the boy's family in assessing his vulnerabilities and to help him plan constructively for his resettlement.

When the boy was found hanging on the morning of 29 November, the staff in attendance found that his body was still warm although they thought he was dead. They made no immediate attempt to resuscitate him. This was despite the fact that Prison Service Order 2700 clearly states that, in such circumstances, an attempt at resuscitation should be made immediately unless rigor mortis has set in. After a delay of nearly four minutes, one member of staff realised that he and his colleagues had a duty to try to revive the boy. Cardio pulmonary resuscitation was therefore commenced. There was a delay of a further three minutes before an ambulance was called.

Numerous young people gave statements to the police after the boy's death. They claimed that others in nearby cells had shouted to him through their windows during the night of 28/29 November telling him that, if he did not hang himself that night, he would be beaten up the following morning. The police conducted a thorough investigation into the claims but found no evidence to raise criminal charges against any individual. The staff on duty in Windermere Unit that night told my investigators they did not hear anyone taunting the boy.

Neither my own investigation, nor that of the Lancashire Police is able to prove whether the boy was bullied, mentally or physically, at any time at Lancaster Farms. However, my investigators visited Windermere at night. None of the young people in the unit was aware of their presence. My team witnessed at first hand a sustained and concerted exchange of frightening and disgusting insults between a number of young people in their cells. They were targeted principally at one individual. This exchange had been preceded by the loud banging of cell doors by numerous young people. On that occasion, there was no effective reaction by the on duty staff. If this is the sort of behaviour the boy experienced, I have no doubt that he would have been frightened. I am persuaded that his death was probably triggered by the mental bullying to which many young people testified afterwards. Although the Governor had put some measures in place to tackle this problem before the boy's death, they were manifestly unsuccessful in reducing the problem at night.

I make recommendations to Lancaster Farms, the local Primary Care Trust, NOMS and the Youth Justice Board that I hope will help prevent further deaths in the secure estate for children and young people. I have also recommended that a copy of this report is shared with the Secretary of State for Justice.

INVESTIGATION PROCESS

1. On the morning of 29 November 2007, I was a guest at the conference of the Prison Service's North West Area. When the news of the boy's death came through, I agreed with the Area Manager that I would attend Lancaster Farms straightaway. I was able to receive a personal briefing from the Deputy Governor and make an initial assessment of the situation. I also read the boy's prison file. As the police were present, I did not open the investigation formally at that point.

2. On returning to London, I appointed a team of four of my colleagues to investigate the boy's death on my behalf. A family liaison officer was also appointed.

3. At midday on 3 December 2007, two of my investigators attended a strategy meeting chaired by a senior manager in the Safeguarding Children Unit at Lancashire County Council. My two investigators were able to explain the nature and scope of the Ombudsman's investigation and meet those involved in the boy's management both in the community and in custody. At 3.00pm that day, one of my investigators met the Governor of Lancaster Farms and a number of his senior managers, two representatives of the local Independent Monitoring Board, a representative of the local branch committee of the Prison Officers' Association, and the investigation liaison officer. At the meeting, my investigator explained the purpose and style of the investigation. Notices were issued the same day to staff and to the young people in the establishment inviting anyone with concerns or information relating to the boy's death to make themselves known to the investigation team. The Governor made a point of asking his Diversity Manager to explain to all young people who were foreign nationals the content of the multi-lingual notice issued. No-one came forward.

4. After the meeting, my investigator took the opportunity to familiarise himself with Buttermere and Windermere, the two units at Lancaster Farms in which the boy was placed. He also examined the cell in which the boy died.

5. My investigator met the Police Liaison Officer for Lancaster Farms on 4 December to agree a protocol for sharing information.

6. My investigator briefed those who attended the Governor's weekly management meeting on 5 December about the nature and scope of the Ombudsman's investigation.

7. On 6 December, my two investigators visited the headquarters of the Youth Justice Board in London and met the Senior Strategy Adviser for the Youth Justice Board, in order to explain the purpose of and methodology for the investigation. My two investigators also interviewed the Head of Placements at the YJB, during the course of the investigation.

8. In all, 32 people were interviewed by my investigators, including staff at St Helens Youth Offending Service. Numerous witness statements were

received from the police relating to the events of the night of 28/29 November when the boy was found hanging, and to claims that he had been taunted that night.

9. I also commissioned a review of the management of the boy's health needs while he was in custody. This was initially conducted by a panel of specialists on behalf of the local Primary Care Trust. The panel comprised:

   The Assistant Director, Commissioning and Performance, North Lancashire PCT

   Child Protection, East Lancashire PCT

   A Consultant Forensic Psychiatrist, Greater Manchester West Mental Health NHS Foundation Trust

   National Treatment Authority North West

   A Consultant Anaesthetist, Royal Lancaster Infirmary, University Hospitals of Morecambe Bay NHS Trust

   The Corporate Services Manager, North Lancashire PCT.

10. I was disappointed that the final, signed and dated version of the clinical review was not despatched to my office until 28 October 2008. Moreover, the brevity of the review report was not, in my view, in line with the complexity of the issues. At consultation stage, the Chief Executive of the PCT expressed his surprise at the delay in the submission of the review by the Assistant Director and at its inadequacies. The Chief Executive of the PCT decided to commission a review of the evidence and statements collected by the initial panel and to provide a revised clinical review to my office. .

11. On 4 December 2007 my senior Family Liaison Officer (FLO), made initial telephone contact with the boy's uncle and aunt who were his legal guardians. The FLO and my investigator met them at their home on 9 January 2008 to discuss the concerns they wanted the investigation to address. These matters are dealt with in this report.

12. My investigation team visited Red Bank Secure Community Home on 15 January 2008 in order to familiarise themselves with the environment in which the boy was managed there, as well as to compare its ethos and regime with that of Lancaster Farms. My investigator later visited HMYOI Hindley in order to examine aspects of the environment, culture and regime in place for young people there.

13. My investigator attended a meeting of the Local Safeguarding Children's Board serious case review on 8 July 2008 in order to share information with the panel members.

14. On 16 July 2008, my investigator discussed matters of policy for the management of young people with the Head of Young People's Team in NOMS.

THE MANAGEMENT OF CHILDREN IN CUSTODY

Youth Justice Board

15. The Youth Justice Board (YJB) is a non-departmental public body set up by the Crime and Disorder Act (section 41). From April 2000, the YJB became the commissioning and purchasing body for all forms of secure accommodation for children and young people. The YJB is also ultimately responsible for allocating young people to appropriate secure establishments, taking into account recommendations made by staff in Youth Offending Teams. The YJB monitors the youth justice system and advises the Secretary of State.

16. The basis of the Board's relationship with NOMS, as the main provider of custodial accommodation, is a strategic partnership. A five year agreement between both parties sets out how the strategic partnership should operate and develop. It also defines roles and responsibilities. The partnership agreement is supported by a Service Level Agreement (SLA) which sets out:

- the number of beds purchased by the YJB
- the financial framework adopted
- the standards/levels of service required across the juvenile estate
- the action that can/will be taken in the case of non-compliance with the requirements set out in the agreement.

Youth Offending Teams

17. The Crime and Disorder Act 1998 (section 39) requires local authorities with responsibilities for Social Services and Education to establish Youth Offending Teams (YOTs), in partnership with the Police, Probation Service, Health Authorities and Social Services. The role of the YOTs is to work with young offenders and those at risk of offending in the community in order to help turn them away from crime. The teams co-ordinate the delivery of a range of youth justice services including bail support and the supervision of community sentences and of young people released from custody. The manner in which these services are to be delivered and funded locally has to be set out in an annual youth justice plan, drawn up by the local authority in consultation with other agencies, and submitted to the YJB for approval and publication. Local custody providers should be consulted in drawing up the plan.

Local Safeguarding Children Boards

18. In the context of the management of children who are offenders, the term "safeguarding" refers to the process of protecting and maintaining their safety and welfare. Section 13 of the Children Act 2004 requires each children's services authority to establish a Local Safeguarding Children Board (LSCB) for their area. It requires the Governor/Director of any prison in the area of the authority to become a partner of the LSCB and co-operate fully with the authority. The Act defines the LSCB's objective as:

"… to co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area of the authority by which it is established; and to ensure the effectiveness of what is done by each such person or body for those purposes."

The Detention and Training Order

19. Section 73 of the Crime and Disorder Act 1998 (now section 10 of the Powers of Criminal Courts (Sentencing) Act 2000), established a new custodial sentence, the Detention and Training Order (DTO) for young people aged under 18. The new sentence was devised to rationalise the sentencing arrangements that previously existed for those aged under 18 and to make custody more effective in preventing re-offending.

20. The only DTO sentences available to the courts are those of 4, 6, 8, 10, 12, 18 and 24 months. Half of the sentence is served in custody and the other half under supervision in the community. The DTO is designed to ensure that the most appropriate form of training is provided for each young offender to help prevent further offending. This might typically be education in numeracy and literacy, a parenting skills course, or NVQs in decorating and plastering.

The secure estate for children and young people

21. There are three types of secure accommodation in which a young person can be placed. These are:

- a Secure Children's Home (SCH)
- a Secure Training Centre (STC)
- a Young Offender Institution (YOI).

Secure Children's Homes

22. Secure Children's Homes focus on attending to the physical, emotional and behavioural needs of the young people they accommodate. They are run by Local Authority Social Services Departments and are overseen by the Department of Health and the Department for Children, Schools and Families. They accommodate young people involved in the criminal justice system as well as those outside it.

23. Secure Children's Homes provide young people with support tailored to individuals' needs. To achieve this, they have a high ratio of staff to young people and are generally small facilities, ranging in capacity from six to 40 beds. There are 14 such facilities in England.

Secure Training Centres (STCs)

24. Secure Training Centres (STCs) are purpose built centres for young offenders up to the age of 17 years. They are run by private operators under contracts which set out detailed operational requirements. There are four STCs in England. They are:

- Oakhill in Milton Keynes
- Hassockfield in Consett, County Durham
- Rainsbrook in Rugby
- Medway in Rochester, Kent.

25. Each centre normally holds between 58 and 87 young and vulnerable people who have been sentenced to custody or remanded to secure accommodation. STCs provide a secure environment in which they can be educated and rehabilitated. They differ from Young Offender Institutions (YOIs) in that they have a higher staff to young person ratio and are smaller. As a result, individual needs should be more easily met.

Young Offender Institutions (YOIs)

26. Young Offender Institutions (YOIs) are run by NOMS and can accommodate 15 to 21 year olds. The YJB web site shows that YOIs generally have lower ratios of staff to young people than STCs and they accommodate larger numbers. Consequently, they are less able to address the individual needs of young people, and are generally considered to be inappropriate for vulnerable young people with high risk factors such as mental health or substance misuse needs. The 16 YOIs in England can accommodate up to 2,874 young people under the age of 18 years.

Placement

27. The YJB is responsible for the allocation of young people to the most appropriate custodial establishment, based upon:

- vulnerability, as assessed by the Youth Offending Team (YOT)
- specific needs, such as a disability or a particular programme
- competing demand for available beds
- location
- age.

28. The vulnerability of a young person is determined by an assessment, completed by the YOT, known as Asset. This is a structured assessment system in place throughout the youth justice system in England and Wales. Its aims are:

- to identify the key factors contributing to offending by young people
- to provide a prediction of reconviction

- to help identify young people who may present a risk of serious harm to others
- to identify situations in which a young person is vulnerable to being harmed
- to identify issues where more in-depth assessment is required.

29. The YOT notifies the YJB of the details of Asset. In turn, the key factors from this assessment influence the placement decision. These factors might include:

- risk of self-harm
- having been bullied
- separation, loss or care episodes
- risk taking
- substance misuse
- other health related needs
- the ability to cope in a YOI or other custodial establishment.

30. The YJB tries to place a young person sentenced to custody in an establishment that is near his family and home and that provides an environment that is suited to his needs based upon the information in the Asset.

31. The following table, taken from the YJB website, shows the method of determining the most appropriate type of establishment:

Gender, age and vulnerability	**Status**	**Type of establishment**
Males and females aged 12 to 14	Court ordered secure remand or sentenced to custody	Secure Children's Home or STC
Vulnerable males aged between 15 to 16	Court ordered secure remand or sentenced to custody	Secure Children's Home or STC
Non vulnerable males aged 15 to 16	Court ordered secure remand or sentenced to custody	YOI

National Standards

32. National Standards for the management of children and young people at high risk of offending are set by the Justice Secretary on advice from the Youth Justice Board and in accordance with relevant legislation. National Standards apply to Youth Offending Teams and secure establishments, but partner agencies in the youth justice system have responsibilities for helping to ensure that they are met through agreed good practice. National Standards make requirements of organisations as a whole, not just of individual members of staff. The National Standards are currently under review and are due to be re-issued in 2009. I hope that the learning from this investigation will inform the revision of this document.

Prison Service Order 4950

33. The policies for the management of young people in prison are set out in Prison Service Order (PSO) 4950, the most recent version of which was issued in December 2006. Other PSOs also apply, such as PSO 2700 which gives guidance on managing risk of self-harm and suicide.

34. The purpose of the PSO is to define the principles upon which Governors must operate the regimes for young people, their key features, and what they must achieve. Its purpose is not to prescribe in great detail but to provide sufficient guidance and clear direction in order to ensure consistency. Scope is left for Governors to determine how the regimes are to be delivered and their operational detail.

HM YOUNG OFFENDER INSTITUTION LANCASTER FARMS

35. Lancaster Farms is located a few miles from the centre of Lancaster. It is a closed Young Offender Institution. At the time of the boy's death, it could hold up to 527 sentenced and remanded offenders although its normal capacity was 480. Approximately half were likely to be young people (aged between 15 and 18), and half were young offenders aged between 18 and 21. Buttermere and Windermere are the units for young people under the age of 18. They are both divided into two sub-units. Buttermere 1 and 2 each hold up to 65 young people. Buttermere 1 is the main residential unit. Buttermere 2 is the first night centre. Windermere 1 and 2 units are two further residential units, each holding up to 60 young people.

36. All young people must by law engage in full time education. They also have access to vocational training such as bricklaying, painting and decorating and joinery. Physical education is available - there is a large gymnasium and an outdoor sports area. Other courses include industrial cleaning, catering, farms and gardens and media skills. The establishment also provides a number of offending behaviour groups and interventions, including the young persons' enhanced thinking skills course. The chaplaincy team offers religious services each Sunday as well as pastoral care on an individual basis.

37. Healthcare at Lancaster Farms is provided by the local Primary Care Trust. Mental health services are provided by Lancashire Care NHS Foundation Trust. GP services are provided by Owen Road GP surgery. Out of hours GP services are provided by Baycall. Nursing and dental services are provided by the local Primary Care Trust. At the time of the boy's death there were beds for 12 inpatients. There is also a care and separation unit (a segregation unit) for those who ask to live separately from the mainstream population, or who are under punishment.

38. The following table shows the young persons population at Lancaster Farms in November 2007:

Average population (overall)	227
Average population (Buttermere)	103
Average population (Windermere)	116
Number of new receptions in November	64
Number of discharges in November	40

According to data provided by the Youth Justice Board, 27 young people aged 15 were at Lancaster Farms on 28 November 2007. There were 23 in the establishment on 31 October 2008.

39. The following table shows how many young people were subject to Assessment, Care in Custody and Teamwork (ACCT) - suicide and self harm monitoring - procedures at Lancaster Farms on 29 November 2007:

Unit	ACCTs
Buttermere 1	3
Buttermere 2	4
Windermere 1	2
Windermere 2	0
Other	1
Totals	10

Her Majesty's Chief Inspector of Prisons' Report

40. Lancaster Farms was last inspected by Her Majesty's Chief Inspector of Prisons in October 2006. The Chief Inspector's concluding remarks in her report were as follows:

> "Lancaster Farms was once the flagship young offender institution in the prison system and, after a period in the doldrums, it appears to be improving. Much has been done recently to enhance the safe and respectful treatment of the challenging mix of young people in the establishment's care, and particular progress has been made in addressing resettlement needs. There is still much to do, particularly in terms of getting young people out of their cells and into purposeful activity."

41. In the context of this investigation, I was particularly keen to examine the appropriateness of the culture in place at Lancaster Farms. In 2006, the Chief Inspector of Prisons wrote:

> "Survey results regarding staff-prisoner relationships were good, and comments in discussion groups with young people were positive. Most staff were at ease with their role in assisting young people towards a better future. There was good interaction between staff and young people during association and at other times out of cell. We found staff to be fair and tolerant in their dealings with young people, and that they generally set a good example to them. Although not all staff knocked on doors before entering cells, they were friendly enough and greeted the occupants courteously."

Independent Monitoring Board (IMB) Report

42. Every Prison Service establishment has an Independent Monitoring Board. This is a panel of local people appointed to monitor the way prisoners are treated. Boards are required to report their findings annually to the Secretary of State for Justice.

43. In their report on Lancaster Farms for the period February 2006 to January 2007, the IMB wrote about the following issues which required a response from the Secretary of State:

> "Purposeful activity remains a big problem. Many young persons spend too much time in their cells. We have now changed to

Education classes of shorter duration, designed to enable all young persons to be out of their cells every day. Whilst we are now seeing an improvement in class attendance it is still not at an acceptable level. Some classes may have only two, three or four young persons present when there should be at least eight.

"The issue of young persons being a long way from home and family has not been improved and has been exacerbated by recent prison population pressures.

"Staff shortages throughout the prison due to high levels of absence have placed continual pressure on the delivery of programmes and activities. We have found far too many occasions of 'dining in' cells this year, usually ascribed to this reason.

"Throughout the year we have had late arrivals in reception. In October 2006, we closely monitored arrivals and had a total of 109 arrivals after 7.00pm, 11 after 8.00pm and six after 9.00pm. This puts tremendous pressure on reception staff. We are concerned that the first night care cannot be as it should be, especially when a young person arrives after 9.00pm and is a long way from home and may have been travelling for over six hours.

"The number of young persons who arrive at Lancaster Farms with mental health issues is very high and yet healthcare staff maintain that they are not suitable for treatment and cannot be located on the healthcare ward. Nevertheless, many of them cannot cope with being on the wings either.

"During the reported period the effects of short stay Young Offenders and Juveniles have not diminished. Custody staff and Prison Management are expected to carry out the task of rehabilitative care whilst offenders are in custody but with such a short stay this is impossible. Staff are doing a good job with great difficulties."

44. I also record here further extracts from the IMB report as I believe them to be relevant to the investigation into the boy's death:

"**Windermere and Buttermere**

"Buttermere 1 is the reception wing for Juveniles and first night care is in operation. The IMB have a 15 minute slot every week to speak to the young persons, explaining how they can make an application to see a member.

"There is a monthly Juvenile Forum with two young persons from each of the Juvenile wings, Buttermere and Windermere,

attending. The meeting is a good 'talking shop' and young persons bring their thoughts and ideas. For example, if they think there are issues with menus, a member from catering attends. This gives everyone a chance to discuss the food available, something which is seen as a big problem.

"Windermere 1 and 2 houses Juveniles. All Juveniles are now financed by the Youth Justice Board. We now have two safer cells (i.e. cells in which the fittings and furniture are such as to reduce the presence of ligature points) on Windermere which can be used when a young person is on intermittent watch (i.e. when he is considered to be at risk of self-harm and therefore needs to be observed intermittently). The Youth Justice Board has financed a further 8 safer cells to be installed in 2007.

"Reception

"Reception staff often stay late to get through the late arrivals and the procedure for first night care. The late arrival of escorts continues to test their forbearance, as does the intake of prisoners who arrive unannounced, some with very little personal information.

"Suicide prevention

"The Suicide Prevention Team has met regularly throughout the year. Due to transfers of duties, the team has twice changed chair. During this time, however, the changeovers have gone smoothly showing a good team spirit where everyone knows their responsibilities and what is required of them.

"Concerns have been expressed about the number of juveniles and young offenders with mental health problems being sent to Lancaster Farms. Healthcare staff look after these young people to the best of their ability but prison is not a suitable environment for them and there is great difficulty finding vacancies in other establishments where more appropriate treatment can be given.

"We are fortunate that our staff are so dedicated and qualified to care for these young people. The number of ACCT (self-harm monitoring) forms opened has been of some concern at times during the year. There are currently 23 open (5.12.06). Reviews are done on a regular basis although the IMB are not always able to attend because times are often changed at the last minute.

"Training for assessors has taken place during the year and recruitment is ongoing for more assessors. As mentioned elsewhere in the report, the distance from home and family only adds to the stress some of these young men are under, a fact that is frustrating for both prison staff and the IMB.

"Violence reduction

"The committee has met on a monthly basis throughout the year. The number of fights, particularly between juveniles, has been of great concern and the staff are to be commended for the sensitive way that they have handled the problem and the implementation of the new minor reports process.

"It is hoped to launch the new anti bullying strategy early in 2007. The launch had to be held over from the autumn because of staff shortages and change of management. A close watch has been kept on the situation when groups of trainees and young offenders from Merseyside and Manchester have transferred into Lancaster Farms as they do not always see eye to eye."

YJB Monitoring Report

45. Each secure establishment's performance is monitored by a YJB performance monitor who works with the establishment to ensure that the YJB's requirements are being met and that it is complying with its contract. Monitors also work with the establishment to offer support to improve performance. In her report dated 24 April 2007 the monitor responsible for Lancaster Farms, summarised her findings on the subject of safeguarding as follows:

"Safeguarding arrangements were monitored on 23 April 2007 using information from the Safeguards team, case file samples, cell sharing risk assessment, discussion with casework team, In-Reach team, and Governor for Juveniles. Data received from the Placements team via the monthly report indicated 34 vulnerable admissions during the month of March with 9 young people being identified as having a history of self-harm. First night alert forms were also used to sample relevant case files. As indicated in the main body of the report, although there has been a significant improvement of T1:Vs [the name given to the form which has to be completed whenever a young person's initial custodial assessment is conducted], in some cases vital information is not included … It is understood … that the issue of Healthcare not having access to the Asset has now been resolved and that from now on, Healthcare will evidence that they have had sight of the Asset and, in particular, substance misuse, emotional, mental health and physical health sections."

46. On 22 October and 1 November 2007, the performance monitor visited Lancaster Farms in order to undertake a review of the Behaviour Management Code of Practice. The monitor chose this theme in the aftermath of the disturbance that occurred at the establishment in August that year (see my comments at paragraph 54 below), and because there had also been a separate, gang related incident. The table below contains relevant extracts from the monitor's report of those visits.

Code of Practice Indicator	Assessment by monitor
Systems should be put in place to monitor the risk in individual cases.	From a sample of eight wing files, evidence of a cell share risk assessment was found in all cases, though the level of detail on some was limited. The completion of T1:V vulnerability assessment does however remain an area of concern. From a sample of six case files, only three had adequately recorded information from documents received. In one case, although the initial T1:V was completed very well, there was no T1:V-R [the form used to update the T1:V] completed when important information relevant to risk eventually arrived. In previous monitoring visits, it had been pleasing to see that the T1:V had been included in wing files giving officers insight into any specific issues of vulnerability and risk. However, none were seen on this occasion and, disappointingly, it would appear that practice has not been sustained in this area.
All interventions to be driven by assessment.	From the six case files sampled, all provided some evidence that interventions had been driven by assessment. Particularly good evidence was seen of remanded young people having objectives set which were relevant to their own individual behaviour. The introduction of the Tackling Anti-Social Behaviour system (TAB) has resulted in those young people who are identified as requiring specific intervention due to bullying or other negative behaviours being monitored by intensive observations. Whilst there appears to be progress in terms of addressing particular negative behaviours, sampling of live TAB documents found no planned action to address negative behaviour.
Where identified risk or need exists, integrated co-ordinated behaviour management arrangements must be in place.	As identified above, the new TAB document has been introduced in order to address bullying and other anti-social behaviours within the establishment. Whilst this is seen as real progress, there continues to be a need to produce more individualised behaviour management **plans** [sic] for those young people with particularly challenging behaviour such as assaults on staff, other young people and cell damage. The TAB documents seen on Buttermere 2 Unit and on Ullswater (the segregation unit) appeared to monitor behaviour but does not address the presenting issues through a plan.

Previous death at Lancaster Farms

47. In January 2005, another young person took his own life at Lancaster Farms. The inquest into his death was being heard when the boy died. In my report of the investigation into that earlier death, I made 16 recommendations to the Governor of Lancaster Farms who accepted all but one (which was found not to apply to the establishment). One of those recommendations was about the

Personal Officer scheme. Although efforts had been made to improve the Personal Officer scheme thereafter, I am disappointed at having cause to make another such recommendation in this report.

Disturbance

48. In August 2007, a serious disturbance took place in the young people's units at Lancaster Farms during which a large number of young people damaged their cells. As a result, both units were temporarily closed while the damage was repaired. When the units were re-opened, the influx of young people was such that staff felt that reception and induction procedures were placed under some strain. The establishment was still trying to cope with the effects of that pressure at the time of the boy's death.

RED BANK SECURE CHILDREN'S HOME

49. Red Bank is situated in Merseyside on the border of the town of Newton-le-Willows. The home has been managed by St Helens Social Services since 1992. It provides specialist care and education for 40 children, aged between ten and 17 years, in three secure units and three open units. Education is provided for every child in residence.

50. The secure provision comprises three houses: Newton, which accommodates 14 boys; Willows, which accommodates seven boys; and Vardy, which accommodates eight girls. The Children's Home Health Team looks after all the mental health and associated needs of the children, and the site nurse caters for their primary health needs. Leisure activities within the units include table tennis, crafts, cookery, computer games, board games, television and video.

51. All staff are social work trained. They are supported by a Children's Home Health Team comprised as follows:

    a general manager
    an art therapist
    a secretary
    a registered mental health nurse
    a speech and language therapist
    a music therapist
    a consultant psychiatrist in young people's and forensic services
    a registered mental health nurse specialist practitioner
    a psychologist.

52. Many of the children will have experienced placement breakdowns and changes in carers which in turn may have led to behavioural problems, disruption to education and mistrust of adults. The children's home staff help them to develop socially, emotionally and intellectually by providing high quality residential care and educational services tailored to individual needs. Great importance is placed upon communication in order to monitor children's well-being and progress. Staff handovers, regular staff meetings, children's meetings, and reviews are all vital components of the communication process. Arrangements for reviewing cases are in line with national guidelines issued by the Youth Justice Board. A care plan is formulated for each child in secure provision in conjunction with all relevant professionals.

53. Residents are able to access facilities within the secure perimeter which include a large sports hall, fitness suite, a games area and all-weather activity court. Where applicable, access to facilities outside the secure perimeter is planned and monitored for each resident via their care plan and risk assessment procedure. This may allow access to open facilities off campus.

54. Individually and together, the team members aim to meet the children's health needs during their time in the home. Approximately 90 per cent of the children present with needs in at least one of the following areas:

mental health, including depression
anxiety
onset of psychosis
deliberate self-harm
emergent personality disorder
substance misuse
development disorders including ADHD (Attention Deficit Hyperactivity Disorder)
autistic spectrum disorders
dyspraxia,
disorders of communication and other congenial or acquired difficulties, such as hearing or learning disabilities.

OFSTED inspection

55. In a report of an OFSTED inspection carried out on 28 November 2007, Red Bank achieved an overall 'good quality' rating. The inspectors found that relationships between staff and residents were positive and friendly. The approach by staff was child centred. They skilfully used positive professional relationships and appropriate humour to persuade the residents in their care to comply with their instructions.

56. The children were told of the procedures for making complaints when they were admitted to the home. The complaints procedures had improved to enable them to use external procedures if they chose to do so. The home offered a number of meetings and opportunities for the residents to raise issues within the daily routines. One example was the food council which gave children a chance to meet the managers and catering staff to discuss meals and make suggestions about menus.

57. The OFSTED inspectors found that there was a clear anti-bullying policy in place that was known by staff and residents. They reported that there was a well developed incentives and bonus scheme that allowed the children to obtain incentives such as extra telephone time, increased pocket money and later nights.

58. A detailed risk assessment was carried out for all children at the point of admission to the home. The assessment of risk and vulnerability was very comprehensive and was ongoing. Procedures for dealing with those attempting suicide or self-harm were linked to the risk assessment and risk management plan.

Visit to Red Bank by investigation team

59. My investigation team visited Red Bank on 15 January 2008 in order to compare the ethos and culture with that of the juvenile units at Lancaster Farms. The team's impressions matched the findings expressed by the OFSTED inspectors. There was a clear 'family' atmosphere in the home. My investigators were told that there was one member of staff for each of the

residents. First name terms were used. Both staff and young people routinely wore civilian clothes. The rooms – not cells – were well decorated and comfortable. The residents seemed proud of their environment. They were encouraged and supported in maintaining links with their families and friends outside. Each of them was closely supervised at all times during the day, and interaction between staff and residents was intense and continuous. My investigators spoke to two boys and one girl. Each gave positive and optimistic responses to the many questions posed, and each confirmed their opinion that they were given appropriate support by staff.

KEY EVENTS

Background

60. Prior to his admission to Lancaster Farms on 8 November 2007, the boy had already amassed a number of court appearances. The first of these, following his arrest for shoplifting, had taken place a year earlier. Thereafter, the boy continued to re-offend on numerous occasions, each time for similar crimes. The youth courts before which he appeared handed down a variety of community based punishments, none of which seemed to have had any deterrent or rehabilitative effect.

61. In May 2007, the boy committed four separate acts of theft from a shop and one of assault. On each occasion he had been drinking. On 26 May, he was remanded to Local Authority accommodation at Willowfield Care Home in Croxteth, Liverpool.

62. On 5 June, the boy's case was heard by St Helens Youth Court. The following extracts from a report to court submitted by a member of staff of the Youth Offending Service drew attention to concerns relating to the possible impact upon the boy of a custodial sentence:

> "The boy is currently residing at Willowfield Care Home in Croxteth, Liverpool following a remand to Local Authority accommodation on 26 May 2007. However, dependent on the outcome of today's sentencing, the boy will hopefully be moving back to live with his legal guardians. The court will be concerned that the boy is a persistent young offender and is before them once again in such a short period of time.
>
> "I would assess the boy's vulnerability as being low to medium. Although the boy stated at his interview there had been a recent incident of self-harm (within the last 3-4 weeks) I have no evidence of this. The boy will receive ongoing support from Child and Adult Mental Health Service (CAMHS) and a range of other professions/agencies. The boy is aware and immensely fearful that the court may be considering imposing a custodial sentence today. The court will be aware of the adverse effects of custody upon a young person."

63. The boy was given a Supervision Order as part of the Intensive Supervision and Surveillance Programme (ISSP). During the early evening of Friday 8 June, when the boy was still subject to the requirements of that order, he allegedly made racial insults to a shopkeeper and threatened him. He was arrested at 7.25pm that day. He remained in police custody over the weekend. The boy was taken to St Helens Youth Court from St Helens police station at about 8.30am on Monday 11 June. The Prisoner Escort Record (PER) for the journey carried a notation that he was at risk of self-harm because he had cut his wrists a month earlier. A concern was also raised about his mental health.

64. At court, the boy was given a four month Detention and Training Order (DTO). A Youth Offending Team (YOT) worker and Senior Practitioner for the ISSP sent a Vulnerability Alert to the Youth Justice Board in which she drew attention to the following concerns about the boy's risks:

> "History of self-harm/suicide attempts. Most recent whilst in police custody on 9 June 07. (self-harm). First time in custody and extremely fearful and anxious about this."

65. In a post-court report, another YOT worker wrote:

> "The boy has never been into custody before and is fearful. He has a history of self-harm, the most recent incident being this weekend whilst in custody at police station. The boy needs the most intensive support package available. I feel he will attempt self-harm again and is at risk of bullying. Please monitor carefully."

66. The YJB decided that the boy was to be placed at HMYOI Thorn Cross and issued a placement confirmation to that effect on the same day that the boy was sentenced. The placement confirmation carried an alert that the boy had previously self-harmed.

67. The boy arrived at Thorn Cross at about 9.40pm on 11 June. A suicide/ self-harm warning form was completed by a Prisoner Custody Officer (PCO) who was tasked by Global Solutions Ltd to take the boy from court to prison. The warning form carried the notation that the boy had self-harmed within the previous month. The source of this information was quoted as the Prisoner Escort Record. No other details were recorded.

HMYOI Thorn Cross 11-20 June

68. Upon his arrival at Thorn Cross, the boy underwent a reception health screen. The following note of the screen was made in his clinical record:

> "Arrived at Thorn Cross late in the evening on 11 June. Reception screen was completed but all information entered onto system one [his electronic medical record] the next day due to the lateness of the hour. The boy was nervous being his first time in prison and it was noted that he caused superficial scratchings and cuts to his arms, neck and chest. He says this was an impulsive act following the distress at being in custody and is now regretful of the incident. He reported that there had not been any other attempts to harm himself and denied the comments about an overdose in the Asset form (Nov 06). The boy also reports that his biological mother was also in a prison and was due to see her next Monday for the first time in nine years. Both of them are due for release in July. He has a visit due this week from his social worker and YOT worker. He is demonstrating that he is thinking

> positively about the future and seemed reassured about being in custody following the support he was getting on DCU [Direct from Court Unit]. Referred for mental health assessment and will see doctor routinely tomorrow. No immediate concerns in terms of health needs."

Cell sharing risk assessment

69. During the reception process, each new arrival must be assessed as to his risk of harming other prisoners. The assessment informs the decision as to whether it is safe to allow him to share a cell. The risk of a person harming others has to be balanced against the risk of harming himself if he were to occupy unshared accommodation. The boy was considered by the reception officer to present a medium risk of harming others. This was because of the nature of his offence and because he had admitted that he was a person who quickly became angry and frustrated. In practical terms, the fact that he was judged as presenting a medium risk meant that there was no immediate risk of harming others but the boy would have to be kept under review.

70. The cell sharing risk assessment process includes an assessment by a member of the healthcare team. In the boy's case, this was completed by a prison nurse. The nurse wrote:

> "The boy self-harmed in police cells. Superficial cuts to arms, neck and chest. Feels regretful. No plans to self-harm further. Planning for the future. Currently relaxed and at ease. Denies previous self-harm in Nov 06."

71. The prison nurse concluded that there was no evidence of a risk of harming others and that the boy was therefore suitable for multi-cell location.

Form T1:VR

72. As part of the normal reception procedures, the prison reception officer completed a form T1:VR. This form is used to assess the vulnerability of newly arrived young people. In answer to the question, "Having interviewed the child/young person, do they give you any cause for immediate concern?" the prison reception officer wrote as follows in the boy's form:

> "Yes, due to cuts on arms neck and chest. The boy appears a very nervous individual, which may be a result of this new environment, but on observation he displays low self-esteem, is difficult to interact with and appears quite withdrawn."

73. However, the prison reception officer also recorded that the boy told him he had no concerns at that point. The boy was nevertheless placed in a safer room for his first night. (Safer cells are designed to make an act of self-harm or suicide as difficult as possible. This is achieved primarily by reducing ligature points as far as is possible. Anti-ligature furniture and fittings are installed as an integral part of the cell fabric. The design also takes account

of the physical needs of the prisoner and the necessary robustness required in the construction of all fixtures and fittings.) The prison reception officer recorded his view that the key points that required follow-up action were an in-depth mental health assessment and safeguarding during the process of his induction assessment.

74. In answer to the question, "Does the child/young person's attitude appear to make them a victim of bullying/victimisation?" the prison reception officer wrote:

> "Easily led by peer group. The majority of previous offending linked to alcohol abuse and peer group pressure. The boy is of slight physical stature and current physical scarring may result in him being recipient of verbal/physical abuse.
>
> "Has presented as vulnerable in the past and although there is little evidence of being victimised, this will need to be monitored if placed in open conditions."

75. The prison reception officer believed that the nature of the boy's crime was significant. He wrote:

> "Racially linked crime. Peer group pressure. Self-harm history. Should others become aware of it, could lead to heightened vulnerability."

76. During his first night at Thorn Cross, the boy was observed in his room once every hour, a standard practice for all newly received young people. The entries made in his first night observation and support record show that he gave none of the staff any cause for concern. He had his breakfast on the morning of 12 June and interacted with the other boys in his unit. On the same day, the following entry was made in the boy's prison record:

> "During next day induction, whilst talking about bullying issues and racially motivated previous convictions, the boy became very agitated, placing both arms up inside his shirt, wringing his hands together and pulling at his shirt. As soon as we moved on to easier subject matters he visibly calmed down."

Assessment, Care in Custody and Teamwork (ACCT) form opened

77. At 5.20pm that day (12 June 2007), a decision was made by a prison officer to open Assessment, Care in Custody and Teamwork (ACCT) procedures. (The ACCT process is a means whereby staff can work together to provide individual care to prisoners/young people who are in distress in order to help diffuse a potentially suicidal crisis and to help individuals with long term needs - such as those with a pattern of repetitive self-injury - to better manage and reduce their distress. Anyone working in a prison who has concerns about a prisoner/young person with whom they are in contact must talk to the person

about their concerns, listen to what they have to say and, if still concerned, open an ACCT plan.)

Concern and keep safe form

78. The reasons for opening the document for the boy were recorded on a "Concern and Keep Safe" form as follows:

> "The boy states he has a history of both self-harm and attempt suicide. The boy states he last self-harmed in police custody on 9 June 07 when awaiting sentence. He states he used a spoon to cut his arms, throat, chest and body. The boy also states the last attempt suicide was two months ago when he cut his wrists. Asset also details further attempt suicide in November 06 when he required hospital admission. Currently on first custodial sentence and was using excessive amounts of both alcohol and class A and B drugs. History of mental health support (ongoing).
>
> "During discussions, the boy appeared quite happy but would become extremely uncomfortable particularly in discussions about family. Has not met his mother in nine years. Given the above, the boy will be very vulnerable and will require close monitoring to ensure safety whilst in Thorn Cross."

Immediate Action Plan

79. As part of normal ACCT procedures, an Immediate Action Plan was drawn up for the boy. The purpose of this plan is to record the most appropriate environment and regime required to support the prisoner prior to his first ACCT case review. The actions listed for him were as follows:

> The boy was to remain in the Direct From Court Unit in a safer cell until a full assessment was made.
>
> He was to be subject to "15 minute observations maximum at irregular intervals and spoken to if awake". Five observations were to be recorded every hour.
>
> A visit with a carer (i.e. a parent or guardian) was to be arranged for the following evening.
>
> The boy was to be reminded that he could speak to staff at any time if he felt the need to do so.

80. The investigation found no evidence to show whether the visit by a carer took place.

ACCT assessment interview

81. The next day, the boy underwent an ACCT assessment interview. He told his assessor that he usually self-harmed when under the influence of alcohol because in this condition he would become emotional. He said his distress was mostly related to his father's death and the fact that his mother was in prison. The boy said he was also affected by the death of his uncle and aunt's son five years earlier.

82. The boy explained that when he was in police custody on 9 June, he had broken a spoon and used it to make superficial cuts to his arm, throat, chest and body. He told his assessor that this behaviour was a coping mechanism rather than a suicide attempt. He said he felt relieved after cutting himself but did not want to die. He admitted that he had started to harm himself two years earlier but could not remember what had triggered this behaviour. He said he usually self-harmed by cutting himself rather than by overdosing. The boy said he used alcohol to block out bad memories and took drugs such as cocaine, ecstasy, LSD and cannabis for recreational reasons.

83. As to his risk of killing himself, the boy told his assessor he had no feelings of hopelessness, no persistent low mood, no lack of interest in work or play, and did not feel increasingly tired. His appetite was normal. He said he did not want to be dead and therefore had no intention or plans to kill himself. He realised his time in prison was brief and that support would be available from family and friends when he was released. The boy was also offered bereavement counselling but he declined as he said he already had a counsellor in the community from whom he expected a visit whilst in prison.

First ACCT case review

84. On 13 June, the boy's first ACCT case review was held. The panel comprised his assessor and his unit manager. The boy was present throughout. The review was summarised as follows:

> "During the course of the case review, the written information provided by the assessor was discussed along with the issues that were raised by the prison officer from Safeguarding. On speaking to the boy, he appears to be happy to be here rather than at a closed establishment. This was also the case of the staff in attendance who feel that closed conditions would not be of any benefit to the boy. He appeared to be fine at the moment but below the surface there are a lot of issues that need to be addressed."

85. The panel considered that the boy's risk of further self-harm was low and decided that he should be observed five times each hour. (I consider that this level of observation is more appropriate for someone whose risk is thought to be much higher.) A contemporaneous record of each observation was to be made. The panel also decided that it was appropriate for the boy to move from a safer room to an ordinary room.

86. On 18 and 19 June, consideration was given to the boy's readiness for open conditions at Thorn Cross. The following email was sent to Cheshire Police:

> "The boy is expected in St Helens Magistrates Court on 4 July. He is on technical bail (i.e. on bail for this offence but already in custody) for an offence of Affray. He has submitted no plea. The case is expected to go to the Crown Court. In order for the Governor to review the boy's suitability for open conditions, we need as soon as possible further details: i.e. the seriousness of the boy's involvement in the offence and the approximate length of sentence he is expected to receive."

87. The police replied as follows:

"The offence for which he is charged is affray, using racially threatening words/behaviour. The offence took place on 8 June 2007. Having looked at his convictions and the fact he is in custody on other matters he may get a custodial sentence. My thoughts are that until a trial date is fixed and the formal remand is in place, he is not suitable for open conditions."

88. On 19 June, the following entry was made in the boy's core prison record:

> "Spoke to YJB placements ref the boy having to be transferred at the soonest possible moment. Message from the Governor the placement had to be a secure unit not a prison environment due to his previous self-harm and an outstanding court appearance of a serious nature. All this was related to YJB placements."

(At consultation stage, the St Helens Youth Offending Service pointed out that the boy was deemed not suitable for open conditions only because there were outstanding matters at court and not because of his vulnerability.)

89. The next day, the boy was transferred to Red Bank with his ACCT form still in force. The PER for the journey to Red Bank made this clear. The last entry in his ACCT ongoing record was made at 9.30am on the day of his transfer. The author wrote, "Transferred to Red Bank. He seems quite happy to be going." The boy arrived at Red Bank at 10.00am.

Red Bank: 20 June-10 August

Initial custodial reception assessment

90. As soon as the boy arrived at Red Bank, a form T1:V (Initial Custodial Reception Assessment) was completed. The aim of the assessment was to consider the boy's current risks. The following table shows the principal conclusions drawn from the assessment with regard to his risk of self harm:

Question	Answer	Comments
Has the detention in a secure facility increased the child's risk of self-harm or suicide?	Yes	Asset suggests that the boy is extremely at risk when in custody. Self-harmed whilst in custody and suicide attempt in

		Nov 06. The boy is only 1 week into a 4 month DTO and has been transferred from Thorn Cross to Red Bank due to the high risk of self-harm.
Is the child a potential victim?	Yes	Due to the boy's past regarding self-harm and his slight build.
What action will the secure facility take to reduce the child's anxiety, vulnerability or risk of self-harm or suicide or the risk they pose to others?		The boy will be put on 5 min nightly checks. He will not be allowed any items in his room until he has been fully risk assessed. The boy's behaviour on the unit will be closely monitored.

91. A week after his arrival at Red Bank, the boy was described as "still finding his feet" with other young people. He seemed to get on well with staff other than those working in the education department. There were no concerns about his health, except in relation to a foot injury he sustained on 22 June. He maintained regular contact with his guardians by telephone and received a visit from them.

92. On 4 July, the boy appeared at St Helens Magistrates Court where he was committed for trial at Liverpool Crown Court for his charge of affray.

93. Later that month, on 20 July, the following letter was written by the Senior Social Work Practitioner, Safeguarding Team at Thorn Cross, to Red Bank:

> "I am writing to you as the Social Worker based in Thorn Cross who interviewed the boy on 12 June 2007 following his arrival. As a result of my interview, a number of concerns became apparent which, whilst you may already be aware of, I feel I need to draw your attention to:
>
> "The boy's history of self-harm and attempted suicide,
> A self-harm incident in police custody whilst awaiting placement in Thorn Cross,
>
> "The boy's previous heavy reliance upon alcohol and drugs and the impact of the loss of these apparent key coping mechanisms.
>
> "The loss of his father at a young age, his previous history as an armed bank robber and the boy's feelings regarding this;
> The abandonment by his mother also at a young age and the recent information about her current whereabouts and the boy's wishes to make contact.
>
> "As a result of my concerns regarding the boy's vulnerability, an ACCT was opened to increase the level of monitoring and the boy remained within the Direct from Court Unit (DCU) whilst further enquiries were made.
>
> "A meeting was arranged at Thorn Cross on 15 June to discuss these concerns with the boy's Social Worker, his CAMHS worker and key staff at Thorn Cross. Following that

meeting, it was agreed that the boy should remain in the DCU whilst he continues to settle and make a gradual transfer to open conditions. It was also agreed that his social worker would make further enquiries regarding developing contact with his mother and explore how, and at what pace, any contact should take given the boy's current circumstances. His CAMHS worker agreed to carry on supporting the boy by continuing her weekly visits and providing any additional assistance he may require following contact with his mother. However, following the realisation that the boy had additional charges, he was transferred to your establishment and no further action could be taken with regard to the issues identified."

94. On 23 July, the boy was due to appear at Liverpool Crown Court on the charge of affray but the case was adjourned. The boy was remanded in custody and returned to Red Bank.

95. By the end of July, the frequency of observations made upon the boy had reduced from five to 15 minute intervals during the night. Although he had generally settled, his behaviour was at times demanding. The following report, written on 31 July, reveals both the positive and negative aspects of his conduct at that stage:

> "The boy has been very positive during his placement at Red Bank. He has followed the routines appropriately and progressed well on the incentives scheme, gaining very high points totals. He does struggle in attending PE sessions and will try to avoid these at any cost. The boy has handled the situation with his mother and personal issues very well and has resumed contact with her although he would now like to meet with her and receive visits. However, this has led to a deterioration in the relationship with his uncle and aunt."

96. In his final review on 3 August, the boy was described as having made good progress at Red Bank. A week later, he was released on licence under the Intensive Supervision and Surveillance Programme (ISSP). The licence conditions required him to conform to curfew arrangements monitored by an electronic tag. For the following two weeks, the boy lived with his aunt and uncle.

Red Bank: 24 August-22 October

97. Three weeks later, on 23 August, the boy appeared again at Liverpool Crown Court to answer the charge of affray. In her pre-sentence report to court, the boy's second Youth Offending Team (YOT) worker wrote:

> "The boy has been involved with the Youth Offending Service since 2006. He has been subject to various community orders and has responded positively to interventions. However, he has

breached orders where there has been an additional curfew element. It is with regret that I must inform the court that the boy has placed himself in breach of his current Notice of Supervision. The boy was released on 10.8.07 with a condition to comply with the ISSP including an 8.00pm to 7.00am curfew. He is required to undertake 25 hours of supervision and be subject to the curfew. The boy has kept all but one of his supervision appointments. However, he has unfortunately breached the curfew element. This incident happened on the evening of his release when he was not available for the equipment to be fitted. A further attempt was made to install the equipment but the boy was absent from home for this visit. As such, he does not have an electronically monitored tag at the current time. The breach case is currently being processed and has to be heard before the Youth Court. However, plans to proceed further will depend upon the outcome of today's case.

"Regardless of today's outcome, the Youth Offending Service will remain involved with the boy on a statutory basis whether that is via a community based order or a DTO. Objectives for supervision/sentence planning would be for the boy to:

- improve his understanding of the effects of crime by participating in victim empathy and consequential
- thinking skills sessions,
- reduce his levels of alcohol use,
- participate in positive activities thus reducing the risk of
- involvement in further offending,
- improve his understanding of the links between peer pressure and his offending,
- improve his coping skills via continued specialist mental health service interventions,
- make reparation for the harm he has caused by his offending by engaging in regular reparation sessions."

98. The second YOT worker recommended to the court that the boy could be given a further ISSP supervision order. However, instead he was given a further four months Detention and Training Order. The boy was initially taken to Newton Aycliffe Young People's Centre in County Durham, but the next day he was transferred to Red Bank, some 150 miles away. In a post-court report, a YOT worker pointed to the boy's vulnerability to self-harm and advised of the need to monitor him closely in the early stages of custody. The boy's admission proforma carried a notation that he was at risk of self-harm or suicide. The following comments were recorded:

"From Asset – He has self-harmed in police custody recently (cuts to arms). If loses contact with mum, risk of vulnerability heightened. Risk at high level. Suicide attempt (2006) overdose."

The boy's attitude towards education

99. The following table contains extracts from later sections of the admissions proforma and shows the boy's attitudes towards compulsory education:

Question	Answer
Do you think it is important to get an education?	No
What do your parents/carers think about your education?	Aunt and Uncle have no say.
Do you go to school regularly?	No
Do you, generally, like school?	No
Have you ever been suspended or excluded from school?	Yes, for poor behaviour.
Did you get into trouble at school?	Yes, for smashing things and bullying.
Have you ever been a victim of bullying?	No
Are you working towards any GCSEs?	Supposed to be working towards 7 GCSEs but not going to.
Whilst you are at Red Bank you will have to attend education classes. How do you feel about that?	Not happy but will try.

100. On a keywork session recording sheet completed on 29 August, the boy's keyworker made the following comments:

> "Generally, the boy is familiar with the rules and regulations governing the unit. The boy has settled in well and is having no trouble from his peers. The boy has to admit when he is wrong and face up to his actions. He can't just bury his head in the sand. All those with a vested interest in the boy believe him to have the ability to do well in his education. It is up to him to prove it.
>
> "The boy is keen to contact his mother who he says is currently 'missing'. Has spoken to his sister who is trying to find mum. Also his aunty is trying to make contact and, if successful, will inform the boy accordingly."

101. A week later, the boy had a further review with his keyworker. The record of the review shows that the boy asked to be transferred, though no further details were recorded. It also shows that the boy had been successful in making contact with his mother by telephone and that she was due to visit him at Red Bank on 6 September. It is not clear from the record whether this visit took place. It was reported that the boy had attended some education classes but not PE. He told his keyworker he was adamant that he would not attend PE whilst at Red Bank.

102. The documents presented to my investigation team contain summaries of further review meetings held on 21 September, 29 September and 15 October. It is not clear whether additional meetings were held on other dates. The available evidence shows that there was an improvement in the boy's attendance at classes towards the end of his time at Red Bank but this improvement was not matched by his general behaviour. Between 22 June

and 11 October, a total of 26 control measures (minor punishments) were invoked because of the boy's poor conduct. On 2 October, the boy received a visit from a family member to whom he became abusive. He was also abusive to staff and had to be restrained. Shortly afterwards, he cut his arms superficially. As a result of his poor behaviour, the boy was not allowed to use the television in his room for four days. There is no evidence to show whether his risk of further self-harm was monitored. However, the boy did not in fact self-harm again.

Release from Red Bank

103. At 9.40am on 22 October, the boy was released from Red Bank to serve the remainder of his DTO under supervision in the community. He attended St Helens YOT that day to confirm that he understood the conditions of his supervision, including compliance with the curfew element of his release. This came into effect at 8.00pm that day when the boy was required to be available for the installation of the monitoring equipment. At 6.32pm, an engineer from a security firm arrived at the boy's home to install the equipment. The boy was not at home. A further visit was made by the engineer at 8.00pm. On this occasion, the boy was present but he was under the influence of alcohol and in bed. Three unsuccessful attempts were made to wake him. This incident was classed as a significant violation of the conditions of his supervision. A formal notice to this effect was issued.

104. The monitoring equipment was installed some time later. During the first week of his release, the boy complied with the supervision element of his licence but accrued two further curfew absences on 27 and 28 October. Thereafter, the boy's behaviour deteriorated further. He refused to engage with the YOT interventions, and failed to attend school or comply with his curfew. On two occasions, he stayed out all night and was reported to police as a missing child. As a consequence, the YOT became increasingly concerned at his risk of re-offending and his vulnerability, and decided that he had breached the conditions of his licence. As a result, a court hearing was arranged for 8 November. As the second YOT worker thought she might still be able to recommend community supervision, the option of recommending his recall was delayed until the last minute. In light of the fact that the boy failed to engage during the two week period between his release from Red Bank and the court hearing, the second YOT worker decided that she had no option but to recommend recall.

Placement alert

105. The role of Placements and Casework at the YJD is to place young offenders appropriately within the young people's secure estate. During interview, the Head of Placements and Casework said the YJB placements process is reliant on receiving accurate information from YOTs.

106. The Head of Placements and Casework explained that YOTs send a Placements Alert form to the YJB, ideally a day before the young person is due to appear in court. In the boy's case, his second YOT worker had

prepared the alert form and tried to fax it through on 7 November. However, as a result of a technical problem, the second YOT worker was unable to fax the form to the YJB until the morning of 8 November, the day of the boy's court appearance. The alert form should provide the latest information about a young person, including any risk factors that should be considered by the YJB Placements team or by the establishment that is destined to receive him. The following information was included on the boy's form:

> "Since last asset forwarded to YJB [at time of original sentence] concerns re vulnerability have continued. The boy has some history of self-harm in custody. Whilst in most recent custodial phase of DTO at Red Bank Secure, he made superficial cuts to his arm on one occasion when he was upset over a family visit. The boy also had two incidents whereby he was physically restrained by staff after hitting out at them when he was upset.
>
> "The boy uses alcohol and he has recently been drinking daily to excess and also possibly using amphetamines both of which have a detrimental effect on his well being, thinking and coping skills. The boy has a mental health worker from local St Helens CAMHS [Child and Adolescent Mental Health Service] who can quickly link in with any custodial mental health services for support. He also has a substance misuse worker who can quickly liaise with custodial facility staff. A request is being made for recall, and it is the Youth Offending Service assessment that the boy's needs can be adequately met in a Young Offender Institution as long as staff consult asset docs post custody report and any vulnerability alert forms which will follow."

107. Below the box on the form in which the above information was recorded, there is a list of other questions that must be answered. Those questions, together with the associated answers, are repeated in the following table:

Question	**Answer**
First time in custody?	No
Potential self-harmer/suicide?	Yes
History of abuse/trauma?	Yes
Risk to others?	Yes
Gang member	No
Substance misuse	Yes
Other health issues	No
Requires detox?	No
Mental health concerns?	Yes
On medication?	No
Is young person a parent?	No

The question and answer list is written in the same font as the rest of the text and does not stand out as having any more importance than the neighbouring text.

108. The Placement Alert form has a "Suggested most appropriate placement" section. The Head of Placement and Casework explained that a YOT worker

will usually have worked with a young person prior to custody, and should be in a position to recommend a suitable placement to meet the young person's needs. The second YOT worker suggested that the boy would be most suitably placed in a YOI and identified Lancaster Farms as the "preferred unit".

109. The YOT worker must then describe the reasons for the suggested placement on the alert form. The second YOT worker wrote as follows:

> "Previously requested Red Bank when the boy had not experienced custody. However this would be the boy's third time in custody and Youth Offending Service (YOS) staff can liaise appropriately with casework staff at Lancaster Farms which is near enough to enable family visits to take place, and also any relevant partnership staff can regularly visit to undertake ongoing interventions and planning meetings."

110. Underneath the suggested placement section of the placement alert form, there is a table which guides a YOT worker to identify the appropriate placement for a young person, according to his or her age and gender. For 14 to 16 year old males who have received a custodial sentence, the following two suggestions are made:

> "If assessed as having significant risk factors: Secure Children's Home (SCH) or Secure Training Centre (STC);
> If not assessed as having significant risk factors: Young Offender Institute (YOI)."

Vulnerability alert

111. The second YOT worker identified the boy as having risk factors, but recommended that he should be placed in a YOI. The Head of Placements and Casework explained that the YJB Placements team has an automated vulnerability alert system. If any risk factors are identified on the alert form by the Placements Officer, they are entered onto a database which triggers an automatic vulnerability alert. The placement confirmation form faxed through to the receiving establishment in advance of a young person's arrival has a red box with details of the young person's risk factors. In large red capitals, the vulnerability alert on the boy's placement confirmation form read:

> "Self-harm/suicide risk
> Previous self-harm attempt
> Potential Self-harmer (threats)."

112. During interview, the second YOT worker explained her recommendation for the boy's placement at Lancaster Farms. She said she did not consider that the Secure Children's Home met his needs. She was concerned about the boy's behaviour since his release from Red Bank because he had been drinking heavily and staying away from home overnight. Despite the fact that The second YOT worker reminded the boy of the consequences of missing

his appointments – including a return to custody – he had continued to do so. The boy told the second YOT worker he did not care.

113. The second YOT worker told my investigators that she was primarily concerned to help the boy to stop re-offending. She said:

> "This would be his third time in custody and being 15, nearly 16, he was going to a juvenile wing of a YOI rather than the Young Offenders Department which I felt would be suitable for him. I think because he had been to Red Bank twice and in a way it hadn't had a big effect on him I think that was what I was thinking. You know a fresh somewhere different may have had a positive effect on him."

114. When asked whether she had considered the need to keep the boy as close to home as possible, the second YOT worker said:

> "We class Lancaster Farms as our local prison. I know there is one closer but it's an open facility which is Thorn Cross. The reason I didn't put Thorn Cross down was because he'd been absconding from home and I felt there might have been a risk that he could have done there."

115. The second YOT worker explained that she did not consider recommending Hindley YOI as the establishment "is the other side of Wigan". She said she consulted two senior practitioners about which YOI would be the best for the boy. The second YOT worker thought Lancaster Farms was close enough to enable family visits to take place and that staff involved in the boy's case would still be able to see him regularly. (At consultation stage, the St Helens Youth Offending Service pointed out that the Youth Justice Board and Prison Service agree the catchment areas for Youth Courts across the country and that Lancaster Farms was the designated YOI for Merseyside courts at the time. Hindley YOI was the designated YOI for youths from Manchester. As a result of the rivalries between these two areas, young people were not mixed at the time. Therefore, Hindley would not have been an option.)

116. My investigators asked the second YOT worker if she had considered how the boy would be able to cope with the assertive environment of a prison and whether he would be susceptible to bullying. She replied:

> "As a case worker you have to consider that for all young people. I didn't think it was an issue for the boy when I was making the decision about which custodial setting to recommend."

117. The second YOT worker told my investigators that she was aware that in court the boy had said he would stop eating and drinking if he were given a custodial penalty. She said she had been told this by his aunt. The second YOT worker asked the court worker to discuss this with the boy when the time came to interview him in the court cells for the purpose of the post court report (see paragraphs 131-133 below). The second YOT worker remembered

speaking to the boy about the fact that she had recommended placing him at Lancaster Farms and that he did not mention any such threat to her.

Asset form

118. The following historical information was included in an Asset form made out by the second YOT worker earlier in 2007:

> "The boy had been bullied in the past,
> his daily functioning was significantly affected by emotions or thoughts resulting from past events,
> he was affected by emotional or psychological difficulties [e.g. phobias, eating or sleeping disorders, suicidal feelings],
> he had previously harmed himself,
> he had previously attempted suicide."

119. At section 9 of the form, under the heading, Emotional and Mental Health, the second YOT worker wrote:

> "The boy presents as an extremely vulnerable young person. He continues to have involvement with CAMHS and continues to drink excessively. There has been a history of self-harm and suicide attempts. Whilst there have not been any recent attempts of suicide, he has most recently self-harmed while in police custody on 9 June 07. The boy received a 4 month DTO on 11 June and as such his vulnerability has escalated. Concerns regarding the impact of this sentence on his emotional and mental health."

120. Under the heading 'Vulnerability' at section 15, the second YOT worker wrote:

> "Pre-sentence report 22 August 07:
>
> THE BOY'S VULNERABILITY NEEDS ASSESSING IF RIC [Received into custody]. HE HAS SELF-HARMED IN POLICE CUSTODY RECENTLY – CUTS TO ARMS – AND AT LAST RIC A REQUEST WAS MADE FOR THE BOY TO BE SENT TO A SCURE REMAND RATHER THAN YOI. SAME ISSUES PRESENT FOR PRE SENTENCE REPORT – SO COURT STAFF WILL NOTIFY ANY CONCERNS VIA POST COURT REPORT IF RIC.
>
> "Pre sentence report Asset:
>
> "The boy has never been in custody and I think he would find it difficult to cope and this will impact on his mental health. I would assess the boy's vulnerability as being low to medium. Although the boy stated at his ISSP interview there had been a recent incident of self-harm (within the last 3-4 weeks), I have no evidence of this. The boy will receive ongoing support from CAMHS and a range of other professional agencies."

121. However, the second YOT worker updated the boy's Asset form on 24 October, by which time the boy had spent a period at Red Bank and been released. Although the above information had not been deleted from the form, the indications were that many of the concerns raised prior to the boy's admission to Red Bank had not materialised.

122. By November, the second YOT worker believed the boy could benefit from the more disciplined regime at Lancaster Farms. She said that Red Bank, "did not seem to have worked for him" and that was the reason for her decision to recommend placement in a YOI. The second YOT worker told my investigation team that she had found it difficult to recommend that the boy's licence be revoked and she was reluctant to recommend a return to custody. However, she believed that his failure to engage with her, coupled with his chaotic behaviour following his release from Red Bank on 22 October, left her with little choice but to recommend a custodial placement in a YOI. The second YOT worker told my investigators, "St Helens has a pattern of identifying Lancaster Farms, it's our local custodial facility." Thus, once she had decided on a recommendation for placement in a YOI, it was in line with normal practice for her to recommend Lancaster Farms. On 7 November, following discussion with her manager at the Youth Offending Team, the second YOT worker completed the Placements Alert form.

Court hearing

123. The boy appeared at St Helens Youth Court at about 11.30am on 8 November. The second YOT worker said that she did not always attend a court appearance for every young person she supervised. However, the second YOT worker did go to see the boy. She explained during interview:

> "I specifically went there because there had been some incidences where he was refusing to see me. I wanted to talk to him on the day just to confirm how he was, his state of mind, you know, his coping skills on the day. I wanted to be there to support the family because I had worked quite closely with particularly his auntie and because he was an intensive case. You do more of those things with the type of case that the boy was as opposed to a lower level referral order."

124. An employee normally employed as a Bail Support Officer for the St Helens Youth Offending Team, was also the designated court worker at St Helens YOT. The court worker was thus responsible for looking after young people from St Helens during any court appearances. The court worker was responsible for reading to the court the report prepared by the second YOT worker, whose concluding remarks were, "It is with regret that a recommendation is made for a recall to custody."

125. In interview, the court worker remembered the court appearance. She told my investigation team that the boy was expecting to go to prison that day. She said:

> "… She [the second YOT worker] told him exactly what she was putting in the report and what she was asking the court to do which was to return him to custody. So far as I was aware, the boy appeared in court under the impression he was going back to custody."

126. The court worker said that she was an experienced youth court worker and it was rare for a judge to disagree with a YOT worker's recommendation for custody. The judge agreed with the second YOT worker's recommendation and decided the boy should spend the remaining 44 days of his sentence in custody. (During the consultation stage of the draft report, the boy's family told my investigator that the hearing and resultant decision to recall the boy, was particularly brief. Whilst investigation decisions made in court is beyond my remit I would like to draw this matter to the attention of the Lord Chancellor and for that purpose, forward this report to him). The court worker said the boy did not seem visibly affected by the recall to custody, and made his way to the court cell after a brief chat with his aunt who then told the court worker that the boy had said he would "refuse food and drink whilst in custody". The court worker recorded this information in the boy's post court report. The court worker would have had a reasonable expectation that the post court report would be studied upon the boy's arrival at Lancaster Farms. However, as will be shown later, there is confusion as to whether the report was available to staff in reception.

127. After the boy left the court room, the court worker contacted the YJB Placements team to confirm that the boy had been recalled to custody. She said that she mentioned the boy's threat of food refusal to the Placements Officer who took the call. The Placements Officer did not remember the court worker mentioning threats to refuse food. He said the boy's vulnerability risk factors were well documented in his records, which were all emailed to Lancaster Farms after the court worker's telephone call. After speaking with the YJB Placements team, the court worker went to speak with the boy in his court cell. She said he was very down and she was worried about him. However, despite his low mood and threats to refuse food, she did not consider changing the boy's placement recommendation. The court worker said that it was not her role to question the suitability of a placement of a young person, and she would always rely on the judgement of the YOT worker who made the placement recommendation. The court worker spoke to the court staff and explained that she was concerned about the boy. She told them that he had a history of self-harm. At interview, the court worker said to my investigators, "When anyone goes into custody we have a yellow envelope and inside that envelope goes a copy of the post court report, a copy of their Asset, any risk of serious harm Asset if it's applicable and a pre-sentence report if they've been sentenced." She confirmed that this procedure was followed for the boy.

Placement confirmed by Youth Justice Board

128. At 1.30pm on 8 November, a placement confirmation form was generated by the Placements Officer confirming the boy's placement to Lancaster Farms.

One copy was sent to St Helens YOT and the other was sent to Lancaster Farms. The form carried a clear and highly visible notation of the fact that the boy had previously self-harmed and that he was therefore considered to be a potential self-harmer in the future. The original version highlighted this information in bold text, coloured red. The version received at Lancaster Farms would have been a copy and therefore not in red.

129. The boy was collected from St Helens Youth Court at 4.40pm that day. Global Solutions Limited (GSL – a private security company), took over his custody from court staff and he was escorted to Lancaster Farms. (At consultation stage, the St Helens Youth Offending Service drew my attention to the court worker's recollection that she verbally advised the escorting staff of the boy's statement that he would refuse food and that he should be monitored.)

Lancaster Farms: 8 - 29 November

130. Before his arrival at Lancaster Farms on 8 November, the boy's Asset, Placement Alert and Placement Confirmation forms were faxed through to the prison. Officers use these documents to create a core prison record.

131. The boy arrived at about 7.00pm along with five other young people who had also appeared in court that day. It is mandatory for a form known as the Prisoner Escort Record (PER) to be completed by whoever is given the task of escorting prisoners between court and prison. The form is used to relay important information about any risk factors the prisoner may present and about any events that occur during the journey. The boy's PER carried no notations of any risk factors, including self-harm. During the journey, the boy was checked about every 30 minutes. The journey passed without incident.

132. Prison Service Order (PSO) 4950 sets out a requirement that every young person must be interviewed within one hour of his arrival in prison so that his health needs, his vulnerabilities and his ability either to cope on his own in a cell without self-harming or to share a cell without harming his cell mate, can all be assessed.

Initial custodial reception assessment

133. During the reception procedures, those under 18 years of age are kept apart from those over 18. The boy was placed in a holding room in the reception building. When my investigators visited this building they noted that the décor was characterless, unlike that which they had seen at Red Bank. They believed that few newcomers to Lancaster Farms would gain an impression of warmth or welcome.

134. At the time of the investigation, young people were routinely strip searched as a normal feature of the initial reception procedures.

135. When the boy was called forward by the reception senior officer, he said he had no particular concerns. The boy might have had a copy of his post court

report with him but the investigation found no firm evidence to clarify whether this was the case.

136. The casework officer for the evening shift went over to the reception area to collect the boy and the other young people who had arrived at the same time. In interview the casework officer explained that, depending on the time of night they arrived, he usually took new young people to the induction unit to complete the initial custodial reception assessment there rather than in reception. The form T1:V helps staff undertaking the reception interview to re-assess the young person's vulnerability, and any risk he might pose to others, and to make plans to minimise the risk of the young person harming himself or other people whilst in custody.

137. However, the casework officer told my investigators that, although he signed the form, he did not conduct the whole of the assessment. He said this had been done by someone else but could not recall who it was. He explained:

> "I would have had general information about the boy through his DTO placement order so I would have filled out the initial part of that form. I think I did sign the bottom of that form, implying that, in anticipation of me doing the interview … that interview was subsequently then done by a member of the first night care team on Buttermere."

138. The casework officer told my investigator that whoever was responsible for completing the reception assessment would normally see any available Asset forms and vulnerability alerts. It was noted on form T1:V that the Asset document indicated the boy was a risk to himself because he had self-harmed seven months earlier.

139. One of the other members of staff interviewed was a unit officer. During his interview, the unit officer said he worked on Buttermere Unit. He said the responsibility for completing the T1:V form rested with the induction team. The unit officer thought that it was the casework officer who completed the boy's form. Later, during a telephone conversation with my investigator, the unit officer recalled that he only completed the boy's history sheet and confirmed that he did not play any part in filling in the T1:V. He said that the form normally had to be completed within one hour of the young person's reception. According to the unit officer, this target was difficult to achieve in cases where the young person arrived late in the evening. He said that, in these circumstances, it was not unusual for another member of staff to complete the task the following day. He thought this might have happened in the boy's case. However, my investigators were unable to identify who actually completed the T1:V form.

140. The boy told his assessor he had no physical or mental health problems. He answered the questions clearly, with good eye contact, and was "polite" throughout the assessment. He said that he knew other young people at Lancaster Farms from his home area and was not worried about any tensions

arising. The assessor indicated that the boy should be "monitored over the initial period" but did not record any specific areas of concern.

First reception health screen

141. The Practice Nurse completed the boy's reception health. The Practice Nurse told my investigators she was regularly detailed to work in the reception area of the prison, especially during her evening shifts when most young people arrived from court. She said health screens took place in a private room, with just the young person and the nurse present. The Practice Nurse said she would talk to the individual and ask him questions about his medical history and mental state, and whether he had any substance misuse needs. She said a screen could take up to half an hour, depending on individual needs. The Practice Nurse explained that the young person's details would be entered onto a computer programme during the interview. She said she felt confident in her use of the computerised information system.

142. At interview, the Practice Nurse explained that the health screen took the form of an interview. No physical examinations were involved. She said she could not recall the boy's health screen clearly but was able to recall some details when prompted by the record.

Alcohol misuse

143. The boy told the Practice Nurse he drank around 50 units of alcohol a week. The Practice Nurse considered this excessive but not unusual, adding that the assessment of a young person's use of alcohol was "usually approximate". She said she tried to encourage young people to think about whether they had been accurate in their recollection by asking them where they normally drank and the type of drinks they liked. The Practice Nurse told my investigator that, as she knew that the boy was likely to be referred, if necessary, to the substance misuse team during his secondary health screen, she did not refer him herself. The Practice Nurse's expectation was that the secondary health screen would be completed about 24 - 48 hours later, and this would form part of the boy's induction programme.

Drug misuse

144. The boy told the Practice Nurse he had a "cocaine type drug dependence". In interview, the Practice Nurse said she believed this to be possible. However, as she did not think the boy was withdrawing from drugs, she did not consider it necessary to refer him to the substance misuse team or to CARATs (Counselling, Assessment, Referral, Advice and Throughcare Service) at that stage. The Practice Nurse said that, as with alcohol misuse, this matter would have been picked up during the boy's secondary health screen at a later stage. She did not take a urine sample from the boy. Neither did she refer him to a doctor in relation to his history of substance misuse.

Self-harm history

145. The Practice Nurse asked the boy about his history of self-harming. The vulnerability alert and the post court report both clearly showed he had a history of self-harming. The post court report indicated that the self-harm took place while the boy was in custody. However, as indicated above, there is some doubt as to whether any of the reception staff had sight of it. In section 9 of the Asset (entitled Emotional and Mental Health), the boy was recorded as having previously self-harmed and attempted suicide. This information was not prominently displayed on the form, but could be found at the end of a checklist of questions with nothing to draw attention to it. The boy's history of self-harm and vulnerability was well chronicled in the "evidence" part of that section. When asked during interview whether she would routinely read the Asset form before or during a first reception health screen, the Practice Nurse replied:

> "That varies on the night, how many young people are coming through, as you've got time constraints really. I do try and look through and it's a big document and we pick out those relevant to us like the physical, the mental and the social side of things."

146. When later asked how much time was available to her to complete each reception health screen, the Practice Nurse said:

> "I mean, as nurse I myself would take as long as I needed. Again, it all depends on the timing you know, the officers finish at half past eight and they need to be clear and there are sometimes pressures on us if we get a late bus and there's six of them on, then obviously you know you have got that pressure but you take as long as you need to, there are no – you've got to be over in ten minutes."

147. The Practice Nurse could not specifically remember whether she read the boy's Asset form. She said she "very rarely" saw post court reports or pre-sentence reports and preferred to base her assessment of a young person's vulnerability on how he presented during the interview rather than on his recorded history. She said she asked all young people whether they had any thoughts of self-harm or suicide. She explained that she did not simply accept the answer they gave but assessed the non-verbal cues when considering their level of risk. The Practice Nurse said she had not been trained specifically in mental health, but relied on her experience as a nurse and her non-professional experience with teenagers. She said she had been trained in ACCT procedures and regularly opened ACCT forms as a result of her assessments during first reception health screens. She said:

> "I'm assessing them from the minute they walk through the door, their body language, their eye contact, how they react in conversation to me to the answers to the question, whether they're laughing, whether they're confident about it, whether they're blasé about it."

148. The Practice Nurse did not open an ACCT document for the boy but did refer him for a mental health assessment. She told my investigators:

> "Because I felt he was happy at the time you know, his body language and his eye contact was good, his answers that were given me told me that [self-harm] was mostly done when he had been drinking. So that I knew that he wasn't going to be drinking, you know, so there were those issues but because he had self-harmed in the past, I wasn't happy just to say that's it, I wanted him further assessed and that's why I referred him to the in-reach team."

149. The Practice Nurse made the following entry in the boy's medical record after she had completed his health screen:

History	No thoughts of deliberate self-harm
Examination	Alcohol consumption the week before custody, 50 units this week.
Social	Alcohol consumption, 50 units/week Moderate smoker, 10 to 19 cigarettes per day Charged with crime affray/recall
Additional	Cocaine type drug dependence
Comment	Discussed self-harm issues and says mostly done when drinking. However, has self-harmed in the past in YO institution. Maintaining good eye contact and appears good in mood. Discussed referral to in-reach team and happy for this to be done. REFERRED.
Additional	I do smoke 21 mg of Niquitin CQ I do not want NRT [Nicotine Replacement Therapy] Psychiatrist involved self-harmer History of deliberate self-harm within prison 7 months ago. Cut self Healthcare services information leaflet given Planned action – no immediate action required Fit for normal location, work and any cell occupancy Patient registered GMS1 Convicted - sentenced 4 months First reception health screen done Juvenile

150. The following comment was made by a caseworker, in the boy's core record on the day of his arrival:

i. "Previous self-harm
ii. Potential self-harmer (threats)
iii. Mental health concerns
iv. Substance misuse."

151. The caseworker also passed this information to Buttermere Unit (where it was written into the staff observation book), the healthcare centre, chaplaincy, the resettlement department and the safeguards department.

Cell sharing risk assessment

152. The Casework Officer and the Practice Nurse also carried out the boy's cell sharing risk assessment. The Casework Officer completed section two of the form. The following table details the questions he was asked and the answers from the boy that were recorded (the comments in italics are mine):

Questions	**Answers**
Does the prisoner have any previous convictions for the following and is the current offence any of the following: murder, sex offence, kidnapping, manslaughter, false imprisonment, GBH, ABH, stalking, arson,	No

aggravated burglary, possession of a firearm with intent to endanger life or resisting arrest?	
Has the prisoner been convicted of a racist or homophobic crime?	No (*In fact, the boy's Asset form showed that he had been convicted of an offence of racially insulting behaviour committed on 8 June 2007.)*
Has the prisoner ever abused alcohol or drugs?	No *(In fact, the boy had been a prolific user of alcohol and had often taken drugs.*)
Is the prisoner currently dependent on alcohol or drugs?	No *(In fact, his Asset form, which the Casework Officer said was available when the cell share risk assessment was completed, indicated that the boy considered substance misuse, including alcohol, to be an essential factor in his lifestyle.)*
Does the prisoner have an open ACCT?	No
Is there any evidence of the prisoner having a previous ACCT?	No (*In fact the boy had been subject to ACCT procedures at Thorn Cross but no details of that were available to Lancaster Farms.)*
Does the prisoner have any concerns about sharing a cell?	Yes. Would prefer single cell.
Does the prisoner describe himself as a person that gets angry/frustrated quickly?	Yes
Based on your knowledge of the prisoner from the information available, please rate the risk of harm to others: High medium low	High (*In other words, there is a clear indication of a high level of risk that the prisoner might assault his cell mate.)*

153. At interview, the Casework Officer did not clarify why he recorded that the boy presented a high risk of harming others despite the other answers shown above.

154. The Practice Nurse completed the healthcare information at section three of the form. The following table records the details:

Questions	**Answers**
During reception screening have you obtained any evidence that this prisoner may be at risk of harming others (due to various factors listed on the form)?	Insufficient evidence to give opinion
Is there any evidence on the PER form or any accompanying documentation that this prisoner may be at risk of harming others because of : current acute psychosis extremely disturbed behaviour agitation or aggression previous behaviour	*No response recorded to any of these questions*
Based on your knowledge of the prisoner from the information available, please rate the risk of harm to others:	Medium (*In other words, no immediate risk but situation will need to be reviewed regularly.)*

high medium low	
Following the self-harm assessment, have any concerns been raised?	No

155. The Casework Officer told my investigators that on Buttermere Unit – the induction wing for young people – there was shared accommodation in cells one to five (where there were bunk beds) and cells 25 to 30, each of which was the equivalent of two cells. The Casework Officer explained that these cells were normally allocated to young people who were orderlies. All other cells in Buttermere Unit were single cells. When asked if the cell sharing risk assessment process was therefore academic, the Casework Officer said:

> "Yes, I mean because what happens is there will be certain elements down to population pressures as well of course, I mean we don't like to double juveniles up obviously with the event of the Mubarek enquiry and things like that. Obviously these things are looked into deeper now and that's one of the reasons why we don't double these lads up straight away until they've been properly assessed and we can check them over a period of time before they do get doubled up. "

(The inquiry to which the Casework Officer referred was the public inquiry that followed the racially motivated murder of Mr Zahid Mubarek by his cellmate at HMYOI Feltham in March 2000. This led to the introduction of the cell sharing risk assessment process that is now a mandatory element of the reception procedures in every closed Prison Service establishment. Under PSO 2750 – Violence Reduction Strategy – all closed prisons must ensure that a cell. Sharing risk assessment is carried out for all prisoners. This provides a risk assessment for accommodation and occasions where space may be shared, such as in the healthcare centre or when with a peer supporter. For prisons without shared accommodation, the cell sharing risk assessment allows informed decision making about the management of potentially violent, racist or homophobic behaviour.)

156. The Practice Nurse described the cell sharing risk assessment as a formality. She said, "... from a first reception point of view, [the cell sharing risk assessment] is a bit of a yeah sign here, you know, because they are going to a single cell."

157. The boy's risk assessment concluded that he should be allocated to a single cell.

First night needs assessment and Induction

158. The unit officer conducted the boy's first night needs assessment. Included in the documents presented to my investigation team was an extract from the boy's core record that carried the notation, 'Cell Sharing Risk Assessments'. Underneath this notation, the following further information was shown:

"1st Night Alert

"Previous self-harm/suicide attempts
History of trauma/abuse
Mental health concerns
Substance misuse
[Details withheld]
Father died."

159. As the entry was not signed it is not clear who made it or whether it was linked to the first night needs assessment documents.

160. My investigators formally interviewed the unit officer and, shortly afterwards, talked to him informally. During the latter discussion, the unit officer said he thought about opening an ACCT document but concluded it was not necessary. He added that if he had opened one it was likely that the document would have been closed the next day as "that was often the case". The unit officer felt that this practice was due in part to the high number of ACCT documents being opened such that staff could not manage the volume.

161. The unit officer ensured that all elements of the first night needs assessment form were completed. The boy was told who his personal officer was. The boy was given two reception letters and, at about 10.00pm, he took advantage of a free two minute telephone call. The rules of the unit were explained and the boy signed Pin-phone, in-cell television and behaviour compacts. He was given an advanced canteen pack containing sweets. Although the boy smoked, he was not allowed a smoker's pack because of his age. The boy was placed on his own in cell 47.

162. The unit officer made the following entry in the boy's core prison record that evening:

> "Received onto Buttermere 2. Is on licence recall and is 15 years old. Has been on Local Authority Care previously. He currently lives with his aunty in St Helens. He does use drugs on the out and drinks alcohol. Very polite during interview."

163. The next day (9 November), the Senior Officer completed the First Night Needs Assessment Managers checklist. At interview, the Senior Officer confirmed that vulnerability issues had been raised and support was identified as necessary. The Senior Officer told my investigator he had seen the cell sharing risk assessment concerning the boy's self-harm history and had made a point of speaking to the boy personally. He said that, after he had done so, he felt there was no need to place the boy on ACCT monitoring. The earlier assessment that the boy was to remain in a single cell was confirmed.

Information to next of kin

164. Governors are also required to make arrangements to provide each young person's next of kin or other appropriate person with information about visiting, personal property, pastoral care, and the sentence planning, review and resettlement arrangements, within 48 hours of their arrival. The family contact log presented to my investigation team records that an initial attempt to contact the boy's aunt was made on 15 November in order to discuss the possibility of putting the boy in touch with his mother. However, on that day nobody answered the telephone. A successful attempt was made four days later.

165. On 9 November, the boy visited the gymnasium and underwent a PE assessment. During the initial interview with the PE Officer, the boy expressed an interest in kayaking. A physical activity readiness questionnaire was also completed. This comprised a simple yes/no response to ten general questions. There were no further comments made on the assessment form. The boy toured the gym and then returned to Buttermere Unit. The boy did not visit the gym to participate in any activity on any other occasion.

166. A member of the family links team also met the boy on 9 November as part of the induction process and opened a file on him. A note was made in the file to the effect that the boy's YOT worker, was to be contacted. However, the investigation found no evidence to confirm that such contact was made.

Food rejection

167. An entry made on the boy's history sheet by a Prison Officer on 10 November records that the boy declined food all that day and during the previous evening. The boy told the Prison Officer he was not hungry and often went without food at home. However, he said he was taking water. The Prison Officer recorded that he was due to be on duty the following day and would monitor him then. When the Prison Officer returned to duty the next day, he noted in the boy's record that he had taken his breakfast.

Secondary healthcare assessment

168. A Healthcare Assistant carried out a routine secondary healthcare assessment on the boy on 11 November. The Healthcare Assistant entered the following details of her assessment in the boy's medical record:

History	History of deliberate self-harm cut up six months ago. OK at moment
Examination	On examination: height 177.8cm On examination: weight 62kg Body mass index: 19.61
Social	Had a discussion with patient, discussed/given information regarding health
Additional	Referral to vaccination clinic Parental support – expects family support and visits Patient understands how to access healthcare here at Lancaster Farms Well man monitor, check done Able to read Able to write

	Juvenile

First contact with Substance Misuse Team

169. On 12 November a member of the Substance Misuse Team met the boy to conduct an initial assessment of his substance misuse. After the boy's death, the member of the Substance Misuse Team submitted a statement to the police in which he said he did not think the boy was vulnerable when he first met him. He said that, if he had thought otherwise, he would have returned the boy to healthcare for further assessment. Following his initial interview with the boy, the member of the Substance Misuse Team was formally allocated to him as his substance misuse caseworker. He set a target date of 22 November to complete a full assessment.

Psychological needs assessment

170. The boy's psychological needs were assessed on 13 November as part of his induction programme. The report of that assessment, conducted by a member of staff in the prison's psychology department, was not signed. The following table shows the principal findings and recommendations:

Subject	**Comments**
Emotional behaviour score (EBS)	This assessment is used to assess adolescent and emotional coping strategies. The boy had scored high on malevolent aggression suggesting he may have poor behavioural conduct. The boy has scored low on social self-esteem suggesting he may experience emotional difficulties and may need extra support from staff. This may be reflected in not adjusting well in custody.
Hopelessness levels	This assessment is related to suicide ideation. It provides an indication as to feelings regarding self, the future and the world. The boy's score suggests that he is feeling moderately hopeless at this time.
Custodial adjustment	This assessment measures the degree of adjustment to the custodial environment. The boy's scores suggest he is adjusting to the environment in the way we would expect at this time.
Recommendations	Due to the score the boy obtained on the Beck's Hopelessness Scale (BHS), staff should be aware that he might need extra support. He is currently experiencing some negative feeling towards himself, the future and the world. Due to the score the boy obtained on the social esteem measure, staff should be aware that he may have a low opinion of himself, especially in social situations, for example, during association. Due to the score the boy obtained on malevolent aggression, it is recommended that he should be referred for the anger management course.

171. The Beck's Hopelessness Scale is a means by which a young person's feeling about himself, the world, and the future can be measured. A note issued by the Psychology Department about the use of the scale contains the following instructions:

> "Please note that you must make an entry into the young person's wing file and the wing observation book about the findings. You **must** also contact Safeguards and Healthcare **in person** and tell them of any concerns you have regarding the young person." (Emphasis in original.)

(The term "Safeguards" refers to the Safeguarding Department. The term "Safeguarding" is defined as the process of protecting the safety and welfare of young people.)

172. My investigators were told that those young people whose score on the subject of hopelessness is high (i.e. over 14) are considered to be vulnerable to suicidal ideation. Their scores are therefore re-checked immediately, with the young person present. If the score is confirmed, appropriate action must be taken, including consideration of opening an ACCT form. A copy of the assessment report must be passed in person to the caseworking office, the education department, the healthcare centre, and the unit in which the young person is resident.

173. The boy's hopelessness score was less than 14 and was therefore considered to be moderate. My investigators were told that, in the case of anyone with a score of 14 or below, a copy of the assessment report must be passed through the internal mail system to the same departments as for a high score. The investigation found no evidence to clarify which of those departments received a copy of the boy's assessment report.

174. The boy's psychological needs assessment clashed with an appointment made earlier for a representative from the mental health in-reach team to see him. Consequently, the mental health assessment was re-scheduled for the following day.

Mental health assessment

175. On 14 November, a third year social work student on a six month placement from Lancaster University and a member of the mental health in-reach team at Lancaster Farms, carried out an assessment of the boy's mental health. This was in response to the referral made by the Practice Nurse during the boy's health screen on 8 November. At interview, the social work student told my investigators she was unqualified and confirmed that this was the first time she had worked in a prison. However, she explained that she had worked with young people in other settings and therefore did not feel disadvantaged in her work at Lancaster Farms. The social work student was supervised by the in-reach team manager and was only one month from completion of her placement.

176. The social work student told my investigators that the boy said he felt alright and had no thoughts of self-harm. She said:

> "I had read his family background and the Asset form when I initially went to see him. [The Asset form was in the boy's medical record, the only file available to her.] When he came out [for the interview] he did quite surprise me because he was happy and bubbly. I was expecting him to be a lot different. I expected it to be a harder session than it was. He did talk freely about things. I asked him how he was feeling about being inside, about being in custody and he said he felt fine. He talked about other previous custody and how he was feeling here. He said he didn't have any worries about people in here. He talked about his self-harm and he told me he felt it was more around when he was stressed. We talked about how he feels stressed and when he doesn't feel stressed."

177. When asked whether she thought the boy was putting on an act of bravado, the social work student said, "No, I didn't feel he was because he was laughing and joking and obviously I do realise that people change".

178. The social work student confirmed that she did not think the boy was "that much at risk of self-harm at that point". The boy told her he was not interested in taking part in education classes, using the gym, or mixing with other young people during association periods in his unit. He said he had been visited by a representative of the Child and Adolescent Mental Health Service in St Helens during the previous two years but did not know why. He told the social work student he had been in Red Bank, Newton Aycliffe Secure Children's Home and in HMYOI Thorn Cross. The boy said he did not know where his mother was and had lived with his uncle and aunt for the previous seven years. He told the social work student he used to go to school but was frequently sent home. He said his friendship group consisted of young boys who, like him, had been in custody. He also said he had few interests beyond getting drunk. When the social work student put to him that it was possible to have fun whilst sober, he replied, "If you're not pissed, everything is crap." In interview, she said the boy was open about the extent of his drinking habits. He said he was used to drinking "Taboo" and vodka at weekends using money given him by his uncle and aunt. He also admitted using ecstasy, cannabis and, occasionally, cocaine. The boy added that he had been in hospital on a number of occasions after taking drugs and alcohol. He said that, on one occasion, he was admitted to hospital after cutting his arms.

179. The social work student concluded that the boy appeared clean, happy, relaxed and able to communicate, albeit with some prompting. She thought the boy had a "fine" perception and good orientation. She made a note of the fact that the boy had self-harmed a month earlier but added that this was not in the context of wanting to kill himself. Rather, she said, it was "just about stress". The social work student also recorded that the boy was not currently subject to self-harm monitoring procedures. She told my investigators that she had no reason to invoke ACCT procedures herself.

180. The boy tried to explain to the social work student why he did not want to take part in association or activities such as PE and education. He said,

"Sometimes I like being on my own and if I want to come out then I will come out." The social work student said she "extended offers to the boy to go the gym and things like that". She said she asked the boy whether he was frightened of other people. He told her he was not. She wrote on the assessment form that her plan was to see the boy again the following week and to keep the case open so that she could "approach self-harm". At interview, she explained that in fact she wanted to see the boy again on 27 November and so she entered this date in her diary. However, she told my investigators she could not meet that appointment because an earlier appointment with another client had taken longer than planned. The social work student said she could not see the boy the next day because it was a staff training day, a consequence of which was that all young people had to remain in their cells. The social work student therefore planned to see the boy on 29 November.

Contact with the boy's aunt

181. The Lancashire Police provided my investigation team with transcripts of telephone calls the boy made to his aunt on 11 and 15 November 2007. The transcripts were compiled by a member of staff in the security department at Lancaster Farms. Although the calls were recorded, they were not simultaneously monitored by staff as there was no security or other reasons for doing so. The police also provided seven original undated letters written by the boy and sent to his aunt and uncle when he was at Lancaster Farms. They were obtained from the boy's family during the course of the police investigation into his death.

182. In the first of his two telephone calls, the boy told his aunt that he hated being at Lancaster Farms and wanted a transfer. He said he was not being bullied, explaining that he could not be bullied because he was locked in his cell all day. He told his aunt he had been asked if he wanted "to go in a room with someone" and he had said he did not. During the call the boy also spoke to his aunt's daughter. He told her he had not eaten anything since his arrival at Lancaster Farms but had eaten his breakfast that morning. He said the meal was "disgusting". Although the transcriber had difficulty hearing every word of the boy's conversation, it seems that at one stage he told his aunt or his sister that he had sent a letter to them and that he had cried as he wrote it. His aunt - whom he called "mum" - told him it would not be long before he was home.

183. In the second call, the boy asked his aunt when she was intending to visit him. She told him she had not yet received a visiting order (VO). (A visiting order is a means by which potential visitors are identified / authenticated and the visit booked.) The boy told his aunt his DTO meeting was due on 5 December. His aunt said she thought it was due on 4 December but the boy said he had been told that day that it was on 5 December. The boy asked his aunt to ring his YOT worker about the question of arranging a transfer. He talked about the length of time he spent in his cell and about his views regarding the standard of food. He specifically mentioned that he did not like eating in front of so many other young people and told his aunt it "did his head

in". When the boy's aunt asked him if he was sleeping alright, he told her he woke up every night at about 4.00am and switched his television on. He also spoke about how cold his cell was and how hard his bed was. The boy told his aunt he would rather be at Red Bank.

184. The undated letters given to my investigators also provide an insight into how badly the boy felt about being at Lancaster Farms. The contents would not have been known to staff as they were not required to read his mail. In each letter he repeated what he had said on the telephone. He explained that he only ate in his cell because he did not like eating in the company of a large number of people. He also spoke of his fear of being arrested immediately upon his release for an outstanding charge. The boy expressed his desire to be transferred. In one letter he wrote:

> "We keep our [unreadable word] in our pad [cell]. I just keep looking at it and thinking should I do it but I don't know why. I think I am just scared of being in here. I will probably end up doing it if I'm in here any longer and don't get a transfer. It's doing my head in. When are you coming to see me? Please make it soon."

185. In two of his letters, the boy wrote that he was going to be tested for ADHD (Attention Deficit Hyperactivity Disorder). However, there is no evidence in his medical record to verify this. In another he wrote that he "needed beer really badly" and thought he was "an alky". In yet another, he wrote:

> "To mum and dad, what are you up to? It's proper s**t being inside again. Can't wait to get out. Counting down the days. Not been eating. I hate it in here mum. Will you ask the second YOT worker to give me a transfer please. It's doing my head in being in here. I can't hack it. Didn't think it would be like this. The room is horrible. It's freezing and am in it nearly all day. I just keep thinking of doing something stupid but just don't see the point. I need a cig really bad. When I got up on that first morning being here and I had to got to breakfast I got it and then you just don't know where to sit. There are so many people on my wing. Just wish I had a way out of here."

186. On 15 November, a member of the family links team at Lancaster Farms rang the boy's aunt because she wanted to discuss the boy's contact with his mother. Unfortunately, there was no reply. On 19 November, she tried again, this time successfully. She made the following record in the boy's family contact log:

> "Rang auntie. She tells me she has no details of mum or sister at all. She has tried ringing mum but there has been no answer. Uncle has gone to the address but there is no sign of mum living there. Mum was supposed to be in crown court for the boy in August but she never turned up and has since not been in contact with auntie. She tells me she'd love to visit with uncle

but hasn't yet received a visiting order. She also told me she is due for an operation on 27th but would still visit by then."

187. The next day, the member of the Family Links Team made the following further note in the boy's file:

> "Spoke to the boy to clarify exactly how/what contact he had in Red Bank with mum and sister. Whilst in Red Bank, the boy wrote to mum but never had her address as he sent it through the social services. He did ring mum but the number is no longer working and he hasn't got a new number. The boy had one visit from mum whilst in Red Bank and visited her once in the community. The boy has never written to his sister whilst being in Red Bank. He rang her once but has lost her number since. She came to visit him with mum in the secure unit. The boy told me that she and mum lived together whilst he was in Red Bank. The boy said that he was going to send out a visiting order to auntie and uncle and did not mention anything about auntie's operation. The boy was very talkative and in a good mood."

188. At interview, the member of the Family Links Team told my investigator:

> "As far as I was aware, the boy was convinced his auntie and uncle wouldn't visit and this is why I found it a bit strange because they were very supportive from what I read in the case notes and also from what I know from the phone conversation. So when I went back I made a point of telling him, 'Your auntie would love to come and visit as well as your uncle.' He was quite surprised. I asked him why. He said he just didn't think they would come. He said he would send out a visiting order."

189. The boy's record of letters and visits show that the only visiting order he sent out was to his aunt and uncle on 23 November. The visiting order was valid for 28 days from that date.

190. The boy's record indicates that he received no family visits whilst he was at Lancaster Farms.

191. The member of the Family Links Team told my investigator that she saw the boy three or four times. She added that the boy never seemed stressed or emotional about his lack of contact with his mother. The member of the Family Links Team said he did not talk to her about transferring from Lancaster Farms. When my investigator put it to her that the boy had written a letter in which he described his hatred of the establishment, she said he did not mention this to her. The member of the Family Links Team said the boy always smiled when she saw him, even on the Monday before his death.

192. The boy's file records no other contact between the family links office and his aunt or uncle.

Detention and Training Order (DTO) Plan

193. YJB National Standards require Governors and the Youth Offending Team (YOT) Manager to ensure that a sentence plan - or DTO plan - is drawn up within at most ten working days (that is two full weeks) of the date of reception. Specific, measurable, achievable, realistic and time bounded and agreed objectives must be set for each individual. Governors, in partnership with the YOT Manager, must ensure that procedures are in place for the young person's progress to be monitored and regularly reviewed with due account being taken of the young person's learning style. The DTO planning meeting should also set out firm arrangements to enable a seamless transition into the community.

194. The boy's DTO meeting should have been scheduled to take place on or before 22 November. On 9 November, a second casework officer had been detailed to work in the casework office. He had just returned to work following an operation and was not allowed direct contact with prisoners. At interview, the second casework officer described his role in the casework office as "administrative work, involving the input of information about prisoners into the database and booking DTO planning meetings". He recalled speaking to the boy's YOT worker. He said he initiated contact with her in order to schedule the DTO planning meeting within the target date. He thought that the second YOT worker's pregnancy would prevent her from attending a meeting in a unit. This meant that the visit had to take place in the legal visits area of the prison. The second casework officer therefore scheduled the meeting for 4 December, the next available date for a legal visit, but eight working days after the target date. (At consultation stage, the St Helens Youth Offending Service pointed out that in fact it was the second YOT worker who initiated the contact rather than the second casework officer. The YOS also said that when the second YOT worker was told of the proposed date, she told the second casework officer that the date fell outside the National Standard.) The second casework officer did not meet or speak to the boy or his family. This was the second casework officer's only involvement in his sentence plan. The second YOT worker recalled that she was told by the prison that this was the earliest available date for a DTO initial planning meeting. She said that, if she had been made aware that her pregnancy had delayed the meeting, she would have sent a colleague to attend in her place.

195. A second prison officer regularly worked in the casework office. During interview, she recalled that she was on holiday at the end of October and the beginning of November. She told my investigators that, "there was a pile of files to do when I came back and it was just a case of grab one, do it". On 15 November, the second prison officer found the boy's casework file and noticed that his T1:A form - the initial sentence plan - had not been completed. This assessment and planning form is to be completed by the staff member from the custodial unit responsible for the co-ordination of the young person's training plan, in consultation with the YOT representative and

prior to the initial planning meeting. The second prison officer went through the boy's Asset page by page and copied the Asset score into a sentence planning tool. She summarised the comments onto a table entitled, "What factors do you consider should be addressed in the young person's training plan?" The second prison officer explained to my investigation team that the table should be a summary of the Asset and how it relates to the sentence planning needs of the young person. She identified the boy's lifestyle, substance misuse, and thinking and behaviour as requiring the most input. The last section of the table - "Indicators of vulnerability" - was scored fairly low, but the second prison officer noted that the boy had previously self-harmed. The second prison officer did not meet with the boy.

196. Following the assessment of the boy's needs through Asset, the second prison officer completed form T:2. This document is used to set out a young person's training plan objectives. It was intended to be the starting point for the boy's sentence plan, and would have informed discussion at his DTO initial planning meeting. After she had prepared the table and provisional training plan, the second prison officer went to see the boy. She told my investigators:

> " … then I'll go and see the boy or anybody else and I'll talk to him about his actual, how long he's going to be here for, which is what I've done here, he's actually said that he's not going to be on licence when he gets out and when he's due for release … And then we talk about the targets I've set him … And I've set him the targets of good behaviour, which is on the [Incentives and Earned Privilege scheme] positive attitude which is not getting himself into trouble or in front of the governor for adjudications; substance misuse which is the four score."

197. The second prison officer explained that all these targets were generic and set for every young person, regardless of the T:1A assessment. She said that, if a young person was not going to be at Lancaster Farms for long, there were limited courses available to them. She explained that the Young People's Enhanced Thinking Skills and Living Skills course was available at Lancaster Farms. However, as the course lasted nine weeks, the boy would not have had time to complete it.

198. The boy had no further contact with the casework team. His DTO Initial Training Planning meeting, scheduled for 4 December, did not of course take place.

Completion of induction and start of education

199. Induction at Lancaster Farms is designed as a "rolling programme" to be completed within a week of arrival. The boy started his programme on 9 November. It should therefore have been completed by 15 November. By then, the boy had only completed about half the modules. The following table shows which modules were completed, together with dates where available:

Session	Tick	Comments
First night assessment	Ticked	Aware
Chaplain visit	9/11	Seen
Domestic training	Ticked	Done
Safeguards	Blank	Blank
Independent Monitoring Board	13/11	Did not appear
National Youth Advocacy Service	13/11	Did not appear
Psychology	13/11	Done
Family links	Ticked	Done
Chaplaincy group visit	9/11	Done
Young People's governor talk	14/11	Did not appear
Violence reduction/anti-bullying	21/11	Done
Race relations	21/11	Done
Use of force	Ticked	Done
Young People's Substance Misuse Service (YPSMS)	Ticked	Seen
Thorn Cross information	Ticked	Done
Healthcare talk	Blank	Blank
Gym induction	9/11	Done
Induction completion interview	Blank	Blank

200. My investigators were told that when young people have completed their induction programme, they are automatically listed on the Local Inmate Database System (LIDS) as being unemployed. If they have never been in custody before, they are expected to attend an 'introduction to work' course that usually runs from Monday to Friday. However, any young people who have been in custody on a previous occasion could be fast tracked as their needs assessment would normally have been completed and their educational needs identified. As the boy had been in custody at Red Bank and at Thorn Cross, he was fast tracked. My investigators were told that, on completion of the induction programme, young people could commence the fast track process on any day of the week by undertaking a test to determine their learning skills. Classes were then allocated according to their needs. Their education programme was normally initiated within the next 48 hours.

201. The boy was introduced to the education department on Friday 23 November – two days after he had undertaken the last of the induction modules he attended and two weeks after his arrival at Lancaster Farms. On that day, he was interviewed by his education keyworker who took him through the enrolment form, the purpose of which was to help her gain an understanding of the boy's self perception rather than to create a profile of his needs. The boy told the education keyworker that he had emotional and behavioural difficulties. She therefore referred him to a special needs coordinator. As she was due to finish work early that day, the education keyworker was unable to complete the boy's learning plan. Her colleague therefore assumed that responsibility.

202. The education keyworker later liaised with a special needs coordinator at Thorn Cross, who gave her the boy's educational needs assessment results over the telephone. However, the boy asked the education keyworker if he could re-sit his numeracy and literacy tests again as he felt he had not applied himself properly at Thorn Cross. He told the education keyworker he wanted to achieve a better assessment score so that he could apply himself anew to his education. The education keyworker told my investigator she would also have checked with the boy's school whether he needed any special needs support.

203. In interview, the education keyworker described the boy as being very polite during the interview. She said she was left with no cause for concern for him. The only other time he attended the education centre was on Tuesday 27 November. On that day, he was interviewed by a Connexions Personal Advisor. The day after the boy died, the Personal Advisor submitted a memorandum to the Governor about that interview.

204. I repeat relevant extracts from her memorandum below:

> "As a Connexions Personal Advisor working specifically with the Merseyside juveniles, I saw the boy in juvenile education on 27 November 2007 for approximately 20 - 30 minutes. As the boy was fast tracked into education, I had not seen him during the induction period. I therefore explained my role and how I would anticipate helping support his educational needs through his sentence and in preparing him for his return to the community in December.
>
> "Although the database is for factual information and we would not normally record value judgements on young people's moods or temperament, anecdotally it is my personal feeling that the boy was fully engaged in our conversation. I feel it is important to convey that the boy was friendly, happy and smiley, so much so that I commented to him about his 'catching smile'. We concluded the interview by agreeing that I would contact his YOT worker and be back to see him after his initial DTO meeting to discuss education further."

205. The Personal Advisor told my investigators this was the only time she met the boy. She knew the boy had been inducted in the department but had not been in a classroom before. The Personal Advisor remembered that the only concern she had about the boy during her interview with him was that he did not once mention his family. Otherwise, the boy gave her no cause for concern. He did not mention anything about bullying or about having any difficulty sleeping or eating. The Personal Advisor said he was looking forward to going home, although not to education. He was especially looking forward to being at home for Christmas.

Contact with Personal Officer

206. The boy was allocated his Personal Officer on his first night at Lancaster Farms. However, the Personal Officer was on leave at the time and was due to complete a period of night duty when he returned.

207. The boy's record shows that the first entry about him by the Personal Officer was made three weeks later on Sunday 25 November, his first day in the unit after his period of leave and night duty. The Personal Officer told my investigators he looked at the roll board in the office in Buttermere Unit and saw that he had been allocated to the boy as his Personal Officer. He therefore went to see him. He confirmed that there was no cover scheme whereby somebody else could stand in for him during any absences. However, he pointed out that all officers were there to support the young people in their charge. The Personal Officer remembered that the boy talked about his time at Thorn Cross, but that he did not mention any problems he had there.

208. The Personal Officer said he was told by another member of staff that the boy was not eating much. When he asked the boy about it, he explained that his loss of appetite was due to the substance misuse treatment he had undergone in the community. The Personal Officer said the boy did not raise any concerns about mealtimes and interacting with other young people. The Personal Officer said that various documents about the young people, such as the record of their first night interview, security information, ACCT forms and Asset forms, were kept in or near the unit office. The Personal Officer stressed that young persons' casework files were stored in the casework office in a separate part of the building. He said he did not see any of the boy's documents when he saw him on 25 November, and neither did he have any prior knowledge of the boy's experience of HMYOI Thorn Cross or Red Bank.

209. My investigators asked the Personal Officer if he was aware of the anxieties the boy had expressed in his letters and telephone calls to his aunt. He said he was not. The Personal Officer said that, if he had known that the boy was scared of eating with others, he would have tried to find other young people from the same area to support him. He said:

> "When I spoke to the boy about why he preferred to stay in his own cell and not eat out, he said it was because he didn't like to mix with young people because he didn't want to start trouble. He wanted to do his time here quietly without getting into trouble. I was quite happy with the explanation because of the short time he was going to be in custody - the length of the recall. I believe he could pass his time easily."

210. The boy's aunt and uncle told one of my investigators that the boy made it clear during some of his telephone conversations that he stayed in his cell all day watching television and that he did not sleep well. When asked about this, the Personal Officer indicated that there were times when there were gaps between the induction and education programmes that were not always filled with any activities. It was also put to the Personal Officer that, in his letters, the boy repeatedly asked to be transferred out of Lancaster Farms. The Personal Officer said he had no knowledge of this. According to the Personal Officer, the boy was happy to stay where he was. The boy's aunt and uncle also brought to the attention of my investigators that the boy walked with a feminine gait which

might have made him a natural target for bullying. My investigator asked the Personal Officer if he had ever noticed the boy's walking and he said he had not.

211. The Personal Officer told my investigator that when he entered the boy's cell to talk to him he was careful to appear relaxed. The Personal Officer thought the boy engaged well with him and seemed to enjoy having someone to talk to. The Personal Officer said:

> "Even though it was five minutes, he welcomed the chance to speak to somebody even though he was putting on a brave face, engage with someone who wasn't a person in custody."

Second contact with Substance Misuse Team

212. On 26 November, a member of the Substance Misuse Team met the boy, as planned, in order to agree a substance misuse care plan. The member of the Substance Misuse Team told my investigators he took the boy into his own department away from Buttermere Unit for the interview, during which the boy spoke about his background. The member of the Substance Misuse Team considered that the boy needed help to address his abuse of alcohol and established a care plan to help him control his alcohol and drug misuse, and to improve his family links. The boy made no reference to feeling depressed during the interview.

213. In his record of the assessment, the member of the Substance Misuse Team wrote that the boy had no objections to his aunt and uncle being contacted about his care plan, the details of which can be seen in the following table:

Issues	**Desired outcomes**	**Interventions**	**Who was responsible**	**Review dates**
Alcohol and links to re-offending	Reduce harm	One to work A to Z DVD Supply info	Substance misuse worker and the boy	15 December 2007
Poly use	Reduce harm	Ditto	Ditto	Ditto
Family links	Improve family relations	Family links	Substance misuse worker	28 November 2007 Completed

214. At interview, the member of the Substance Misuse Team said that he did not have sight of the boy's custodial record for the period he was in Red Bank before seeing him on 11 and 26 November. Thus, he was unaware whether a sentence plan had been drawn up for the period of the DTO.

Interview with Connexions personal advisor

215. On 27 November, only two days before the boy died, he was interviewed by the Personal Advisor in the education department. At interview, the Personal Advisor described her role as follows:

> "I work in a specific role with young people returning to the Greater Merseyside area. My main role is looking at education training and employment for when they return back to their home area. We also cover every single other issue that may come up and will liaise with other agencies and signpost young people to different agencies and advocate on their behalf to YOT workers, social workers, basically anything. If there's a barrier to them engaging in employment, education or training, we will work with them."

216. The Personal Advisor confirmed that she interviewed the boy because he was from the Merseyside area. She told my investigators:

> "I only met the boy once for about 25 minutes. It was just an initial interview to get to know him a little bit – build a sort of rapport and see what he actually wanted to do when he was going home. He was very positive and happy. I even actually commented to him, 'you smile a lot, it's catching'. He was very jokey. We didn't talk about family issues in a lot of detail. I just knew he was living with auntie and uncle and he was happy to go back there. He was actually looking forward to going home although not to go into education. He didn't do that."

217. The Personal Advisor said the boy told her he wanted to continue doing what he had been doing before he went into custody. She said the boy had mentioned that he wanted to sell drugs. She recalled noticing that the boy did not mention his mother or father during the interview, but in all other respects the boy gave her no cause for concern. He was looking forward to being released in time to be home for Christmas. The Personal Advisor recounted how the boy had talked about his plans for the future. As far as she knew, he was not having any difficulty sleeping or eating and he did not seem to have been bullied.

Transfer to Windermere Unit

218. As the boy's induction period was deemed to have been completed, his time in Buttermere 2 Unit had come to an end. Arrangements were therefore made to transfer him to Windermere Unit on 28 November.

219. During the previous day, the boy had spoken to another young person who later gave a statement to the police in which he said that the boy had told him he would refuse to move from the unit. The young person said the boy generally stayed in his cell for dining and association but came out to shower and use the telephone. When he had asked the boy why he stayed in his cell, the boy replied that it was because he was scared of being bullied. He never saw the boy speaking to other young people and he said the boy felt scared and intimidated. They had discussed being in Red Bank and agreed that moving to Lancaster Farms would have been a major culture shock for the boy. The young person concerned said that he nevertheless did not think the

boy had actually been bullied. He also said he did not think the boy had ever spoken to staff about his fears. There is no evidence that the young person concerned told staff what the boy had said.

220. The boy moved to Windermere 2 Unit at about 3.00pm on 28 November. As this was a staff training day, all young people throughout the entire establishment were required to remain in their cells until the evening period when association could resume. However, a third prison officer was available to look after the boy when he moved into Windermere Unit. At interview, the third prison officer explained the circumstances of the boy's transfer. He said:

> "There was a lock down, it was a Wednesday. I had heard that we may get one or two people on. We only had two empty cells so I checked them out and one had previously been smashed which was cell 44 but had been repaired. But I noticed that it smelt a little of urine so I opened the windows and left the door open for a couple of hours. Then, just after half past three, an officer from Buttermere arrived with two trainees I wasn't expecting – I thought they were coming on Thursday. Their cells had been allocated to them by other staff who were in the unit.
>
> "They arrived. I came over from Windermere 1 and the staff said, 'brought two' and I said, 'I thought they were to come tomorrow'. I went out to see them and the officer from Buttermere. I said, 'Well I have got one good cell and one that is a bit smelly. I am not too pleased that you have brought them over.' He said, 'Well it's up to you. You know I can take them back or stay.' I spoke to a young man I found later on to be called the boy, and I explained the situation to him that the cell had earlier been smashed but repaired but there was still a little bit of a smell of urine in there. So I said he could either go back to Buttermere or maybe come over the following day or they could come and have a look at the cell with me. So the boy agreed to come into the cell with the officer from Bettermere and he said it wasn't too bad and he agreed to stay.
>
> "He was a nice young man. He was very polite. He went into the cell, said it wasn't too bad. I said I will change the mattress. I got him a brand new mattress. I said you can brush and mop it out which he did. He then asked me if he could have a change of clothing because he only had one set of clothes with him that he was wearing.
>
> "I shouted down to our laundry orderly and I said, 'Can you take this lad and sort him out with some clothes?' So he went down and came back with some clothes a short while later."

221. The boy's cell was at the end of a row of cells on the first floor. It was a single cell and contained sanitary facilities. It was fitted with a wooden cupboard, a bed and a chair. As with all other cells, the security of the cell window was

reinforced by bars. The third prison officer told my investigator he did not lock the boy into his cell. When asked if there was anything about the boy's demeanour that caused him to be concerned, the third prison officer said, "Not at all. He was very polite. He had good eye contact." The third prison officer was not sure if the boy had any toiletries with him at the time.

222. At about 4.00pm, the boy was given a television set for use in his cell. At about 4.30pm, a fourth prison officer gave the boy some cleaning materials. At 4.44pm a fifth prison officer unlocked the boy's cell door so that he could collect his tea meal. In interview, the third prison officer remembered seeing the boy at the hotplate. He said the boy seemed fine as he collected his meal. The third prison officer did not see other young people talking to the boy at the time. He said it was normal for officers to listen to what was being said by or to new arrivals in the unit. The third prison officer confirmed that the boy returned to his cell to eat his meal. This, he said, was usual on days when there was a lock down (i.e. a period when all young people have to be kept locked in their cells) for staff training. Otherwise, most young people ate their meals in association with each other.

223. The investigation found that the association period scheduled for that evening did not take place because officers from Windermere Unit had to be re-deployed to Buttermere to allow association in that unit.

224. Shortly before 8.00pm, the third prison officer issued hot water and biscuits to each young person in the unit. At interview, the third prison officer explained what happened when he reached the boy's cell. He said:

> "I got to cell 44. I offered the boy hot water which I think he declined. I think I gave him an extra biscuit because we had a few extra biscuits left. And I spoke to him. I asked him how the cell was because an officer had given him an air freshener. She had asked me previously if he could borrow this. He shouldn't have had it but I said it won't hurt. I asked him how the cell was and he said, 'It's a lot better, it's not too bad.' He said, 'I just spray it occasionally.' The last thing I actually said to him was that I was on at half seven in the morning and, if it hadn't improved, then I would look into getting him another cell or move him to another unit."

225. The third prison officer thought the boy was otherwise alright. He told my investigator that earlier that evening, at about 7.20pm, he heard some shouting coming from the upstairs landing (the same landing as the boy). He said he therefore went upstairs and spoke to three young people who were shouting at one particular young person – not the boy – who they were instructing to smash his cell. The victim of this taunting was three cells away from that occupied by the boy. The third prison officer confirmed that he heard nobody shouting at the boy. He went off duty just before 9.00pm.

226. The third prison officer said that shouting through the cell windows had been a problem at Lancaster Farms. However, he thought that matters had improved

because staff were now authorised to block the windows in the cells occupied by the perpetrators. He explained that windows could be blocked by placing wooden blocks between the windows and the bars so that the windows could not be opened. This, he said, had the effect of sound-proofing the cell. The third prison officer also explained that staff were authorised to confront perpetrators and, where necessary, impose penalties (such as the temporary removal of television sets) upon the individuals concerned. (I have not investigated the question of such penalties further, and for that reason have made no formal recommendation. I understand their purpose. However, informal 'punishments' are not permitted under the Prison Rules and the Governor and Area Manager will wish to review the practice to ensure that it is properly authorised.)

227. My investigators also interviewed the Principal Officer, the manager of Windermere Unit. They wanted to hear her views about the boy's transfer into Windermere as well as the wider regime and cultural issues in relation to the unit.

228. The Principal Officer confirmed that she was aware that the boy's cell had been damaged by another occupant but that it had been repaired. She said the smell was not of urine but of an adhesive that had been used to repair the linoleum and the toilet. As to the boy's morale at the time he arrived in the unit, the Principal Officer said she personally did not see the boy or speak to him. However, she described the third prison officer as one of the most experienced and caring officers in the establishment, who, if necessary, would voluntarily remain on duty beyond his shift until his responsibilities towards his charges had been fully met. (I should say that the third prison officer's concern for young people shines through in the extracts from his interview with my investigator that I have cited above.) The Principal Officer also had this to say about the boy's transfer into the wing:

> "It was a lock down day right across the prison. There was several of the Windermere staff loaned out to Buttermere for the evening. It was quite clear that there was going to be no association on Windermere 2 that evening, so it meant that the young boy came onto the wing while it was a lock down training day. So he would have had no interaction with other lads, apart from the serving of the tea and I don't really know why he had to be moved on to the unit that day. Coming on to the unit with no association that evening would have been maybe another worrying factor to him, I don't know."

229. When my investigator put to the Principal Officer the suggestion that, had the boy remained on Buttermere Unit that day, he would not have had association there either because it was a staff training day, the Principal Officer said, "That is not correct because there were three staff loaned out to Buttermere staff for the evening association period." The Principal Officer emphasised that the fact that 28 November was a staff training day was not the cause of the loss of the evening association period in Windermere Unit. It was, she

said, solely because three of her staff were re-deployed to Buttermere in order to allow association to take place there.

230. The Principal Officer told my investigator:

> "I didn't know him [the boy] at all. However, he would not have known when he came on the wing that there was no association that evening because that could have changed. For example, if certain staff had returned from sick leave that afternoon that could have changed the whole thing. That's why the lads would not have been told.
>
> "On the day the boy came onto the unit, had there been association and had the boy not come out of his cell, I can guarantee that the third prison officer would have been in that room, sitting on the boy's bed and talking to him. The third prison officer has a son of his own and he has so much time for these young lads, it is unbelievable. There's a lot of good quality staff on this wing and they go that extra mile with the young lads, and in return they are rewarded with respect."

Events during the night of 28/29 November

231. On duty on Windermere Unit during the night of 28-29 November was a sixth prison officer and an Operational Support Grade (OSG). Both arrived on the wing to start their shift at around 8.30pm. They told my investigators they received a verbal handover from the staff who had worked the evening shift. The sixth prison officer said he was told that "everything was okay, nothing untoward had happened". He also checked the wing observation book, and saw an entry that there was a new 15 year old on the wing.

232. At around 8.40pm, the sixth prison officer and the OSG carried out the last roll check (the counting of young people) of the day. It was the sixth prison officer who went to the boy's cell. He asked the boy if he was alright. The boy said he was "fine" and so the sixth prison officer moved to the next cell. Despite the fact that the local security strategy instructs staff to complete a further roll check between 10.30pm and midnight, one was not carried out.

233. The sixth prison officer remarked at interview that Windermere Unit was slightly noisier than normal that night. He thought this was because of the lock down that day. He said the young people were more likely to shout to each other more when they had not seen each other during the day.

234. The night staff were required to deal with two specific incidents on Windermere in the first hours of their shift. At around 11.00pm, they attended cell 23 as the occupant was being noisy. The OSG recalled that the individual concerned was shouting abuse at staff and also at another young person in cell 58, with whom he had had an argument the previous evening. At the time, both a Senior Officer (SO) and an assistant night Orderly Officer were on the wing as part of their rounds. As Orderly Officer, the SO was in charge of the prison overnight. The young person in cell 58 settled down after the Orderly Officer spoke to him. About an hour later, after the Orderly Officer and the assistant Orderly Officer left the wing, the OSG answered a call bell from cell 58. The young person swore at the OSG who placed him on a disciplinary report for an offence under the Prison Rules. The night staff said they did not recall hearing any other shouting or loud noises coming from other young people on the unit during the night. However, overwhelming, but unproven, evidence provided to the police and to my investigators after the boy's death leads me to believe that shouting did take place.

235. The next day, the first roll check was conducted by the OSG at about 5.30am. At interview, the OSG recalled that he saw the boy lying in bed and that he appeared to be asleep. The OSG did not think anything was untoward.

236. Evidence seen by my investigators shows that the night staff carried out 'pegging' on three occasions during the night. ('Pegging' is the term used throughout the Prison Service to describe the process of recording the periods during which night staff patrol their units. This does not involve the checking of individual cells.)

The boy found hanging

237. The table below shows the timing of events recorded on closed circuit television cameras. The investigation found that these timings are about four minutes ahead of those recorded on the control room log.

Time	Event
7.10.40am	A seventh Officer arrives at the boy's cell and looks through observation panel.
7.10.47am	The seventh Officer runs off to raise alarm.
7.11.15am	Landing lights come on.
7.11.20am	The seventh Officer returns to the boy's cell and enters on her own.
7.11.24am	The sixth Prison Officer arrives at cell and enters.
7.11.28am	The assistant Orderly Officer arrives at cell and enters.
7.11.30am	The OSG arrives at cell and enters.
7.11.47am	The OSG leaves cell and disappears from view.
7.11.52am	An eighth Officer arrives.
7.11.58am	The OSG returns to view, radio in hand (presumably having called for assistance). Does not enter cell.
7.12.15am	A ninth Officer arrives at cell and enters followed by an tenth Officer who does not enter cell.
7.12.20am	An eleventh PO on arrives at cell but does not enter.
7.12.33am	The Orderly Officer arrives at cell with the twelth Officer. The Orderly Officer and the tenth prison officer enter cell. The assistant Orderly Officer and the eight prison officer leave cell.
7.12.41am	The Orderly Officer stands outside cell at doorway.
7.12.52am	The ninth and tenth prison officers leave cell.
7.13.18am	A thirteenth prison officer arrives at cell.
7.12.22am	The sixth prison officer leaves cell.
7.13.27am	The seventh prison officer leaves cell.
7.13.32am	Cell door pulled to (not locked) by the thirteen prison officer.
7.14.11am	The tenth prison officer opens door for a few seconds. He and the assistant Orderly Officer look into cell.
7.14.26am	The tenth prison officer enters cell.
7.14.37am	The Orderly Officer enters cell, having appeared to take a piece of equipment (? mouthpiece) from the assistant Orderly Officer.
7.14.47am	The Orderly Officer leaves cell briefly then returns. The assistant Orderly Officer, the sixth and eighth prison officers seen standing outside cell.
7.15.19am	A Healthcare Nurse and a HCA arrive at cell and enter immediately.
7.15.46am	The Healthcare Nurse appears at entrance to cell and asks for something.
7.22.38am	The seventh prison officer returns to view. Looks in cell but does not enter.
7.22.58am	The seventh prison officer leaves area.
7.23.23am	The assistant Orderly Officer opens fire exit next to cell (?to facilitate access by ambulance crew).
7.25.26am	The tenth prison officer leaves cell.
7.25.42am	The tenth prison officer re-enters cell.
7.26.35am	The tenth prison officer leaves cell again.
7.26.59am	The tenth prison officer re-enters cell.
7.27.25am	The tenth prison officer leaves cell.
7.27.58am	Paramedics arrive and enter cell.

238. At about 7.00am, the seventh prison officer arrived on Windermere 2, the first officer from the day shift to arrive. Her first task was to do her own roll check to ensure that the figures given by the night staff tallied with the numbers she found. The seventh prison officer was required to attract a verbal or physical response from each cell occupant. At 7.10am, the seventh prison officer reached the boy's cell (number 44). At interview, she said that she could not see him at first as he was not on his bed. However, she thought she saw the boy on the floor. Her first impression was that he might have fallen out of bed. But she then thought she could see the boy's face looking towards her. The seventh prison officer said that, although she could see nothing else at that point, she "instinctively knew something was wrong".

239. The seventh prison officer ran to the alarm button adjacent to cell 55 in order to raise the alarm. Although another alarm bell was situated outside the boy's cell, the seventh prison officer said she thought that she would struggle to find it without the lights on. The alarm button outside cell 55 was also visible to the staff office on the floor beneath. The seventh prison officer told my investigator:

> "I went deliberately to that one [alarm button nearest cell 55] because apart from the cell bell at 44 is right round the corner, it was in the dark and I would have struggled to find that bell anyway without the lights on but I knew that I needed to let the staff know where I was as raising the alarm. I needed to let them to come straight upstairs, not look around the wing to see where I was."

240. The seventh prison officer said she pressed the alarm button at the same time as she sent a request for help over the radio. She could not recall exactly what she said. However, she admitted that she did not ask for medical assistance at that stage because she did not know what was wrong. Having just come on duty, she still had her coat on. As she was hot she decided to take her coat off. As she did so, her radio fell away from her belt. At this point, the seventh prison officer saw that some colleagues were looking towards her from the wing office. She returned to the boy's cell door and opened the observation flap "to observe what was going on".

241. The seventh prison officer unlocked the door and entered the boy's cell, followed within a few seconds by the sixth prison officer and assistant Orderly Officer. The OSG also followed them but remained outside the cell. They found the boy hanging from a ligature made from a bedsheet. He had pushed the sheet through his open window, and then closed the window so that it was held firmly. The sixth prison officer supported the boy's body whilst the assistant Orderly Officer cut the ligature. They then laid the boy on the floor of the cell and, between them; the assistant Orderly Officer and the seventh prison officer removed the ligature from the boy's neck. Around 17 seconds after he arrived at the cell, the OSG used his radio to call for urgent medical assistance.

242. At interview, both the assistant Orderly Officer and the seventh prison officer said that they considered administering CPR but, as they were not first aid trained, they thought they would do more harm than good.

243. At consultation stage, the seventh prison officer expressed her view that the report should reflect the point, made in her interview with my investigator, that she was prepared to administer CPR. I repeat here the following extract from the transcript of that interview:

> "I asked the staff to help me lower him [the boy] flat on the floor because I knew that CPR would have to take place … And as we laid him down, I sort of positioned my hand on his chest because going through my mind was I'm going to have to start CPR once we get him to lay on the flat on the floor, in the correct position, we are going to have to start CPR … And I was trying to feel for a heart beat and I couldn't feel anything at all."

244. When asked whether she did commence CPR, the seventh prison officer replied as follows:

> "No, because by that point, the tenth prison officer was in the cell, there were other people by the door and sort of in the background I could hear that someone was calling for medical assistance or somebody was talking about medical assistance. I'm not first aid trained; thoughts that were going through my mind were I don't want to hurt him any more than I have to. I don't want to break his ribs; I might do more harm than good. The fact that I knew medical staff were on the way, I thought its better that they do it and do it properly than I do something and cause him an injury which might be more detrimental. But I was poised to do CPR but I do recall looking up at the tenth prison officer and just saying, he's gone. And maybe that was instinct, that's what I believed at the time and he said just put him in the recovery position then, which I did. I did place him in the recovery position."

245. When asked to estimate the time lapse between cutting the boy down and putting him in the recovery position, the seventh prison officer replied that it was "a couple of minutes".

246. While the OSG was making his call for urgent medical assistance, the eighth prison officer arrived and went inside the cell. He was followed about 20 seconds later by the ninth prison officer. Within another 20 seconds both the tenth prison officer and Orderly Officer arrived, together with the twelfth prison officer.

247. When the tenth prison officer went into the boy's cell, the seventh prison officer told him that the boy had died. The tenth prison officer asked that the boy be put in the recovery position, and he checked his pulse for signs of life. At interview, he recalled that the boy was very warm but had no pulse. At around this time, the ninth prison officer asked if anyone was competent in

cardio-pulmonary resuscitation (CPR), but received no response. She put this down to the staff being "shell shocked".

248. At 7.13am, just over a minute after he arrived at the cell, the tenth prison officer asked all the staff to leave and the cell door was closed. At interview, the tenth prison officer told my investigators that, as some people were peering into the cell, he closed the door because of a need to preserve evidence. The tenth and the thirteenth prison officer, who had arrived about 15 seconds before the door was closed, then had a short conversation. They agreed that the thirteen prison officer would deal with matters such as alerting other people to the events. At interview, the thirteen prison officer said he then went to the wing office and asked for an ambulance to be called.

249. The Orderly Officer told the tenth prison officer that they had a responsibility to try to resuscitate the boy. Therefore, at 7.14am, about a minute after the cell door was closed, the tenth prison officer and the Orderly Officer re-entered the boy's cell and began cardio-pulmonary resuscitation (CPR). The Orderly Officer gave mouth to mouth resuscitation while the tenth prison officer applied chest compressions. At interview, the Orderly Officer said he had been trained in emergency first aid as did the ninth prison officer. The tenth prison officer said that, although he used to be first aider, he had not received refresher training for a number of years.

250. At 7.15am, the Healthcare Nurse and Healthcare Assistant (HCA) arrived at the boy's cell in response to the call for medical assistance made by the OSG. Between them they took over the application of CPR. The Healthcare Nurse also checked that an ambulance had been called. In between breaths he checked for signs of life, but could find no pulse and noticed that the boy was not breathing.

251. At interview, the Healthcare Nurse told my investigator that the first indication he received that there was a problem in the establishment was at about 7.07am when the general alarm sounded. (The CCTV footage shows that the alarm was raised a few seconds before 7.11am.) The Healthcare Nurse said that, whenever this alarm was sounded, the radio net was placed on "talk through" (which enables all call signs to hear every transmission). The Healthcare Nurse said that "after a minute or two" he heard a further message on the radio in which a request was made for medical assistance in Windermere Unit. He knew at that point that something serious had happened, although he did not know that the boy had been found hanging. The Healthcare Nurse therefore ran to the clinic in the healthcare centre where the emergency first aid bag was kept and took it with him to the unit. He asked the HCA to accompany him. As he arrived at the boy's cell he saw "one or two officers hovering outside the door". He said he could see the Orderly Officer and the tenth prison officer administering cardio-pulmonary resuscitation to the boy on the floor of his cell. The Healthcare Nurse told my investigator:

> "I could find no pulse, there was no breathing and his skin was very sort of pale and like an ashen grey colour. His pupils were

quite wide and fixed. There was no sign of life. I took over the ventilations and then shortly after that the HCA took over compressions to give the tenth prison officer a break. We continued doing that until the paramedics arrived which was around 7.27am."

252. The Healthcare Nurse explained that the emergency bag he took with him from the healthcare centre included oxygen, an ambu-bag (a device that enables oxygen to be passed into a patient's lungs via the throat), gloves, bandages, sterile strips, and other items that are needed to deal with every day eventualities in which first aid is required. The Healthcare Nurse explained that, although a defibrillator was available, he did not use it as he felt he was not adequately trained in its use.

253. As soon as the paramedics arrived, they and the healthcare staff shared the administration of emergency first aid. At 7.45am, the paramedics took the decision that they had done all that they could for the boy, and his death was pronounced. No note was found in the boy's cell indicating his intention to take his own life.

254. The Governor at the time of Lancaster Farms was told over the telephone at 7.15am that the boy had been found hanging and that the matter was being treated as a death in custody. (In fact, at that stage, the boy had not been pronounced dead.) At this time, the former Governor was at the conference of the Prison Service North West Area that I was attending myself. At about 7.45am, after briefing his Area Manager, the former Governor left for his establishment. During a telephone conversation with his deputy governor on the way to Lancaster Farms, the former Governor discussed the tasks to be carried out, including the confirmation of next of kin details. The former Governor was concerned to be ready to make a decision upon his arrival at the establishment as to how the next of kin should be informed. He also left a message on the chaplain's telephone, alerting him to the probability that he and the chaplain would break the news of the boy's death to his family. The former Governor arrived at Lancaster Farms at about 8.30am. By that stage, a notice to staff announcing the boy's death had been posted at the gate by the deputy governor.

255. After receiving a full briefing on events, the former Governor went to the prison chapel to speak to the staff who had discovered the boy hanging and who had attempted to revive him. He then went on to Windermere Unit to see the staff on duty there. At 9.00am, a notice to young people was issued telling them of the boy's death.

Informing the next of kin

256. At 10.00am, the chaplain arrived at the establishment and reported to the Governor for a briefing. At 10.30am, the former Governor and the chaplain left Lancaster Farms to break the news of the boy's death in person to his aunt and uncle. In keeping with arrangements made by the Governor, he and the chaplain were to be joined by a representative from the St Helens Youth

Offending Team. It was therefore agreed that they would initially meet at the representative's office.

257. The Governor and chaplain met the representative as planned at about 11.30am. They then left together for the boy's family home. When they arrived, the door was answered by one his cousins. After explaining who he was, the former Governor asked if he and his colleagues could go into the house. The former Governor decided that, in the circumstances, it was appropriate to break the news of the boy's death to the cousin. She wanted to call her father straightaway but was advised by the former Governor that she should consider first seeking support from a close friend. The advice was taken and the chaplain left briefly to bring a chosen friend to her. The friend then rang the boy's uncle and asked him to come home quickly as she needed him. At this stage no details of the boy's death was given to his uncle. However, he called his daughter to ask her why he was needed. His daughter told him that staff from the prison had arrived. At this point, the former Governor took the telephone and broke the news of the boy's death to his uncle. The former Governor agreed to remain where he was until the boy's uncle arrived. The former Governor suggested that he and his colleagues could wait elsewhere while they were waiting for the boy's uncle to arrive but they were told they were welcome to stay. When the boy's uncle arrived, the former Governor told him as much as he could about the circumstances of the boy's death and tried to answer the family's questions. The former Governor and his colleagues then left.

Support for young people and staff

258. Notices were issued to young people and staff informing them of the boy's death and offering additional support to anyone – young people and staff alike – who felt in need of it. The Deputy Governor chaired a 'hot' debrief of those staff involved in the discovery of the boy's hanging and in the attempts to save his life. The Governor also spoke to them separately and visited the staff in Windermere 2 Unit. He also addressed key managers before departing to break the news of the boy's death to his family.

259. Arrangements were made to review the case of all those young people who, at the time, were subject to ACCT procedures.

260. Later, the Governor arranged for two members of the Lancashire County Council Critical Incident Support Team to visit Lancaster Farms on Friday 7 December in order to provide support for young people and staff who might have been affected by the boy's death.

Ongoing contact with the boy's family

261. As a result of legal complications that arose after the boy's death, his funeral did not take place until Monday 16 June 2008. My investigators were told that the establishment Family Liaison Officer (FLO) maintained contact with the boy's family at times during that difficult period, as did the family links coordinator. The FLO also arranged for the boy's family to visit Lancaster

Farms in order to meet the Governor, the chaplain, representatives of the Youth Offending Team and the staff who found the boy. The family visited the boy's cell and laid flowers.

262. The Governor offered to meet the full costs of the boy's funeral. He also wrote to the boy's aunt and uncle with regard to additional costs incurred at the boy's wake. The Acting Governor and a chaplain from the chaplaincy represented NOMS at the funeral.

ISSUES

263. I have serious concerns about a number of issues arising from this investigation. They relate to aspects of the boy's management from the time he was first considered for placement at Lancaster Farms to the day he died. (Whilst I make no judgements about his management at Red Bank Secure Children's Home and at HMYOI Thorn Cross, I do comment on aspects of the interface between those establishments and HMYOI Lancaster Farms.) The issues I explore are listed below:

- Whether the decision to recommend placing the boy at Lancaster Farms was appropriate.

- Whether, once the decision to place the boy at Lancaster Farms was confirmed by the YJB, adequate information about his self-harm history and related vulnerabilities was made available to the establishment prior to his arrival there on 8 November 2007.

- Whether the boy's healthcare needs and risk of self-harm were properly assessed when he arrived at Lancaster Farms, and whether they were followed up and acted upon thereafter.

- Whether adequate provision was made for the boy's induction, sentence planning and access to education and other regime activities.

- Whether there was an effective Personal Officer scheme in place.

- Whether the boy was in any way bullied or taunted while he was at Lancaster Farms and, if so, whether any measures were made to safeguard him. I also consider whether his death could have been linked to bullying.

- Whether the response to the discovery of the boy hanging on 29 November was prompt and appropriate.

- Whether the news of the boy's death was promptly communicated to his next of kin and whether appropriate courtesies and support were offered to his family in the aftermath of his death.

At the end of each section of this chapter I list my findings and recommendations. The latter are summarised at the end of my report.

The decision to place the boy at Lancaster Farms

264. The boy's YOT worker explained to my investigation team that she worked with the boy closely and knew him and his family well. She had supported the boy through his sentence at Red Bank from August to October 2007, and was responsible for supervising him when he was released on licence. Although the boy breached the conditions of his licence on the evening of his release from Red Bank, the YOT worker said that she would have been prepared to

recommend a continuation of the boy's licence if he had made an effort to comply with its conditions. (It should be noted that although the YOT worker can make recommendation for recall or for continuation of the licence period, it is the court that makes the final decision.) The YOT worker wrote in the boy's pre-sentence report:

> "Unfortunately, since this breach was listed, the boy's situation has deteriorated. He is now refusing to engage with any Youth Offending Service interventions and apart from his first day back at school, he has since refused to attend any further education. In addition there have been several further incidents of failure to comply with his curfew, including two nights when he was absent for the whole curfew period and was reported to police as a missing young person. The boy has refused to engage with any sessions to address these concerns."

265. The YOT worker told my investigation team that she waited until the day before the boy's court appearance on 8 November before writing the report, because she considered custody as an absolute last resort. She consulted her colleague who had supervised the boy on his previous custodial sentence, as well as her line manager, about the recommendation for recall. She also spoke to the boy's aunt and uncle on a number of occasions between his release on 22 October and his court appearance. At interview, she explained that she felt she had no choice but to recommend the boy's recall because of the "escalation in the boy's risk of re-offending and his vulnerability".

266. The success of community sentences is dependent upon the engagement, cooperation and motivation of the person being supervised. The boy refused to answer telephone calls from his YOT worker or to attend his appointments. In addition, his behaviour became more and more erratic as time passed. I therefore understand the YOT worker's belief that she had no choice but to recommend a recall to custody, and that the erratic behaviour the boy had sometimes shown at Red Bank suggested that he had outgrown the positive influence that the Secure Children's Home could have on him.

267. However, as I have said elsewhere in this report, my investigation team were struck by the immense difference between Lancaster Farms and Red Bank. The mid-way option between a Secure Children's Home and a Young Offender Institution is a Secure Training Centre, an establishment designed to look after young people between the ages of 12 and 17. They are significantly smaller than YOIs and young people live in small residential units. However, there are only four in the country and none in the North West. Young people from the St Helens area who are recommended for a Secure Training Centre are sent to Hassockfield Secure Training Centre in County Durham, 150 miles away. St Helens has made referrals to Secure Training Centres, but the YOT worker did not consider this for the boy. The relative proximity of Lancaster Farms meant that regular visits were possible and the boy might have had more opportunity to see his family.

268. I agree with the YOT worker and the Head of the YJB Placements Team that the boy was no longer suitable for placement at Red Bank. His disruptive behaviour at the children's home aside, it is difficult to overlook the increasingly risky behaviour that the boy engaged in when he was released from Red Bank on licence in October. The YOT worker described her repeated attempts to engage with him and his reckless behaviour in response. (At consultation stage the solicitor representing the boy's family, commented that the YOT worker's conclusion that the boy was no longer suitable for placement at Red Bank appeared to have been reached without input from anyone at the Children's Home. The solicitor also commented that the YOT worker's opinion was at odds with the findings of the author of the St Helen's review - i.e. the
independent Serious Case Review conducted by the St Helens Local Safeguarding Children's Board - who recorded that the boy had benefited from Red Bank. It is not for me to comment on the findings of that review. However, I remain satisfied that the conclusions reached by the YOT worker and the Head of Placements from the YJB were reasonable given the boy's deteriorating behaviour both at Red Bank and afterwards in the community.)

269. By 7 November, the placement options for the boy were therefore very limited. Although Red Bank was appropriate given the boy's vulnerability and its proximity to his family, the escalation in his offending behaviour showed that he was unlikely to achieve anything by returning. There were no Secure Training Centres in the vicinity of his home. (I have not considered the matter in any detail, but on the face of it the absence of an STC in the North West is very surprising. The YJB will obviously wish to satisfy itself that the geographical spread of STC provision is optimal.) It seemed to the boy's YOT worker that the only option was to recommend the boy's placement at Lancaster Farms, one of the Prison Service's 16 YOIs.

270. At the time of the investigation, there were 2,730 places for young men in Young Offender Institutions in England and Wales. There were only 536 non-YOI places, which were then, as now, also used for young women. The Head of the YJB Placements Team explained that in reaching its decisions the team has to balance the competing needs of young people for non-YOI places because there are far fewer of them. He said that if a YOI has been recommended with reasonable justification, the Placements Team would rarely need to consult the young person's document that accompanies the placement alert form. As the boy's YOT worker recommended that he be placed at Lancaster Farms and went on to justify her recommendation, the Head of Placements thought it was unlikely that the placement officer at the YJB dealing with the alert form would have consulted the boy's documents.

271. The boy had been placed in Thorn Cross YOI in June 2007, where he stayed for ten days before being moved to Red Bank to serve the rest of his sentence. At the time of the boy's placement, Thorn Cross was the only YOI with open conditions. (The YJB has since ceased purchasing the 60 places that were available for juveniles at Thorn Cross and it now only accommodates 18-21 year olds.) The Head of Placements explained that, at that time, Thorn Cross operated a small unit with closed conditions, known as

the Direct from Court Unit which was intended to assess a young person's ability to cope with the different demands of open conditions. The closed unit had a higher ratio of staff than the open unit and the emphasis was on the assessment of young people's vulnerabilities and needs and whether they could be effectively met by the more relaxed open conditions. In the boy's case, the YOI alerted the YJB Placements Team and the boy's YOT worker that it was their opinion that the boy was too vulnerable to cope with the conditions at Thorn Cross and any YOI. (The police had also advised Thorn Cross that, in their view, the boy was not suitable for open conditions because he was facing a further trial.)

272. The boy's Asset form detailed his history of self-harm in some detail under section 15, "Vulnerability". Serious concern was raised at the beginning of the boy's sentence, on 22 August, about his vulnerability if he were remanded to custody. While the boy was at Red Bank on this sentence, the following entry was made in his file:

> "Start DTO – 18.9.07 – appropriate measures/steps were taken by YOS [Youth Offending Service] to ensure vulnerability issues were addressed. The boy is now at Red Bank and to my knowledge there have been no concerns about self harm. Anxiety levels need to be monitored."

273. After the boy was released on licence, the following entry was raised about his vulnerability:

> "DTO licence 24.10.07 following on from info below, staff have responded to incident of self harm … Child and Adolescent Mental Health Services [CAMHS]] have been seeing the boy on weekly basis, and support package for the boy and family is in place from YOS and CAMHS."

274. These are the last two entries before the boy was recalled to custody. His vulnerability appeared to have been reduced by interventions from the Community Mental Health Service and the intervention of the YOT worker. During her interview with my investigators, she was asked about her view on the boy's vulnerability, especially in the environment of a YOI. She explained:

> "I think, you know, as a case worker, you've got to consider that for all young people. I didn't think it was an issue for the boy when I was making the decision about which custodial setting to recommend."

275. The YOT worker was aware of the boy's unsuccessful period at Thorn Cross. She understood his mental health issues and how they were being treated in the community. She also knew about, and recorded the details of, his history of self-harm in the Asset document. With all these factors in mind, the YOT worker did not think that vulnerability "was an issue" for the boy when she recommended him for placement at Lancaster Farms. Indeed, she wrote on the placement alert form she submitted to the YJB on 7 November:

> "Previously requested Red Bank when the boy had not experienced custody. However, this would be his third time in custody and YOS staff can liaise appropriately with casework staff at Lancaster Farms. Lancaster Farms is near enough to enable family visits to take place and also any relevant partnership staff can regularly also visit to undertake ongoing interventions and planning meetings."

276. The YJB website refers to the key factors Youth Offending Teams must take into consideration when considering placement options. Examples quoted are:

- risk of self-harm
- having been bullied
- separation, loss or care episodes
- risk taking
- substance misuse
- other health related needs
- the ability to cope in a YOI or other custodial establishment.

277. Most of these factors applied in the boy's case. The YOT worker did not think the boy would find it hard to adjust to a prison environment, saying "He mixed really well with young people." It is difficult to argue that anyone could be better placed to make this judgment than the YOT worker, who had worked so closely with the boy over the previous months. However, nothing could have been further from the truth. The boy did find it hard to adjust at Lancaster Farms. Such was his fear and perception of the prison environment that he hardly left his cell. He certainly did not mix well with other young people.

278. In his interview, the Head of Placements said he thought the YOT worker's recommendation and the reason for it seemed appropriate. He said that, unless a placements officer had to prioritise a non-YOI secure placement or there was no clear recommendation for placement on the alert form, his Placements Team did not need to refer to the documentation accompanying the alert form, for example the young person's latest Asset. He said that the accompanying documentation was for the receiving establishment to look through to plan how to care for each young person they received. The Head of Placements did not think the Placements Team had any reason to question the YOT worker's judgement. He said the boy was therefore placed at Lancaster Farms directly as a result of her recommendation.

279. In all the circumstances, I do not consider that it was unreasonable for the YOT worker to recommend the boy's placement in a YOI. Nevertheless, as the YJB are ultimately responsible for making placement decisions, I do not think they should rely solely on the recommendations of the YOT worker. In para 38 above, I reproduced a table showing the criteria for placement options as explained on the YJB website. For vulnerable males between 15 and 16, it recommends a Secure Children's Home or STC.

280. I interpret the table as clearly indicating that, given the serious concerns about the boy's vulnerabilities, he should have been placed in a Secure Children's Home or a Secure Training Centre. (At consultation stage the family's solicitor, commented as follows:

> "…There is a disparity between policy and practice. The YJB have no choice but to place children younger than 15 – whether or not vulnerable – in either Secure Training Centres or Secure Children's homes. The YJB policy on 15 and 16 year old boys is that if they are vulnerable they will be placed in non Prison Service establishments. The YJB practice though is that large numbers of vulnerable 15 and 16 year olds are placed in Prison Service YOIs.")

281. I am also concerned that the decision to place the boy at Lancaster Farms was not informed by any assessment of the physical and cultural environment to which he was to be sent. However, if - as I believe to be the case - not all senior managers at Lancaster Farms knew of the extent of the mental bullying that took place in Windermere Unit by night, the YOT worker cannot be blamed for not knowing this either. Nevertheless, such an assessment should become a standard element of the placement process in order to minimise the risk of a further tragedy occurring. (At consultation stage, the St Helens Youth Offending Service questioned how field workers could assess the physical and cultural environment of a YOI and expressed the view that they – the field workers – had a reasonable expectation that establishments should provide proper care and safety for young people. I have some sympathy with his view. However, I maintain that it is not unreasonable to expect YOS staff to have a knowledge of those aspects of their establishments.)

282. As I have said, it is surprising that there is no Secure Training Centre in the North West. Had one been available, I assume the YOT worker would have recommended it for the boy.

Summary of findings

283. As the YJB are ultimately responsible for making placement decisions, they should not rely solely on the recommendations of the YOT worker.

284. The decision to place the boy at Lancaster Farms was not informed by any assessment of the physical and cultural environment to which he was to be sent.

285. The table on the YJB website explaining the criteria for the placement of young people within the secure children's estate shows that, given the boy's vulnerabilities, he should have been placed in a Secure Training Centre or Secure Children's Home.

286. There is no Secure Training Centre in the North West.

Recommendation

Urgent steps should be taken by the YJB to ensure that placement decisions are made in accordance with the criteria explained on its website. Placement recommendations and decisions should be informed by an assessment of young people's ability to cope with the physical and cultural environment of the establishments under consideration. Placement recommendations and decisions should also take account of all available information about the young people under consideration, including home circumstances, Asset details, vulnerabilities and risks, as well as any relevant suggestions made by staff in the establishments in which young people have previously been held.

The information made available to Lancaster Farms about the boy's risks and vulnerabilities prior to his arrival

287. Paragraph 5.4 of Prison Service Order 4950, sets out the following guidance with regard to the assessment of young people's needs on reception:

> "Governors must ensure that the prescribed systems are in place for recording receipt of key documents – for example, Asset, Pre-sentence report, post court report, YJB vulnerability alert and suicide/self harm warning form; for informing YJB of missing documentation; and for ensuring that outstanding information is received as soon as possible.

288. The casework officer, who conducted the boy's general reception interview, told my investigators that the boy's Asset document was available to him. But there was some confusion as to what happened to his pre-sentence report and post court report. The court worker said that the post court report was placed in a yellow envelope and given to the staff who escorted the boy to Lancaster Farms. The YJB monitor confirmed that she saw this report in the boy's file after his death. The casework officer confirmed that, although the Prisoner Escort Record contained no mention of any risk of self-harm, the boy's Asset form carried a notation that he was at risk because he had harmed himself seven months earlier. At interview, the Practice Nurse, who conducted the boy's initial reception health screen, said Asset forms were not always received on the day of a young person's reception.

Summary of findings

289. The investigation found no evidence to show that any effort was made by anyone at Lancaster Farms to clarify which forms had been received or to ask the YJB to obtain those that were missing.

290. A little over a fortnight elapsed between the boy's release from Red Bank and his admission to Lancaster Farms. Despite the fact that important information about his time at Red Bank was contained in this file it was not passed to Lancaster Farms until requested by the Governor after the boy's death. The documents also included vital information about the boy's experience at Thorn Cross. My investigation found that no clear system was in place for the

transfer of information between Secure Children's Homes and Young Offender Institutions.

Recommendations

A protocol should be agreed between the YJB and the Prison Service for the prompt and efficient transfer of young people's custodial records when they move between Secure Children's Homes, Secure Training Centres and Prison Service establishments. The protocol should make it clear that YOT workers are responsible for arranging the transfer of such documents.

The Governor should take urgent steps to ensure that, in keeping with paragraph 5.4 of PSO 4950, systems are in place to record accurate details of which forms have been received in reception and that missing documents are requested through the YJB.

The assessment and management of the boy's healthcare needs and risk of self-harm and other vulnerabilities

291. Paragraph 5.5 of Prison Service Order 4950 sets out the following guidance for the assessment of young people's immediate needs:

> "Every young person must be screened on the day of arrival to ensure their safety and to identify all immediate healthcare needs. An assessment must be made of their likelihood of their harming themselves and of the need for further in depth assessment of physical, mental health and substance misuse history.
>
> "Every young person must be interviewed within one hour of their arrival to assess their needs and vulnerability and complete the form T1:V."

Initial healthcare screen

292. The boy's reception health screen was conducted by the Practice Nurse whose experience of managing children and young people had been gained during the year she had spent at Lancaster Farms.

Risk of suicide or self-harm

293. The Practice Nurse regularly undertook the evening duty in the reception area of Lancaster Farms and felt experienced in the first reception health screen process. She had received ACCT training. Although she did not have formal mental health training, she had worked with patients with mental health problems in the community and felt sufficiently knowledgeable in this area. Her non-professional experience with teenagers also helped her to make judgments during the screening process.

294. The Practice Nurse considered that the boy was not at risk of suicide. She assessed the way he answered her questions, his body language and his good eye contact. In interview, The Practice Nurse said she saw the boy's Asset form but as it was such a large document it was difficult to read in the

time available. The Practice Nurse said the Placement Confirmation form or "first night alert" was also available to her and she would have questioned the boy about its contents. The Asset form is central to the care of young people. It guides staff in their assessment of risk and factors associated with their offending behaviour. It also provides an opportunity to record any concerns about young people's welfare.

295. Although I am disappointed that the Practice Nurse did not look at all the relevant evidence available to her before drawing her conclusion that the boy was not at risk of self-harm, I consider that her decision not to open an ACCT form was understandable given his presentation during the health screen.

296. The Asset form is designed with the intention of identifying the reasons a young person offends. Its primary purpose is not to highlight a young person's vulnerability. However, I think much could be done to make the design of Asset more user-friendly in a custodial environment. Information such as an attempt at suicide is critical and should not simply be another item on a checklist. When my investigators put this to the Head of Placements at the YJB, he agreed that the tool was not designed with custodial staff in mind. However, he said that a project was underway for the use of 'eAsset', an electronic assessment tool. One of the objectives of that project is to ensure it was compatible with use in a custodial environment. (I have seen eAsset in operation at HMYOI Castington and I strongly support it.)

297. During the course of the investigation, my investigators were told that many staff would not place individuals on ACCT documents as they were often closed the following day. My investigators discovered that over 80 ACCT documents were opened during the last quarter of 2007. More than 20 per cent were closed on the same day or the day after they were opened. (This seems a surprisingly high proportion.) If a member of staff opens an ACCT document they may well be reluctant to open further documents if they see them closed the next day. In my opinion, it is highly unlikely that the underlying issues behind opening an ACCT form on a young person will have been removed overnight. Although I make no formal recommendation on this point, it may be that the NOMS Safer Custody and Offender Policy Group will consider commissioning comparative research into the proportion of ACCT forms opened and closed within 24 hours. There may be some important learning to be gained.

Cell sharing risk assessment

298. The cell sharing risk assessment conducted by the casework officer and the Practice Nurse was informed only by the responses the boy gave to the questions listed on the assessment form. Despite the fact that the Asset form was available at the time (on the casework officer's own account), there is no evidence that its contents were taken into account during the assessment interview. Hence, a number of important aspects of the boy's history were ignored, as can be seen from my investigators' comments in the table shown in para 159 above and repeated here for convenience:

Questions	Answers
Has the prisoner been convicted of a racist or homophobic crime?	No. *(In fact, the boy's Asset form shows that he had been convicted of an offence of racially insulting behaviour committed on 8 June 2007.)*
Has the prisoner ever abused alcohol or drugs?	No. *(In fact, the boy had been a prolific user of alcohol and often taken drugs.)*
Is the prisoner currently dependent on alcohol or drugs?	No. *(In fact his Asset form, which the casework officer said was available when the cell share risk assessment was completed, indicated that the boy considered substance misuse, including alcohol, to be an essential factor in his life style.)*
Is there any evidence of the prisoner having a previous ACCT?	No. *(In fact, the boy had been subject to ACCT procedures at Thorn Cross, but no details of that were available to Lancaster Farms.)*

299. My experience of other investigations has shown that it is not uncommon for reception staff to record only the responses given by prisoners during cell sharing risk assessments. I am also conscious that, in the boy's case, no matter what his responses his placement in a single cell was almost inevitable as there were no shared cells available for him. However, I do not approve a practice that relies solely on those current responses rather than taking into account relevant historical information. As with the need for the ACCT process to take historical information into account when considering risk, so must the cell sharing risk assessment. The details in the Asset form available to staff at the time of the boy's assessment should have been studied and taken into account irrespective of the lack of shared cells available. The historical factors ignored in the boy's case might have changed the course of his general management in the establishment had they been considered.

Substance misuse

300. The Practice Nurse did not refer the boy to the substance misuse team, despite his "excessive" use of alcohol and probable "cocaine type drug dependence". She thought the boy's substance misuse was not unusual and knew that it would be followed up at the secondary health screen. Although the investigation found that all young people are interviewed by a member of the establishment's Young Person's Substance Misuse Service (YPSMS) as a matter of routine, I consider that the boy's history of significant recent substance misuse was such that the Practice Nurse should have referred him immediately to the YPSMS and to a doctor. In the absence of any physical examination of the boy – no urine test was conducted – the Practice Nurse could not have known whether the boy was in need of detoxification from drugs or alcohol. The clinical review panel have commented, at paragraph 7.4 of their report, that "although his experience of alcohol and drug misuse was identified, the boy was not referred directly to the YPSMS as it was standard practice for that to occur as part of the routine induction protocol … As part of a national roll out programme, PCTs are now required to commission Integrated Drug Treatment Services (ITDS) for their population, including prison services ..."

301. A member of the Substance Misuse Service, confirmed that his team automatically sees every young person who comes into Lancaster Farms irrespective of whether they have any substance misuse problems. The member conducted an initial assessment of the boy's needs three days after he arrived and then completed a full assessment on 26 November.

302. The investigation found no evidence that the boy was offered any medical support for his alcohol dependency whilst he was at Lancaster Farms.

Secondary healthcare assessment

303. A secondary health screen was conducted on 11 November by a Healthcare Assistant. She recorded that, although the boy had self-harmed six months earlier, he was "ok at the moment".

Mental health assessment

304. On 14 November, six days after arriving at Lancaster Farms, the boy was assessed by a social work student, a member of the mental health in-reach team, in response to the referral made during his reception health screen. The social work student noted that the boy was not currently subject to ACCT procedures and had told her he had no thoughts of self-harm. During his interview, the boy said he did not want to take part in education, gymnasium or association. He explained this by saying that sometimes he liked to be on his own but would come out of his cell if he wanted to. He told the social work student he was not afraid of other people. The effect of the boy's reluctance to engage in any activities, especially association, was likely to make him feel isolated. But the social work student emphasised that the boy was "quite happy and bubbly" when she interviewed him. She said she did not expect him to be so open about how he felt. He told her he did not have any worries about other people at Lancaster Farms and said he was only likely to self-harm at times when he became stressed. The social work student did not believe the boy was putting on an act of bravado. She said she considered whether, in view of the boy's history of self-harm, she should open an ACCT form. However, she decided it was not necessary to do so given the boy's presentation during her assessment of him.

305. The investigation later found evidence, principally from letters written by the boy and his telephone calls, that he was frightened to leave his cell. However, it seems that he told no members of staff how he really felt. Although, with the benefit of hindsight, it seems the social work student was mistaken in her perceptions of the boy's morale, his demeanour at the time was positive. The social work student planned to assess the boy again two weeks later. However, she was unable to do so as that day was designated a staff training day. As the boy died the next day, the social work student did not see him again.

Summary of findings

306. Here I add my own findings to those included in the clinical review appended to this report.

307. The nurse who conducted the first reception health screen should have taken a urine sample from the boy in order to measure what, if any, immediate substance misuse interventions were necessary.

308. Given the boy's significant history of alcohol abuse, the nurse should have made an immediate referral to a doctor and to the Young Person's Substance Misuse Service. The investigation found no evidence that the boy was offered any medical support for his alcohol dependency whilst he was at Lancaster Farms.

309. I am concerned that the first reception health screen seemed not to take account of the concerns about the boy's self-harm history recorded in his Asset form. In my view, the decision whether self-harm monitoring procedures should be invoked should not ignore available historical information about the person being assessed.

310. Just as the ACCT process takes into account historical information about a young person when considering risk, so the cell sharing risk assessment should do the same.

311. At consultation stage the family solicitor, questioned whether the Practice Nurse and the social work student were sufficiently qualified and experienced to assess the boy's needs. The solicitor commented that the Practice Nurse had no formal mental health training and no specific training to work with young men.
The solicitor also pointed out that the social work student was a 3rd year student social work student with no formal psychiatric or psychological qualifications. He said:

> "We would suggest that suggest that issues around the boy's vulnerability may have been missed by the Practice Nurse and the social work student which may have been picked up by more qualified mental health professionals …"

The solicitor asked for a recommendation to be made that staff should receive proper training specific to issues faced by vulnerable young people. I have some sympathy with the solicitor's views. However, the view of the panel who conducted the clinical review of the management of the boy's health needs is different. At paragraph 7.2 of the clinical review, the comment is made that the assessment carried out at first reception health screen provided clear information and the actions of the practice nurse in initiating the referral to the Mental Health In-Reach Team were reasonable and proportionate. At paragraph 7.4 the further comment is made that the nurses on the Primary Care Team undertaking the screening have access to RMN (Registered Mental Nurse) qualified nurses on the ward if they have any concerns and require immediate assistance.

Where the social work student is concerned the clinical review states at paragraph that the panel considered her level of training was appropriate for mental health assessments provided that adequate supervision was available. However, the panel were concerned that the supervision procedures in place for the social work student appeared not to have been followed completely.

I am not in a position to question the professional views expressed by the clinical review panel and I therefore make no formal recommendation. However, the Coroner may wish to consider the matter further at the boy's inquest.

Recommendations

Those staff responsible for completing healthcare screens should pay full attention to the information contained in Asset forms, especially where the assessment of self-harm or suicide risk is concerned.

Urine samples should be taken during first reception health screens in order to inform decisions about young people's needs for detoxification or other appropriate substance misuse interventions.

Healthcare staff conducting first reception health screens should, where necessary, make an immediate referral of young people with a recent history of significant substance misuse to a doctor and to the Young People's Substance Misuse Service so that decisions about detoxification and other interventions can be made without delay.

Consideration should be given to the remodelling of the Asset form for easier use in a custodial environment so that critical information such as self-harm risk is clearly visible.

The Governor should satisfy himself that there is no impediment to opening an ACCT form such as the perception by staff that forms will be closed at such a speed as to render their use pointless. ACCT documents should remain open until staff are satisfied that all issues have been identified and effectively managed through appropriate case reviews. Relevant training should be offered to staff in this regard.

The Governor, in conjunction with the PCT, should ensure that those staff who carry out cell sharing risk assessments take into account relevant historical information about a young person, such as that which may be contained in Asset forms.

Induction, sentence planning, access to education and other regime activities.

312. During the reception procedures, those under 18 years of age are kept apart from those over 18. The boy was placed in a holding room in the reception building. When my investigators visited this building they judged that the décor was bland, lacking in imagination, and offering neither warmth nor welcome. They contrasted this with what they had seen at Red Bank. There

are clear lessons here both for Lancaster Farms and for all Prison Service establishments holding juveniles.

First night procedures and induction

313. Prison Service Order 4950 requires Governors to ensure the following outcome for the induction of young people:

> "To introduce every young person to the culture, rules, opportunities and standards of behaviour of the establishment during a formal, structured induction programme of at least one week and to identify, assess and record the needs, abilities and aptitudes of every individual and to draw up a plan to address them."

314. This outcome is embraced by the provisions of paragraph 5.19 of the PSO which is as follows:

> "Each young person must have an induction period of at least one week that must include an introduction to the establishment and its routines. The induction programme should ensure that young people are fully and purposefully occupied in their first few days in custody."

315. During his first night interview with the unit officer, the boy was told who his Personal Officer was to be. The boy was given two reception letters and, at about 10.00pm, he used a free two minute telephone call (although it is not clear who he called). The boy signed his Pin-phone, in-cell television and behaviour compacts. He was given an advanced canteen pack containing sweets. Although he smoked, he was not allowed a smoker's pack because of his age. The details of the first night procedures and outcomes were appropriately recorded. The formality and structure attaching to these procedures were, of course, very different from those the boy would have experienced at Red Bank.

316. One of my investigators observed the first night interview process on Buttermere Unit during a normal midweek evening, and was surprised to see an officer conducting an interview with a young person seated at a dining table outside a cell within earshot of other young people. Another officer was conducting an interview in the normal interview room. There was little confidentiality attached to the process.

317. Paragraph 5.12 of Prison Service Order 4950 requires Governors to make arrangements to provide each young person's next of kin or family or other appropriate person with information about visiting, personal property, pastoral care and the sentence planning, review and resettlement arrangements. This should be done within 48 hours of their arrival. This target was not met. The boy's family were frustrated at the lack of official contact with them. They told

my Senior Family Liaison Officer that they received a letter bearing the boy's name and prison number but did not know how to contact him. The boy's aunt therefore rang Lancaster Farms and was given a number to try for a member of the Family Links Team. When she tried this extension, the boy's aunt discovered it was the wrong number. Later, she tried again and was given the correct extension. The boy's aunt told my Senior Family Liaison Officer she felt that information about how to contact the boy was given to her piecemeal. She said the only helpful source of information was the Youth Offending Team. The boy's aunt emphasised that she wanted to help staff at Lancaster Farms to look after the boy. She believed that, if she and her husband had been involved in his management, they could have explained how frightened he was.

318. I consider that the lack of engagement with the boy's family was a significant failure. I cannot overstate the importance I attach to the need for staff to engage with the families of young people in their charge.

319. The first night element of the induction process requires the provision of a great deal of information to young people in the early stages of custody. In addition, forms have to be completed and general guidance provided. Induction staff at Lancaster Farms said that the time available to them was limited and the number of new receptions was often high. It was not uncommon for some young people to arrive at the establishment quite late in the day. Thus, the priority seemed to be to get young people settled into their cell for the first night. Staff told my investigator they believed their priority during the remainder of the induction process was to make sure that they set the appropriate basic standards relating to discipline and control for young people. They explained, for example, that on Buttermere Unit, bed packs had to be made up each morning (that is sheets, blankets and pillows had to be neatly folded and packed together). The unit officer said this was necessary for hygiene reasons. However, the Head of Young People at Lancaster Farms confirmed that this practice was about to cease as he had ordered duvets for every cell in the Juvenile units. I welcome this change.

320. Although induction staff had ample forms and checklists to complete, there was little evidence that the process included arrangements for finding out how well a young person was settling in and helping them adapt to the Lancaster Farms regime. The Head of Young People said he would have expected his staff to have explained the establishment's regime and routine to the boy in order to take away his fear and let him know what he faced during the 44 days he was required to spend in custody. The Head of Young People said the boy ought to have had an understanding of what time he had to get up, when he could go to the gym, what time he would go to school, and when he could contact his family. He also confirmed that in normal circumstances, a young person's induction should take no longer than five working days. According to the provisions of PSO 4950, there is no maximum limit on the time the induction process should last.

321. The Head of Young People also told my investigators he believed that the induction process had been hampered by the influx of a high number of

receptions in the aftermath of the disturbance that had taken place in the young people's units on 29 August 2007, when prison officers took industrial action. During the disturbance, a great deal of damage was done to the buildings and the accommodation had to be temporarily taken out of commission. The Head of Young People explained that the units re-opened about a month later.

322. The Head of Young People told my investigators:

> "We were under immense pressure to get the spaces filled up as quickly as possible, so I spoke to the YJB and agreed that we would only take a certain amount each week. If they were going to send us overcrowding drafts, say ten from Stoke Heath on Monday, and then eight from Castington and our normal courts, it would affect the induction process because we wouldn't be able to put all the lads through in that space of time."

323. The Head of Young People said that in the four week period prior to the boy's arrival, 91 young people were received at Lancaster Farms. He pointed out that he had telephoned the YJB on a number of occasions about how many people the establishment could reasonably take. He said:

> "The YJB have been under pressure and they were contacting me, saying you're going to have to take more. I went on leave and came back at the beginning of November and we'd had an influx of overcrowding drafts, so what that meant was we were getting maybe four or five on a Monday and three or four on a Wednesday. Monday turned up and we had 12 lads arrive and then three days later we had another ten lads arrive. So to try to get all those lads through induction, it just wasn't feasible to get everybody on."

324. The data on the number of receptions at the material time given to my investigators by the YJB did not match those presented by managers at the establishment. The operational pressures on Lancaster Farms and other parts of the Prison Service estate during the second half of 2007 were very substantial. However, from the figures I have been given, the YJB made every effort to minimise the impact on Lancaster Farms by reducing the weekly intake of young people to a realistic level.

325. At consultation stage the family solicitor, commented as follows:

> "It appears to us from the evidence of staff at Lancaster Farms that there was significant pressure on the reception facilities leading up to and at the time of the boy's arrival at Lancaster Farms. It does not appear to have been simply a problem of the volume of new arrivals each week but that they often arrived late in the evening making it difficult for staff to induct them properly…The arrival of large numbers of young people late in the evening seems to have been a significant concern to staff in terms of their ability to follow reception procedures."

I have briefly alluded to this problem at paragraph 326 above. However, although I have some sympathy with the solicitor's views, the investigation found no evidence to show that there were any significant pressures on staff at the time of the boy's reception.

Summary of findings

326. At the time of the investigation, the décor in the reception building was bland and lacking in imagination.

327. The investigation found no evidence that the disturbance in August 2007 had unduly hardened staff attitudes towards young people. The management of challenging behaviour of so many young people in custody demands a healthy and sensible mixture of firmness and fairness by staff. However, the induction process appeared to be mechanistic in its style and was not tailored to the personality or to the history of each individual. The culture shock the boy experienced upon his arrival at Lancaster Farms must have been substantial. Induction staff at Lancaster Farms did not seem to have much understanding of the adjustment the boy would have had to make.

328. During the boy's induction programme, he was interviewed and assessed by a range of specialists. However, he did not complete the induction process within the programme timeframes. Several sessions were missed or not delivered, including "Safeguards" (the protection and maintenance of child welfare) which might have been of particular benefit to him. Although the boy signed to say he had completed his induction on 22 November, this clearly was not the case. The delay in completing the programme meant that the boy had very little to occupy him. There were no obvious incentives for young people to complete induction nor was there any apparent drive by staff for them to do so. In fact, my investigators formed the impression that the greatest driving factor was the pressure to create cell spaces for new receptions. There was some evidence that the boy did not want to move from Buttermere. Thus, he may have believed the delay was to his advantage. Nevertheless, the induction process should be completed to the prescribed timescales and tailored to the needs of the individual. The boy's induction process did not culminate in any plan to address his particular needs.

329. It is crucial that induction and other interviews are conducted in appropriate surroundings, even during busy periods. It is unlikely that a young person will discuss issues openly if he feels other young people may be able to overhear his discussion with an interviewer.

330. The investigation found that official contact with the boy's uncle and aunt was not attempted until 15 November, one week after the boy's arrival. Bearing in mind that we are talking about a vulnerable 15 year old child, I think this was simply unacceptable.

Recommendations

The Governor should take steps to improve the décor and image of the reception building in order to create an atmosphere of warmth and welcome.

The Governor should ensure that all first night interviews take place in conditions of privacy and sensitivity.

The Governor should ensure that official contact with young people's next of kin is made within the 48 hour timescale laid down in PSO 4950 unless there are exceptional reasons for not doing so.

The Governor should require his induction staff to familiarise themselves with the culture and ethos of Secure Children's Homes and Secure Training Centres so as to improve the quality and style of the induction of young people at Lancaster Farms.

The Governor should consider the introduction of a peer support system through which newly arrived young people can be helped to settle during their early days.

The Governor should ensure that all elements of the induction programme for young people are delivered within appropriate timescales.

Education

331. The boy was assessed by the education department on 23 November, and allocated to classes to commence the next working day - Monday 26 November. The prison policy does not allow education assessments to be carried out until the induction programme has been fully completed. The delay in completing the induction programme meant that the boy had little formal contact with education staff for almost two weeks. Had the induction programme run to the timetable and all sessions been delivered, the boy might have had more contact with staff and have been on education classes for over a week before he was moved from Buttermere to Windermere Unit. At the time of the investigation, the education assessment was carried out after the induction had been completed. I believe that the assessment should be completed as an integral part of the induction programme. This would help to reduce the risk of a gap between the completion of induction and the start of education, and the likelihood of young people being left in their cells with little to occupy themselves. It would also mean that skills needs would be more promptly identified.

332. Some of the assessments by staff during the boy's induction period included key information that does not appear to have been acted on. The first night needs assessment manager's check list completed by the SO identified support as being necessary from the safeguards team. I could find no documentary evidence that this support was provided. I am surprised that staff working with the boy on the unit on a daily basis did not appear to have any of the information available to them. The boy's wing history sheet

contains very little information and the only entries of note were made by the Prison Officer. This related to the boy's failure to eat for a short period.

Summary of findings

333. Completion of the education assessment as part of the induction programme would allow an individual's skills needs to be identified more promptly and would enable him to commence classes earlier. This would also help to reduce the risk of young people being left in their cells with little to occupy themselves. It would also mean that skills needs would be more promptly identified.

334. Had information gathered by all staff from a variety of disciplines been entered on the boy's history sheet, a better overall impression of his progress might have been possible.

Recommendations

The Governor should ensure that the education assessment is completed as part of the induction programme.

The Governor should ensure that a brief summary of all interviews and assessments carried out during the induction process is entered on young people's history sheets.

Sentence planning (DTO) meeting

335. Paragraph 5.26 of Prison Service Order 4950 sets out the following guidance for young people's sentence management:

> "Governors and the Youth Offending Team manager must ensure that the sentence plan and individual learning plan is drawn up within at most ten working days of reception and that specific, measurable, achievable, realistic time-bounded and agreed objectives are set for each individual. The plan must also identify the individual needs of the young person in relation to community resettlement and take account of any needs arising from vulnerability. The young person's daily programme must be based upon the plan."

336. The YJB's Strategy for the Secure Estate for Children and Young People, published in 2007, sets out the following guidance on sentence planning:

> "The YJB believes that all institutions within the secure estate for children and young people should be characterised by end-to-end sentence planning arrangements focused from the outset on the resettlement of young people in the community."

337. The YJB underlines the importance of sentence planning in a young person's experience of custody. In the boy's case, the sentence began at Red Bank.

He was released from there but recalled to custody to complete the remainder. The information about his sentence plan and time at Red Bank was not transferred to Lancaster Farms. Neither was the fact that the boy was placed on an ACCT at Thorn Cross communicated to Lancaster Farms. Nor was the comment made at Thorn Cross that the boy should not be placed in any YOI.

338. My investigation team examined YJB National Standards, the NOMS/YJB Service Level Agreement and PSO 4950 to determine who was responsible for the transfer of sentence planning information from one establishment to another. There is no such requirement. I am surprised that, with such an emphasis on "end-to-end sentence planning", a young person who is recalled to a different establishment has to begin his sentence plan as if it had never been started.

339. The boy arrived at Lancaster Farms on 8 November. The DTO planning meeting should therefore have been scheduled to take place by 22 November.

340. The second prison officer regularly worked in the casework office but was on leave when the boy arrived and only came across his file on 15 November. She noticed that his sentence plan had not been completed. She therefore went through the boy's Asset page by page and copied the Asset score into a sentence planning tool. The last section – headed 'Indicators of vulnerability' was scored fairly low, but the second prison officer noted the boy's history of self-harm.

341. The second prison officer then completed a provisional training plan for the boy and went to see him to discuss the targets she had set him. The second prison officer told my investigators the targets were generic to all the young people at Lancaster Farms. She said that, as the boy was not going to be at Lancaster Farms very long, the number of courses available to him was limited. For example, the Juvenile Enhanced Thinking Skills course was a nine week course and he would be unable to complete it. The boy had no further contact with the casework team.

342. The reason for the failure to organise the sentence planning meeting on time is difficult to determine from the evidence. The Head of Young People at Lancaster Farms showed my investigation team the casework diary to illustrate that the planning meeting could have taken place within the required ten days. The Buttermere Unit casework team thought that the YOT worker's pregnancy would prevent her from attending a meeting in a unit at that stage. It was said that she therefore organised a time for the meeting to take place in legal visits and communicated with the casework team that the meeting was due to take place on 4 December. However, during her interview, the YOT worker made it clear that she was prepared to go to Buttermere Unit to attend the meeting. She said that if she had not been able to attend the meeting because of her pregnancy, she would have arranged for a colleague to attend on her part. She said she was advised that 4 December was the earliest available date for the DTO Initial Planning meeting to take place.

343. The DTO Initial Planning meeting was not just an opportunity for the boy to plan how he could address his offending behaviour. It was an opportunity for him to see his family, who would have been brought to the YOI by the YOT worker. In the absence of a Personal Officer, the boy did not seem to establish a relationship with any particular member of prison staff. He did not have an opportunity to confide his feelings to anyone other than his family. Although they wrote to the boy, they could not easily visit him.

344. I am concerned that, on the day the boy was transferred to Windermere Unit, there was no association for the young people in that unit. This was because staff were being trained and because three officers were loaned to Buttermere Unit to guarantee association there. Although I am reluctant to comment upon the availability and deployment of staff in the establishment, and therefore make no formal recommendation on the matter, I wish to emphasise the importance I attach to the avoidance of interruptions to the regime for young people. I believe this to be especially important in light of the disturbance that occurred at Lancaster Farms in August 2007.

Summary of findings

345. No information about the boy's sentence plan and time at Red Bank was transferred to Lancaster Farms. Neither was the fact that he was placed on an ACCT at Thorn Cross. Nor was the comment made at Thorn Cross that the boy should not be placed in any YOI.

346. Neither the YJB National Standards nor the NOMS/YJB Service Level Agreement nor PSO 4950 determine who is responsible for the transfer of sentence planning information from one establishment to another following a recall resulting in a placement to a different establishment.

347. The boy's DTO planning meeting was not scheduled to take place until 4 December, 19 working days after he arrived at Lancaster Farms. It should have taken place on or before 22 November.

348. The fact that the boy did not complete all the modules in his induction programme, lack of contact with his Personal Officer until 25 November, and the failure to organise a sentence planning meeting on time, suggests that Lancaster Farms and St Helens YOT failed in their combined duty to help him make the best use of his short time in custody.

349. Interruptions to the regime for young people should be avoided.

Recommendations

A protocol should be agreed between the YJB and NOMS for the prompt and efficient transfer of young people's custodial records when they move between Secure Children's Homes, Secure Training Centres and NOMS establishments. The protocol should make it clear that YOT workers are responsible for arranging the transfer of such documents.

The Governor should examine the DTO Initial Planning procedures in order to ensure that, other than in exceptional circumstances, the requirement to hold a DTO meeting within ten working days is met.

The Personal Officer scheme

350. The following guidance for the Personal Officer scheme for young people is set out at paragraph 5.36 of Prison Service Order 4950:

> "Every young person must have assigned to them a personal officer/caseworker during the induction programme. They must know who the assigned officer is and the personal officer or caseworker system must be fully and clearly explained to them. Arrangements must be made so that the young person knows who he can contact when the personal officer is absent."

351. My investigation of the previous death of a young person at Lancaster Farms examined, in some detail, the Personal Officer Scheme at Lancaster Farms. I made the following recommendation about the Personal Officer Scheme:

> "The Governor should oversee a further review of the Personal Officer Scheme. This review should clearly state the role of the Personal Officer. It should also identify a system to ensure that YOT supervisors and families of young people are appropriately informed about incidents and events that occur whilst the young person is in custody in line with YJB National Standards and PSO 4950. The new scheme should promote general dialogue between the prison and the family of young person so that their particular circumstances and culture can be better understood."

352. The Prison Service accepted my recommendation. This investigation into the boy's death found that most of the specific objectives included in my recommendation had been achieved. However, I am disappointed by what we have discovered about the Personal Officer scheme as it affected the boy. He was allocated a named Personal Officer on his first night at Lancaster Farms, but the officer was on leave to be followed by a period of night duty. Thus, the officer was not due to return to duty for another 17 days. The investigation found no evidence that an alternative Personal Officer was appointed. This is unacceptable.

353. My investigators were told that the responsibility for supporting young people fell to all officers, not just the Personal Officer. I am sure that is right, but that response misses the point that each young person must have a specific member of staff to whom he can turn. In effect, the boy had no such person to turn to until 25 November, three days before he moved to Windermere Unit and four days before he took his own life. This represents a failure by the establishment to provide for the boy the level of support he clearly should have been given. The officer who conducted the boy's initial reception assessment recorded that he needed to be "monitored over the initial period". If ever there was a role for a Personal Officer, this was it. Although entries were made in the boy's wing history showing that staff did interact with the boy, no Personal Officer was available to him during this crucial time.

354. The boy's designated Personal Officer explained that he did not usually consult a young person's Asset or casework file unless he had a serious concern about him. He said that he would do so if a young person's offending history was such that he might put others at risk. The Personal Officer said that the Casework team used the information in the casework file and officers did not usually access this information. By contrast, the second prison officer said that officers accessed this information all the time in order to inform the care of a young person on the wing. However, she explained that the Personal Officer rarely had an input into the sentence planning procedures. She said:

> " … the Personal Officer should be writing in the wing file and then we have the wing file with us [at the DTO initial planning meeting] and we do actually go through the wing file in the meetings as well, say how he's been behaving, if there's poor behaviour, if there's good behaviour, it's all in there. And that's the input from the Personal Officer."

Summary of findings

355. The fact that the boy had not been eating in the early days at Lancaster Farms, was apparently not associating with other young people, and did not participate in any activities in the gym, should have been observed and noted by his Personal Officer or other unit staff. If all these facts had been clearly documented in his history file, I would have expected a Personal Officer to follow up this unusual behaviour by talking to the boy and trying to establish whether he was worried about being bullied.

356. There should be no confusion about the responsibility of unit staff to study historical information about the young people in their charge, especially that contained in Asset forms.

357. I think it is unreasonable that the boy was allocated a Personal Officer who was on leave followed by night duty when appointed, and who was unable to engage with him until 17 days after the boy's arrival at Lancaster Farms. It is unacceptable that no alternative Personal Officer was appointed.

358. Personal officers should take responsibility for ensuring that periods during which young people are left in their cells with little to do are reduced to an absolute minimum.

359. At consultation stage the family solicitor offered the following views:

> "We submit consideration should be given to making a strong recommendation that the Personal Officer should have early significant contact – preferably face to face meeting but at the very least telephone calls – with the YOT worker and family. This would help the Personal Officer to understand how the young person deals with things, to pick up signs of vulnerability, to assess the suitability of placement, if necessary to make a transfer request and to ensure that appropriate measures are in place to safeguard the child."

Whilst I sympathise with the solicitor's views, it is clear to me that a mechanism is already in place to ensure that contact is made at an early stage of a child's period in custody between the various agencies and individuals responsible for his care. This mechanism is the DTO meeting which, in the boy's case, did not materialise. Had it occurred, the objectives listed by the solicitor would in my view have had a good chance of being met.

Recommendations

The Governor should ensure that staff designated to be a Personal Officer are available when appointed and that arrangements are in place for temporary cover by an alternative Personal Officer at times when the original Officer is absent from duty.

The Governor should ensure that Personal Officers familiarise themselves with the contents of Asset forms relating to each young person in their charge. Particular attention should be paid by Personal Officers to information relating to young people's risks and vulnerabilities.

The Governor should ensure that the Personal Officer Scheme makes clear the responsibility carried by officers designated that role for reducing to an absolute minimum the time young people spend in their cells with little to occupy them.

Bullying and taunting

360. On the day of the boy's death, another young person who knew him and who became upset when he learned of his death, was interviewed by staff. The young person said:

> "The boy was a normal happy person. I spoke to him the other day at the doctor's and he was happy. We discussed when he was getting out and he said he couldn't wait to get out. I asked the boy why he stayed in his cell on Buttermere 2 Unit. He said he was scared of being bullied. I reassured him that no one would bully him and that I would look after him.
>
> "I last spoke to the boy on Tuesday 27 November 2007 on association on Buttermere 2 Unit, and he mentioned that he refused to move units last time and that he didn't want to move this time.
>
> "I never saw the boy speaking to anyone else on Buttermere 2 Unit and he would generally stay in his cell for dining and association. The boy generally came out to use the phone and the showers. The boy felt scared/intimidated but appeared generally happy. We had a discussion about being in Red Bank

and knew it would be a major culture shock moving from Red Bank to Lancaster Farms YOI.

"I wasn't his best mate but I used to talk to him on association. I don't think the boy was being bullied. I don't think the boy spoke to staff about his problems.

(It is not clear what the boy meant if, as reported, he said he had earlier refused to move from the unit. The investigation found no evidence that he had previously been in Lancaster Farms nor that he had refused to move from Buttermere 2 Unit on a previous occasion during his current sentence.)

361. Another young person who arrived at Lancaster Farms the same day as the boy said in his police statement that they had met in reception. He added that, whilst on Buttermere Unit, the boy did not mix with others and stayed in his cell during meal times and association. He saw the boy when he moved to Windermere 2 Unit during the afternoon of 28 November but they did not speak to each other. He recalled gaining an impression that, when he had met the boy on the first day in reception, he was frightened to be there. None of the staff who had contact with the boy in the days before he moved to Windermere Unit said the boy mentioned being scared or afraid. Most said they had no concerns for the boy.

362. Later on 29 November, after the boy had died, numerous security information reports were submitted by a range of staff, each alluding to claims from third parties that the boy had been taunted during the previous night. Some examples of those claims are shown below.

- The boy had received threats from other young people in nearby cells over a sustained period from about 8.00pm.
- One named individual had allegedly told the boy he was going to "bang him out" (in other words fight with him) the next day.
- Unnamed young people had told the boy to "string himself up" and said they were going to "kick the s**t out of him" the next day if he didn't.
- The boy had been made to sing and say a nursery rhyme in order to make him feel "stupid".
- Unnamed young people shouted to the boy words to the effect, "you victim" and "suck your mum".

363. Some of the reports contained third party claims that the boy made threats of his own that he would kill his aggressors when he and they were released.

364. Each of the security information reports was referred to the Lancashire Police who conducted an investigation into the claims. The police interviewed the individuals named in the reports. No criminal charges have been brought.

365. My investigation team visited Windermere 2 Unit by night in order to acquaint themselves with its atmosphere and culture during the dark hours. At about 10.00pm, they witnessed a prolonged period of concerted banging of doors

followed by an exchange of insults of a disgusting nature between a number of young people, most of which seemed to be directed at one particular individual. My investigators described this experience to the Principal Officer and asked her if it was common practice. She replied:

> "I'm led to believe it is. I've never ever done nights in this establishment and when I've come on duty in the morning there's either something in the observation book or indeed told to me at the gate coming in verbally. Yes, it is a regular occurrence.
>
> "I think it's a gang thing. If there's somebody new comes on and they are shouting out of the windows, well it's not always out the windows, it can be door to door in the middle you know. They ask where you come from and I believe it starts then."

366. The fact that young people often shouted at each other through their cell windows had been known to the Governor for some time. On 31 July 2007, he had issued the following notice to staff:

> "Shouting out of windows
>
> "Please note that all staff must respond to instances of witnessing a young person shouting out of a cell window. If the shouting is not abusive, the residential unit must be informed and a P mark issued or the young person placed on a minor report. [The letter 'P' stands for poor conduct – staff are authorised to award P marks to young people for minor infringements of rules. If a young person is given seven P marks, a manager can then impose a minor punishment such as the removal of a young person' s television set from his cell. Again, I have not studied this system in detail, but my comments at para 233 refer.]
>
> "If the shouting is abusive, as a minimum, the young person should be placed on a minor report. If not, the young person must be placed on adjudication, thus reflecting the seriousness of the abuse.
>
> "Please note that numbers have now been placed outside cell windows to help staff identify young people who are shouting out of the windows and, while it is not always possible to identify the young person who is shouting, on the occasions when it is, all staff must action as above to tackle this ongoing unacceptable situation."

367. This following notice was issued the same day to young people:

> "Incidents of racism and homophobia
>
> "Violence in any form is unacceptable. This includes verbal, racist and homophobic abuse shouted out of windows. You are reminded that staff at Lancaster Farms will not tolerate any such behaviour.

"Everyone has a right to be treated with dignity and respect. Whilst here, you will be expected to behave in a manner which promotes tolerance and understanding of any other person's beliefs, skin colour, gender or sexual orientation.

"If you shout racist or homophobic abuse out of windows, write insulting words in letters, write graffiti, threaten anyone using words or actions or indeed assault another person because of their beliefs, skin colour, gender or sexual orientation, you will be dealt with accordingly. This will involve a governor's adjudication, IEP marking which will affect your incentive level, loss of privileges and may involve removal from unit. You could also be placed on Tackling Anti-Social Behaviour procedures.

"Matters of this nature are treated very seriously and any information could be passed to the police and criminal proceedings may follow."

368. In her interview, the seventh prison officer expressed her views about the bullying problem. She said:

> "The gang culture that you've got outside is becoming more prevalent inside prison and because of the overcrowding, the way boys are moved from prison to prison, we find that if we get a large group of say the Liverpool lads and the Manchester lads or the black lads, that comes into play. We have problems because of that. The culture that's outside regards discipline is also followed through in prison. It's very hard to deal with in a group basis. There is bullying that goes on. We are trying our best at the moment to combat the bullying issues but it's always a major problem in prisons. And because of staffing levels it is hard to keep on top of that all the time."

369. When asked whether the practice of shouting out of the windows had been a problem, the seventh prison officer said:

> "That has been a problem. We changed what we call the IEP (Incentives and Earned Privileges) scheme whereby we couldn't actually discipline the boys immediately, so if we found a boy shouting out of the windows we could actually do something at that point - either pop him away in his room for five minutes to cool down or we could remove any privileges he may have had for a short term. It was up to us as individuals on the unit to deal with it."

Once more, while I understand the need to respond quickly to acts of intimidation, my comments at para 233 are relevant.

370. Other staff to whom my investigators spoke reported that the Governor's notices did help to reduce the amount of shouting by day. (And I should make clear that I welcome the Governor taking the action he did.) Indeed, as my investigators walked through the establishment during daylight hours, they noticed very few instances of abusive shouting. However, their experience of the extremely abusive and threatening behaviour in Windermere 2 Unit showed that the situation was very different at night. Indeed, during the night of 28/29 November, the staff on duty in Windermere Unit had to deal with two instances of shouting, as a result of which one young person was placed on a disciplinary report.

371. My investigators were told that Duty Governors were required to visit the establishment by night only once a month. I wonder if this is sufficiently frequent or carries the risk of creating a 'knowledge vacuum' within the managerial team as to the nature and extent of the prison's nocturnal culture. If, as may well have been the case, the boy was subjected to abuse during his first and only night in Windermere 2 Unit, it is very likely that he would have been frightened.

372. During the course of the investigation, the investigation team leader spent a brief period at Hindley (another Young Offender Institution that holds juveniles), primarily to ascertain whether that establishment experienced similar problems where shouting through windows is concerned. He discovered that the windows in place at Hindley are designed differently from those at Lancaster Farms such that they form a sound barrier, limiting the ability of young people to shout to each other. Staff at Hindley told my investigator the establishment did experience episodes of bullying as they too had to contend with a gang culture. They imagined that it was not such a severe problem as at Lancaster Farms, primarily because of the relative inability of young people to shout through the windows.

373. At the time of the investigation, Lancaster Farms was operating an anti-bullying policy known as "TAB" – Tackling Anti-Social Behaviour. A copy of the policy document was presented to my investigation team. Amongst the examples of such behaviour listed in the document are intimidation, insults/name calling and making fun of someone. The document also lists a number of objectives. These include "the creation of a safe environment for all" and the intention "to identify and confront all forms of anti-social behaviour". The following three further objectives are set out in the document:

- The TAB process will be proactive, focussing on targets of anti-social behaviour in addition to those suspected of anti-social behaviour.
- To provide structured support and encouragement for those who are targets of anti-social behaviour.
- To ensure that the whole prison is involved, acting proactively to stamp out anti-social behaviour at HMYOI Lancaster Farms.

374. As has been said above, my investigation team witnessed first hand through a night visit many of the forms of anti-social behaviour listed in the TAB policy document which seemed to be unchallenged. I do not conclude that this is the

complete picture, but the random night visit to the very unit where the boy died suggests to me that such behaviour may be common at night. I am not convinced that the TAB process was as proactive as the authors of the policy document expected it to be. Neither am I convinced that, in relation to the nocturnal culture, the level of structured support for those who were targets of anti-social behaviour was as envisaged by the TAB policy. Although the Governor had clearly taken steps to reduce shouting through windows during daylight hours, there was no evidence that the "whole prison" was involved in efforts "proactively to stamp out anti-social behaviour" at Lancaster Farms by night.

375. At consultation stage the family solicitor expressed his view that it was difficult to see how two staff on duty in a young person's unit could hope to stop bullying/taunting between 120 children. The solicitor said staff felt overburdened and were unable to do what was required of them. I disagree. In my view, it was open to night duty staff to issue at least a verbal warning to any young person who could be heard shouting and threatening others and to follow up the warning with appropriate action the following day.

Summary of findings

376. Although nothing has been proven, I am persuaded from the evidence made available to my investigation team that the boy probably was taunted during the night of 28/29 November and that this may have contributed to his decision to hang himself.

377. Notwithstanding the efforts made to reduce the level of day time shouting, it is alarming that taunting and abuse at night by some young people upon others has continued. If boys as young as the boy are to be sent to any young people's establishment, the nocturnal culture of bullying and intimidation found at Lancaster Farms must be stopped. This will be no easy task, given the problems of controlling 'gang' oriented behaviour and the 'macho' attitudes that accompany it. Night duty staff should be especially vigilant about safeguarding of young people new to the unit. If the aspirations expressed in the TAB document are to be realised, the establishment must make greater effort to confront and eradicate the problem.

Recommendations

Consideration should be given to the installation of new cell windows where necessary in any juvenile unit that experiences the level of shouting discovered at Lancaster Farms in order to reduce the ability of the occupants to taunt each other. The windows at Hindley are reported to be effective in this respect.

The Governor should increase the frequency of night visits by senior managers in order that they can measure any threats to the safety and security of young people and, in support of unit staff, respond to examples of anti-social behaviour.

NOMS should ensure that Governors of establishments holding juveniles give clear guidelines to staff regarding the need for vigilance and effective intervention in dealing with taunting, especially by night.

The discovery of the boy hanging

378. For ease of reference, I repeat here the table shown in para 244.

Time	Event
7.10.40am	A seventh Officer arrives at the boy's cell and looks through observation panel.
7.10.47am	The seventh Officer runs off to raise alarm.
7.11.15am	Landing lights come on.
7.11.20am	The seventh Officer returns to the boy's cell and enters on her own.
7.11.24am	The sixth Prison Officer arrives at cell and enters.
7.11.28am	The assistant Orderly Officer arrives at cell and enters.
7.11.30am	The OSG arrives at cell and enters.
7.11.47am	The OSG leaves cell and disappears from view.
7.11.52am	An eighth Officer arrives.
7.11.58am	The OSG returns to view, radio in hand (presumably having called for assistance). Does not enter cell.
7.12.15am	A ninth Officer arrives at cell and enters followed by an tenth Officer who does not enter cell.
7.12.20am	An eleventh PO on arrives at cell but does not enter.
7.12.33am	The Orderly Officer arrives at cell with the twelth Officer. The Orderly Officer and the tenth prison officer enter cell. The assistant Orderly Officer and the eight prison officer leave cell.
7.12.41am	The Orderly Officer stands outside cell at doorway.
7.12.52am	The ninth and tenth prison officers leave cell.
7.13.18am	A thirteenth prison officer arrives at cell.
7.12.22am	The sixth prison officer leaves cell.
7.13.27am	The seventh prison officer leaves cell.
7.13.32am	Cell door pulled to (not locked) by the thirteen prison officer.
7.14.11am	The tenth prison officer opens door for a few seconds. He and the assistant Orderly Officer look into cell.
7.14.26am	The tenth prison officer enters cell.
7.14.37am	The Orderly Officer enters cell, having appeared to take a piece of equipment (? mouthpiece) from the assistant Orderly Officer.
7.14.47am	The Orderly Officer leaves cell briefly then returns. The assistant Orderly Officer, the sixth and eighth prison officers seen standing outside cell.
7.15.19am	A Healthcare Nurse and a HCA arrive at cell and enter immediately.
7.15.46am	The Healthcare Nurse appears at entrance to cell and asks for something.
7.22.38am	The seventh prison officer returns to view. Looks in cell but does not enter.
7.22.58am	The seventh prison officer leaves area.
7.23.23am	The assistant Orderly Officer opens fire exit next to cell (?to facilitate access by ambulance crew).
7.25.26am	The tenth prison officer leaves cell.
7.25.42am	The tenth prison officer re-enters cell.
7.26.35am	The tenth prison officer leaves cell again.
7.26.59am	The tenth prison officer re-enters cell.
7.27.25am	The tenth prison officer leaves cell.
7.27.58am	Paramedics arrive and enter cell.

379. Although the times shown are different from those recorded in the control room log which are reportedly four minutes ahead, they represent the delays described below with pinpoint accuracy.

Delay in applying emergency first aid

380. After discovering the boy during her morning count, the seventh prison officer promptly requested assistance and went into the boy's cell. The ligature was quickly cut and removed from the boy's neck, and he was placed in the recovery position. However, at this point none of the staff present began CPR. The ninth prison officer thought this might have been because they were "shell shocked". At interview the sixth prison officer, assistant Orderly Officer and the seventh prison officer all said that they thought the boy was dead. Both the assistant Orderly Officer and the seventh prison officer said that they considered administering CPR but, as they were not first aid trained, they thought they would do more harm than good. The seventh prison officer pointed out that she positioned the boy on the floor and placed her hand on his chest because she knew that CPR would have to take place. When asked if she did administer CPR she said she did not, "because by that point, the tenth prison officer was in the cell, there were other people by the door and in the background I could hear that somebody was calling for medical assistance." She added that she was concerned that she might hurt or injure the boy.

381. The table above shows that there was a delay of over three minutes between the time the seventh prison officer first entered the boy's cell (7:11:20am) and the time the tenth prison officer re-entered the cell after realising that staff had a duty to attempt resuscitation. When the boy was checked for signs of life, he was not breathing and had no pulse. However, his body was still warm.

382. I accept that the staff concerned were likely to have been in shock and may not have been properly trained in the administration of CPR. However, I consider they were wrong in assuming that the boy was already dead and, even without training, they should have made attempts to revive the boy without delay.

383. The following guidance to staff who discover a life threatening situation is set out at Annex 13A of Prison Service Order 2700 issued in October 2007:

> "If the prisoner is not breathing and/or no pulse is present, clear the airway and attempt resuscitation using a face mask with a non-return valve, unless rigor mortis of the limbs has clearly set in."

384. Local contingency plans to be followed by staff who discover self-harm by strangulation also give a clear instruction that resuscitation should be attempted in order to save life.

385. There is no evidence that rigor mortis had set in when the boy was discovered hanging. I believe, therefore, that there is no question but that attempts to resuscitate the boy should have been made straightaway. This is notwithstanding the seventh prison officer's concern that she was not trained in emergency first aid, and her fear that she might have done more harm than good by applying CPR. The seventh prison officer's concerns may well have been shared by the other staff who were present, and I do not underestimate the sense of shock they would all have felt. However, in many of my investigations I commend prison staff for the speed with which they commence CPR in situations which are no less shocking. I make no formal recommendation about what happened on this occasion, but leave it to the Governor at Lancaster Farms to decide whether, at this late stage, those who failed to attempt to resuscitate the boy as soon as he was found should be subject to a disciplinary investigation. At the inquest into the boy's death, the Coroner may wish to seek answers from witnesses better qualified than I to judge whether the boy's life could have been saved. (At consultation stage, NOMS confirmed that a formal investigation would be conducted and that it would be a led by a manager external to Lancaster Farms.)

Delay in calling an ambulance

386. A protocol was established in August 2004 between Lancaster Farms and the Lancashire Ambulance Service NHS Trust. The protocol sets out that:

> "The critical factor in survival rates is the time it takes a trained paramedic to reach the patient … it is not necessary for the prison healthcare team to be present at the scene before emergency services are called."

387. It appears that an ambulance was not called until the thirteenth prison officer requested one from the Windermere 2 office, after the boy's cell door was shut. According to the CCTV footage, the call for an ambulance would therefore have been made shortly after 7.14am, three minutes after the seventh prison officer first entered the boy's cell. This time accords with that shown on the Lancashire Ambulance Service Patient Record, which shows that they received a call at 7:14:36am. In my view, an ambulance should have been called as soon as the seventh prison officer entered the boy's cell and found him hanging.

388. The local contingency plan for managing life threatening situations does not contain any instructions to staff about calling an ambulance. This is unsatisfactory.

Confusion over who was in charge when the boy was discovered

389. A SO was the orderly officer during the night of 28/29 November and was in charge of the establishment. In this role he was given the radio call-sign Oscar 1 (nights). The tenth prison officer was the permanent orderly officer during the daytime. His call-sign was Oscar 1 (days). The tenth prison

officer's shift officially started at 7.30am, although he told my investigator he usually comes on duty earlier so that he can avoid traffic congestion.

390. An additional Principal Officer started duty at 6.30am to supervise court discharges, taking the role of Oscar 1 (days) until handing over to the tenth prison officer at about 7.30am. On 29 November, the thirteenth prison officer was Oscar 1 (days) from 6.30am.

391. At interview, the thirteen prison officer said he did not realise the tenth prison officer was in the prison on 29 November until he saw him at the boy's cell. However, the thirteenth prison officer was clear that he was the orderly officer at that time and that he was in possession of the correct radio.

392. The tenth prison officer confirmed he was not the orderly officer at that time. However, he said nobody was in charge at the scene "until there was no more we could do for the boy," and he then assumed control. When the thirteen prison officer arrived at the cell, they had a discussion, and divided the responsibilities. In any emergency, normal procedures tend to fray. However, there should be no doubt about who is in charge in such circumstances. The determination of who is in charge should not pivot around the limits of what can be done to save a young person's life.

393. The Orderly Officer said that he was still identified on the radio net as Oscar 1 (nights) when the thirteen prison officer arrived to manage the court discharges. He told my investigator, "At that point I don't know whether he is in charge of the prison or I'm in charge of the prison."

Roll checks

394. Section 2.76 of the security strategy in place at Lancaster Farms at the time of the investigation instructed that night staff should carry out a roll check between 10.30pm and midnight and a further check between 5.45am and 6.15am.

395. The investigation found that, contrary to the security strategy, no roll check was conducted between 10.30pm and midnight on 28/29 November.

Pegging

396. The security strategy in place at Lancaster Farms at the time of the investigation required night staff "to carry out pegging as directed by the night orderly officer". But there was no guidance as to how regular or often the task was to be completed. The investigation found that during the night of 28/29 November, Windermere 2 Unit was pegged at 10.00pm, 4.30am and 5.30am. At interview, the OSG said that pegging was to be carried out twice in each hour at random intervals. However, this does not accord with what actually occurred.

Summary of findings

397. During the night of 28/29 November, roll checks were not carried out in accordance with local instructions.

398. The instructions contained in the local security strategy at the time of the investigation for pegging by night staff did not clarify how frequently the task should be completed.

399. Of those staff present at the boy's cell, only the Orderly Officer and the ninth prison officer had been trained in emergency first aid and had up to date qualifications. The tenth prison officer said he used to be a first aider but had not had any refresher training for a number of years.

400. As I have pointed out in many of my reports following deaths in custody, speedy intervention by properly trained and qualified staff can make the difference between life and death. In the boy's case, I am unable to say whether earlier administration of CPR would have saved his life. However, I believe that the staff were wrong to assume that he was already dead. I also believe it is essential that officers have the knowledge and confidence to carry out CPR effectively. Such skills can only be maintained by regular training.

401. The following comments are made on this matter at paragraph 7.12 of the clinical review:

> "The CCTV footage shows there was a delay of between 3 and 4 minutes before CPR was commenced. The professional advice available to the panel stated clearly that in such circumstances CPR should be commenced immediately and that is consistent with prison policy. On the basis of the evidence available, the panel were unable to conclude whether immediate resuscitation may have produced a different outcome."

In addition to those comments, I make the stronger point that PSO 2700 is perfectly clear on this issue: it says that, when dealing with a life-threatening situation, staff should always attempt resuscitation unless rigor mortis has set in.

402. The three minute delay in calling an ambulance was also unacceptable. An ambulance should have been called as soon as staff entered the boy's cell and found him hanging. (I note that at paragraph 8.10 of the clinical review, the panel concur.) The local contingency plans for managing a life threatening situation contain no instructions to staff about calling an ambulance.

403. When the boy was discovered hanging, there were two different orderly officers on duty with the same call-sign. There should be no doubt about who is in charge. Nor should the determination of who is in charge pivot around the limits of what can be done to save a young person's life. Although this did not adversely affect the manner in which the emergency was managed, it did cause confusion between the individuals concerned. This situation should be avoided at all costs in the future.

Recommendations

The Governor should remind night duty staff that roll checks must be carried out at the times set out in his local security strategy.

The Governor should review his local security strategy to ensure that it clearly instructs staff about the frequency of pegging.

The Governor should ensure that his contingency plans for the management of a life threatening emergency reinforce the point, clearly set out in PSO 2700, that an attempt at resuscitation should always be made unless rigor mortis has set in.

The Governor should ensure that his contingency plans contain clear guidance about the importance of calling for an ambulance promptly and about the method of doing so.

The Governor should ensure that appropriate staff who are in contact with prisoners receive proper initial and refresher training in the administration of emergency first aid.

The Governor should issue a notice clarifying to staff who takes the role of Orderly Officer between 6.30am and 7.30am.

The communication of the boy's death to his aunt and uncle and the contact with them thereafter.

404. I applaud the Governor's decision to take personal charge of the responsibility for informing the boy's family, and for the manner in which he demonstrated leadership by being visible to his staff after the boy had died. Although four hours elapsed before the news of the boy's death was communicated to the family, I believe that the Governor's decision not to leave the establishment for the family home until he had gathered the necessary information about the boy, and until the chaplain and the representative from the St Helens YOT could accompany him, was justified in the circumstances. The boy's uncle and aunt have expressed their concern that they were initially told that the boy was in intensive care and was okay. My investigator checked this point with the Governor. He categorically denied saying anything of the sort himself, and was of the view that it was highly unlikely that any of his staff would have said so.

405. However, the boy's uncle and aunt have said that their distress at viewing the boy's body was exacerbated by the fact that no one from the prison was there to support them after allegedly promising to do so. Both the Governor and the establishment's Family Liaison Officer expressed the view that there had been a misunderstanding within the Coroner's office about who was to attend. Nevertheless, the prison FLO has quite properly expressed his regret at any distress this confusion may have caused.

406. Notwithstanding the above points, I am pleased to be able to record that when the boy's family met my Senior Family Liaison Officer and investigation team leader, they confirmed that they thought the staff at Lancaster Farms had done all they could in the aftermath of the boy's death, describing them as "fantastic and 100 per cent helpful".

407. Sadly, the boy's funeral could not take place until 16 June 2008, some seven months after he died. Throughout the intervening period, contact was maintained between Lancaster Farms and the boy's family. The Governor offered to meet the full costs of the boy's funeral and sent representatives to the service.

Summary of findings

408. Although it was four hours before the news of the boy's death was shared with his family, I believe that the Governor's decision not to leave the establishment for the family home until he had gathered the necessary information about the boy, and until the chaplain and the representative from the St Helens YOT could accompany him, was justified in the circumstances.

409. When the boy's family met my Senior Family Liaison Officer and investigation team leader, they said they thought staff at Lancaster Farms had done all they could in the aftermath of the boy's death.

FAMILY CONCERNS NOT COVERED IN MAIN BODY OF REPORT

Why was the first visiting order sent to the family left blank?

410. My investigators were unfortunately unable to clarify what led to this reported error. Included amongst the documents presented to my investigation was a copy of the boy's record of letters and visits. They show that the boy applied for only one visit while he was at Lancaster Farms. The visiting order was sent to his aunt and uncle on 23 November so that they could visit him at any time in the following 28 days. The records show that no visit took place thereafter.

Why was the family told that the boy had self-harmed and was "okay in intensive care"?

411. My investigators failed to ascertain who may have imparted this information. In a telephone conversation with the then Governor, he said he could clearly recall what he said to the family and was adamant that he did not say that the boy was "okay in intensive care" or any other words that could have been similarly construed.

Was the boy strip searched everywhere he went at Lancaster Farms?

412. At the time of the investigation, young people were routinely strip searched as a normal feature of the initial reception procedures. They were only strip searched on other occasions if they were suspected of presenting a risk to security. In such circumstances, they could only be strip searched on the express and written authority of the Orderly Officer or Duty Governor of the day. Details of the search had to be recorded in the young person's record. No such detail was found in the boy's history sheet.

Was the boy subjected to cold showers?

413. As far as being subjected to cold showers is concerned, my lead investigator was told that young people at Lancaster Farms normally take their showers in the dedicated shower room in each unit. They do so behind a privacy screen and are monitored from a distance by an officer. If the showers were cold at any time the boy was at Lancaster Farms, it is likely that the supervising officer would have known or that the boy would have made a complaint. The boy's files contain no record of any complaints by him on any matter. The word, "subjected" carries with it the notion that the boy was forced to have cold showers. I can report that the investigation found no evidence of this. Whilst it is, of course, possible that such behaviour can go undetected, I have no reason to believe that anyone in authority at Lancaster Farms would have treated the boy in this way.

Did an officer sit with the boy during phone calls?

414. With regard to the suggestion that an officer sat in with the boy when he made a telephone call, I can report that the investigation found no evidence of this.

When making personal telephone calls, young people at Lancaster Farms are expected to use the telephones provided for them in the units. When the boy was at Lancaster Farms there was one such telephone on each of the landings in Buttermere and Windermere Units. Although the telephone is inside a booth, it is highly unlikely that a young person's conversation will be overheard given the normal noise level in the unit. Prison officers do not station themselves near the telephones. However, if the boy was at any stage allowed to use an official telephone, then a member of staff would have been with him when he made the call.

The boy claimed that an unnamed young person swore at him and threatened him. The boy also claimed that prison officers threatened him. Are these claims true?

415. In the absence of any further details it has not been possible to investigate these reports

Was the boy frightened that he would be subject to a gate arrest on the day of his release?

416. My investigators were told by the police after the boy's death that he knew he faced a further charge and that he could have been arrested upon or after his release. However, there was no evidence that the boy told staff that he was afraid.

SUMMARY OF FINDINGS AND CONCLUSIONS

417. The investigation has highlighted some critical systemic failures relating to the manner in which the boy's placement at Lancaster Farms was decided upon, and to aspects of his management in the establishment before he died. Most shocking of all my findings is that relating to the response to the discovery of the boy hanging, when there was a significant delay in administering emergency first aid by some staff and a delay in calling an ambulance.

418. The decision to place the boy at Lancaster Farms was not informed by any assessment of his ability to cope with the establishment's subculture which, especially by night, was characterised by cruel taunting of some young people by their peers.

419. Detailed information about the boy's experiences at Red Bank was not passed to Lancaster Farms in time to be taken into account by reception and induction staff. During the reception process, little attention was paid to the information that was available about the boy, principally in his Asset form. His risk of self-harm or suicide took no account of any such historical evidence.

420. The induction process seemed mechanistic and more suited to the needs of the establishment than to those of individual young people. The boy's first night interview was conducted in an open area within earshot of other young people, thereby putting at risk the confidentiality that such an important interview should attract. This is not the approach to the care of a young person that I would expect.

421. The officer appointed as the boy's Personal Officer was on leave followed by night duty when appointed. Nobody was asked to cover the officer's absence. Thus, for most of his time at Lancaster Farms, the boy had no identifiable reference point amongst the staff to whom he could turn for help and with whom he could build a relationship. I criticised the Personal Officer scheme at Lancaster Farms in the context of a previous self-inflicted death of a young person there. I should not have found it necessary to do so again. During his time in the induction unit, the boy hardly left his cell. Little effort was made to discover why. Had a Personal Officer been available to him, the boy's fears of being bullied might have become known and managed.

422. Despite the fact that the boy did not complete all the induction modules, he was deemed ready to transfer out of the induction unit on 28 November, a day when all young people had to be locked in their cells to enable staff to attend a training programme. The investigation found that one particular officer went out of his way to help the boy settle into his new unit. However, the boy was unable to mix with anyone else because of the lockdown during the day and because of the absence of any association during the evening.

423. The sentence planning, or DTO, meeting that should have taken place within ten working days of his arrival at Lancaster Farms, was not scheduled until 4 December 2007. It never happened because the boy had died six days

earlier. The opportunity was lost to plan how to use his time in the establishment and to prepare for his release.

424. Some of the staff who found the boy hanging early in the morning of 29 November were untrained in the administration of emergency first aid. There was delay of over three minutes before emergency first aid was applied. There was a similar delay in calling for an ambulance. I am shocked by these findings. I leave it to the Governor to decide whether, at this late stage, the staff involved should be subject to a disciplinary investigation.

425. I have commended the Governor for taking personal charge of the responsibility for breaking the news of the boy's death to the family, and for the manner in which he demonstrated leadership by being visible to his staff after the boy had died. Although four hours elapsed before the family were told, I believe that the Governor's decision not to leave the establishment immediately for the family home was justified in the particular circumstances.

426. I have reported that the boy's family have told my Senior Family Liaison Officer and investigation team leader that staff at Lancaster Farms did all they could in the aftermath of the boy's death.

427. The investigation found direct evidence of taunting by some young people through cell windows at night. I believe this may have contributed to the boy's death. This is a culture that must be rigorously challenged, not only at Lancaster Farms but at any other NOMS establishment that holds young people.

428. When considered individually, each of the above findings and conclusions is significant. When considered together, they demonstrate a lamentable standard of care for a vulnerable 15 year old boy in the charge of the state.

429. In light of the seriousness of the matters raised in this investigation, I believe that a copy of this report should be considered at the highest level. I am recommending therefore that copies be sent to the Secretary of State for Justice and the chair of the Justice Select Committee.

Recommendation

Copies of this report should be sent to the Secretary of State for Justice and the chair of the Justice Select Committee for their consideration.

RECOMMENDATIONS

Recommendations made jointly to the Youth Justice Board and NOMS

1. A protocol should be agreed for the prompt and efficient transfer of young people's custodial records when they move between Secure Children's Homes, Secure Training Centres and Prison Service establishments. The protocol should make it clear that YOT workers are responsible for arranging the transfer of such documents.

2. Consideration should be given to the implementation of a system for the effective transfer of information when a young person serves his sentence in more than one location, whether that be a Secure Children's Home, a Secure Training Centre or a YOI.

At consultation stage, in response to these two recommendations, the YJB commented as follows:

> "The YJB has developed an electronic sentence management system (e.Asset) for all children and young people within the secure estate that enables all sentence management information to be shared electronically by secure estate staff between secure establishments. The responsibility for this process rests with the secure estate staff and not with YOT worker, as secure estate staff have responsibility for managing eAsset and also because it is the secure estate, with the authorisation of the YJB Placement and Casework Service, that undertake transfers within the secure estate. All transfers are managed through the transfer protocol which has been developed by the YJB Placement and Casework Service. Service Level Agreements and contracts between the YJB and secure estate providers also outline the process for transferring children and young people between establishments. To further reinforce this process, revised National Standards (anticipated to come into effect on 30 November 2009) now include a requirement for the secure estate to use eAsset to send sentence management information from the transferring establishment to the receiving establishment in advance of the transfer, where possible, or at the latest within one hour of the transfer taking place. This covers young people on remand, on DTOs and on long term sentences."

3. Copies of this report should be sent to the Secretary of State for Justice and the chair of the Justice Select Committee for their consideration.

Recommendations to the Youth Justice Board

1. Urgent steps should be taken to ensure that placement decisions are made in accordance with the criteria explained on the YJB website. Placement recommendations and decisions must be informed by an assessment of young people's ability to cope with the physical and cultural environment of the establishments under consideration. Placement recommendations and decisions should also take account of all available information about the young people under consideration including home circumstances, Asset details, vulnerabilities and risks, as well as any relevant suggestions made by

staff in the establishments in which young people may already have been held.

At consultation stage, the YJB provided the following response:

> "The YJB is confident that placement decisions are made in accordance with the stated criteria. Factors in placement choice also include competing demand for non YOI places. The YJB is satisfied that during the placement of the boy at Lancaster Farms, sufficient attention was given to this decision in the light of the boy's individual needs and risks to himself and others. YOI's have been established to provide a safe and secure regime for young people of the boy's age and maturity. There are robust procedures in place to allow either a YOT or staff at a YOI to discuss the placement following admission if there are concerns as to the young person's safety. This placement was as a result of a breach of the community part of the DTO and as such the YOT were fully aware of he circumstances surrounding this and clearly advised the court that a return to custody was the most suitable option in relation to the breach. The fact that the boy had served previously in a Secure Children's Home (SCH) does not mean that a Secure Training Centre (STC) place was the most suitable as it would have meant a placement further from home, something the YOT felt would not be helpful.
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> "The YJB had a conversation with the YOT on the day of sentence to discuss whether a place at an STC or SCH would be preferable. The YOT re-stated their view that Lancaster Farms would be the most suitable placement for the boy."

2. Consideration should be given to the remodelling of the Asset form for easier use in a custodial environment so that critical information such as self-harm risk is clearly visible.

At consultation stage, in response to this recommendation, the YJB commented as follows:

> "The YJB recognises that assessment processes need to assist practitioners in identifying young people who may be at risk of committing self-harm or of attempting suicide. The YJB is currently reviewing the assessment tools used by youth justice practitioners and developing an assessment strategy which will set out plans for future improvements in assessment processes and practice. One of the aims of the strategy will be to ensure that there is a closer integration of the assessment and planning processes used in the community with those used in the secure estate. There will also be a number of changes to the design and content of assessment tools like Asset and this will include ensuring that significant risks and concerns, such as those relating to self-harm, are recorded in a clear and more visible way."

Recommendations to the North Lancashire Primary Care Trust

1. Those staff responsible for completing healthcare screens should pay full attention to the information contained in Asset forms, especially where the assessment of self-harm or suicide risk is concerned.

2. Urine samples should be taken during first reception health screens in order to inform decisions about young people's needs for detoxification or other appropriate substance misuse interventions.

3. Healthcare staff conducting first reception health screens should, where necessary, make an immediate referral of young people with a recent history of substance misuse to a doctor and to the Young People's Substance Misuse Service so that decisions about detoxification and other interventions can be made without delay.

Recommendations to NOMS

1. Consideration should be given to the installation of new cell windows in any juvenile unit that experiences the level of shouting discovered at Lancaster Farms in order to reduce the ability of the occupants to taunt each other. The windows at HMYOI Hindley are reported to be effective in this respect.

2. Governors of establishments holding juveniles should give clear guidelines to staff with regard to the need for vigilance and effective intervention in dealing with taunting, especially by night.

Recommendations to the Governor of Lancaster Farms

1. The Governor should take urgent steps to ensure that, in keeping with paragraph 5.4 of PSO 4950, systems are in place to record accurate details of which forms have been received in reception and that missing documents are requested through the YJB.

2. The Governor should satisfy himself that there is no impediment to opening ACCT forms, such as the perception by staff that forms will be closed at such a speed as to render their use pointless. ACCT forms should remain open until staff are satisfied that all issues have been identified and effectively managed through appropriate case reviews. Relevant training should be offered to staff in this regard.

3. The Governor, in conjunction with the PCT, should ensure that those staff who carry out cell sharing risk assessments take into account relevant historical information about a young person, such as that which may be contained in Asset forms.

4. The Governor should take steps to improve the décor and image of the reception building in order to create an atmosphere of warmth and welcome.

5. The Governor should ensure that all first night interviews take place in conditions of privacy and sensitivity.

6. The Governor should ensure that official contact with young people's next of kin is made within the 48 hour timescale laid down in PSO 4950 unless there are exceptional reasons for not doing so.

7. The Governor should require his induction staff to familiarise themselves with the culture and ethos of Secure Children's Homes and Secure Training Centres so as to improve the quality and style of the induction of young people at Lancaster Farms.

8. The Governor should consider the introduction of a peer support system through which newly arrived young people can be helped to settle during their early days.

9. The Governor should ensure that all elements of the induction programme for young people are delivered within appropriate timescales.

10. The Governor should ensure that the education assessment is completed as part of the induction programme.

11. The Governor should ensure that a brief summary of all interviews and assessments carried out during the induction process is entered on young people's history sheets.

12. The Governor should examine the DTO Initial Planning procedures in order to ensure that, other than in exceptional circumstances, the requirement to hold a DTO meeting within ten days is met.

13. The Governor should ensure that staff designated to be a Personal Officer are available when appointed and that arrangements are in place for temporary cover by an alternative Personal Officer at times when the original Officer is absent from duty.

14. The Governor should ensure that Personal Officers familiarise themselves with the contents of Asset forms relating to each young person in their charge. Particular attention should be paid by Personal Officers to information relating to young people's risks and vulnerabilities.

15. The Governor should ensure that the Personal Officer Scheme makes clear the responsibility carried by officers designated that role for reducing to an absolute minimum the amount of time young people spend in their cells with little to occupy them.

16. The Governor should increase the frequency of night visits by senior managers in order that they can measure any threats to the safety and security of young people and, in support of unit staff, respond to examples of anti-social behaviour..

17. The Governor should remind night duty staff that roll checks must be carried out at the times set out in his local security strategy.

18. The Governor should review his local security strategy to ensure that it clearly instructs staff about the frequency of pegging.

19. The Governor should ensure that his contingency plans for the management of a life threatening emergency reinforce the point, clearly set out in PSO 2700, that an attempt at resuscitation should always be made unless rigor mortis has set in.

20. The Governor should ensure that his contingency plans contain clear guidance about the importance of calling for an ambulance promptly and about the method of doing so.

21. The Governor should ensure that appropriate members of staff who are in contact with prisoners receive proper initial and refresher training in the administration of emergency first aid.

22. The Governor should issue a notice clarifying to staff who should take the role of Orderly Officer between 6.30am and 7.30am.