PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of young person in April 2011, while in the custody of HMYOI Wetherby

Report by the Prisons and Probation Ombudsman for England and Wales

This is the report of an investigation into the circumstances surrounding the death of a young person at HMYOI Wetherby in April 2011, when he was found hanging in his cell. He was 17 years old. I would like to offer my sincere sympathy to his family for their loss.

The local Primary Care Trust (PCT) appointed a clinical reviewer to review the clinical care that the young person received in custody. The Governor of Wetherby and her staff, Leeds Youth Offending Service and Leeds Children's Services co-operated fully with the investigation. This was a long and involved investigation. Because of its scale it has taken several months to complete the report and I apologise for the delay in issuing it.

The young person had been in care from a very young age. A settled foster placement broke down as his behaviour became more disruptive in his teenage years. He received several community based punishments, but this was his first time in custody. A note from the police about an incident of self-harm was insufficiently followed up by staff at court and in Wetherby's reception. The first night vulnerability assessment was confused and there was scope for a fuller mental health assessment.

Not long after his arrival at Wetherby, the young person became very angry and threatened staff. A poorly investigated adjudication resulted in a severe punishment. Despite his distressed state, he did not receive appropriate support from staff. On the night of his death, two young people shouted threats at him out of their windows. It does not appear that there was sufficient challenge of this bullying behaviour.

The young person appears to have died some time during the night and there was an unacceptable delay in staff finding him the next morning. Two roll counts and checks on young people due at 6.30am and around 7.30am were not carried out, resulting in disciplinary investigation against the staff involved.

While it would have been very difficult for staff at Wetherby to have identified any intention on the young person's part to hang himself that night, I am concerned that weaknesses in the personal officer scheme limited the scope for him to have a member of staff whom he could trust and with whom he could share some of his concerns. More generally, a number of our criticisms suggest a lack of a child-centred approach to aspects of his management from which Wetherby needs to learn.

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

Nigel Newcomen
Prisons and Probation Ombudsman **September 2013**

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SUMMARY

1. The young person was first convicted of an offence when he was 13 years old. Over the next four years, he received several community sentences and was supervised by Leeds Youth Offending Service. From the age of 18 months, he was in the care of the local authority. After the breakdown of his second long-term foster placement, he lived in bed and breakfast accommodation, and he was arrested for robbery in March 2011 when he was 17.

2. While the young person was in police custody, he deliberately banged his head against his cell wall. On his records, an officer noted "previous self harm by banging head on cell wall". It does not appear that anyone spoke to him about this act of self-harm while he was at court or when he arrived at Wetherby. Throughout his time in custody, he was not assessed as at risk of suicide or self-harm.

3. Despite not having all of the required initial information for his placement, the Youth Justice Board allocated the young person to HMYOI Wetherby. Throughout reception and first night assessments, he was not assessed as at risk to himself, although he was considered a high risk to other young people. He was referred for a mental health assessment by the first night assessor, which was completed the next day. This concluded that he had no mental health needs.

4. After four days in the induction unit the young person , who had been unable to contact his mother on Mothers' Day, was involved in an altercation with a female officer that quickly escalated. He smashed up his cell and urinated on the floor. As a result of this incident, he was punished by having his television taken off him and for seven days he was not allowed out of his cell in the evenings or at other times when young people usually spend time together. He was also moved off the induction unit to another residential unit. Other than the disciplinary hearing there was no investigation of the incident between him and the officer to examine the underlying reasons for his behaviour. No consideration was given to referring him to the mental health team again.

5. The young person continued with his induction for the following two weeks. On the evening before he died, he was overheard shouting through the window arguing with two other young people on his wing. At about midnight, he asked his friend in the cell next door to press his cell bell because he was going to hang himself. The friend did not think he was serious and he did not ring the cell bell because he did not want to get himself in trouble.

6. YOI staff should carry out a roll check at 6.30am and another roll check at 7.30am. On the morning the young person was found, they reported to the central office that they had carried out the checks and that all young people were in their cells. In fact, neither check was carried out. At 7.55am he was found hanging in his cell.

7. Officers and nurses tried to resuscitate the young person , despite clear signs of rigor mortis. He was taken to hospital where he was pronounced dead at 8.55am.

8. Whether the self-harm recorded on the young person's records by police was current or serious was not explored by staff, either at court or in reception at Wetherby. He was placed at Wetherby, despite key information being missing, although we do not think it was an inappropriate placement.

9. The first night vulnerability assessor recorded conflicting accounts of the young person during her first night assessment. His mental health assessment relied on him reporting his own mental health needs and took no account of the information on his records. We are critical of staff's response to the events on Mothers' Day and the severe punishment he received at such an early stage of his first time in custody. Although Wetherby had a good policy to tackle shouting out of windows, the investigators found very little evidence that staff adequately challenged young people about it.

10. The young person was not found until his cell was unlocked at 7.55am. We support the Governor's decision to conduct an internal investigation into this matter and take disciplinary action. When he was found he appeared to have been dead for some time yet officers and nurses attempted resuscitation contrary to national Prison Service guidelines. We are not critical about this but it is unnecessarily distressing for those involved.

INVESTIGATION PROCESS

11. Two investigators visited HMYOI Wetherby on 20 April 2011 and met the Deputy Governor, a member of the Independent Monitoring Board and members from the Prison Officers' Association. They went to Drake unit to see the young person's cell and observed young people in reception. Notices were posted to staff and young people in Wetherby about the investigation. No one responded to these notices. The investigators returned to Wetherby between 7 and 17 June and interviewed members of staff and young people. The staff interviews were recorded and the transcripts are attached to this report. Notes of the interviews with young people are also attached to the investigation report.

12. The local Primary Care Trust (PCT) appointed a clinical reviewer to review the young person's clinical care. The review was received at the end of April 2012.

13. The investigator wrote to Her Majesty's Coroner to inform him of the investigation. A copy of the investigation report will be sent to the Coroner to assist his enquiries.

14. One of the Ombudsman's family liaison officers and the investigator met the young person's mother on 9 June 2011, and she raised the following concerns:

- She was told of his death by her brother. Prison representatives did not arrive at her house until 1.25pm on 18 April, nearly five hours after he was pronounced dead.
- She was told that rigor mortis had set in when he was found. However, she was also told that resuscitation was attempted.
- She wanted clarification on how he was found, in particular whether night observation checks were completed.
- She had been told that two young persons at Wetherby had been shouting and threatening him the previous evening. She was concerned about the arrangements for monitoring shouting between young people, especially at night.
- She understood that he had been assessed as high risk after banging his head in police custody, and asked whether he was monitored accordingly.
- She was worried that his small size made him a potential victim in custody and whether his fear caused him to commit suicide.

15. The young person 's family received a copy of the draft report as part of the consultation period. Written representations were provided on behalf of the family. Having had the opportunity to consider the findings of the investigation, the family commented on a number of points. The investigator reviewed the findings of the investigation and has, where appropriate, amended the report to reflect their comments. Some of the issues raised were more appropriately addressed outside of this report in separate correspondence to his family and legal representative.

THE MANAGEMENT OF CHILDREN IN CUSTODY

Youth Justice Board

16. The Youth Justice Board (YJB) is a non-departmental public body set up by the Crime and Disorder Act (section 41) in 1997. 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.

17. A Service Level Agreement was in place between the Youth Justice Board and the Prison Service covering the period 2008 – 2011.

18. 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

Youth Offending Teams

19. The Crime and Disorder Act 1998 (section 39) requires local authorities with responsibility 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 YOT is to work with young offenders and those at risk of offending in the community in order to help turn them away from crime. YOTs co-ordinate the delivery of a range of youth justice services, including bail support and community supervision.

Local Safeguarding Children Boards

20. 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

21. Section 73 of the Crime and Disorder Act 1998 (now section 100 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.

22. 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 secure estate for children and young people

23. 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 (SCHs)

24. Secure Children's Homes accommodate 10 to 17 year olds and are run mostly by Local Authority Social Services Departments or the voluntary sector. They are overseen by the Department of Health and the Department for Education. Not all young people in an SCH will be in custody, some are placed there by the local authority for welfare reasons.

25. Secure Children's Homes provide young people with support tailored to individual need. 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 17 such facilities in England.

Secure Training Centres (STCs)

26. Secure Training Centres (STCs) are purpose built centres for young offenders between 12 and 17 years old. They are run by private operators under contracts which set out detailed operational requirements. There are four STCs in England. They are:

- Oakhill in Buckinghamshire
- Hassockfield in County Durham
- Rainsbrook in Northamptonshire
- Medway in Kent

27. Each centre can accommodate 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.

Young Offender Institutions (YOIs)

28. Young Offender Institutions (YOIs) are run by the National Offender Management Service (NOMS). Wetherby YOI can accommodate those aged up to 18 years of age. Those aged 17 years old and upwards, like the young person, are regarded as adults for remand purposes and cannot be sent to an SCH or an STC. The YJB indicates on its website that the expected placement for those who have appeared at Leeds Court is Wetherby YOI.

Asset

29. 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.

Care Order / Looked after children

30. The term "looked after children and young people" is generally used to mean those looked after by the state, according to relevant national legislation which differs between England, Northern Ireland, Scotland and Wales. This includes those who are subject to a Care Order (Section 31 of the Children Act 1989). A Care Order is a court order that places a child under the care of a local authority. The local authority then shares parental responsibility for the child with the parents. The local authority will make most of the important decisions about the child's upbringing, for example where they live and how they are educated.

HMYOI WETHERBY

31. Wetherby Young Offender Institution is a dedicated establishment for young male offenders aged 15 to 18 years old. It can accommodate up to 396 young people, but does not normally operate at full capacity. The living accommodation consists of single occupancy rooms. The main accommodation site is split into five units housing 60 young people on each unit.

32. Benbow unit accommodates new receptions and provides an induction programme. Collingwood, Drake, Exmouth and Frobisher units accommodate the majority of young people. There is a unit for long term and life sentenced young people and an enhanced support unit, Keppel.

Her Majesty's Inspectorate of Prisons (HMIP)

33. Her Majesty's Inspectorate of Prisons for England and Wales (HMIP) carried out an unannounced short follow-up inspection between 9 and 13 August 2010. Significantly more young people than in other similar institutions told the Inspectorate that shouting through windows was a problem at Wetherby, although 89 per cent of young people felt safe compared to 76 per cent across the country. The Inspectorate found that bullying procedures had improved since their inspection the year before, but staff had still not been adequately trained to implement them effectively:

> "The majority of young people said they felt safe on their first night. Work had been carried out to improve the quality of vulnerability assessments. There were sound arrangements to care for young people who arrived without documentation and missing information was obtained quickly."
>
> "Serious bullying was not widespread and procedures to manage bullying had improved, although not all staff had been trained to implement them. Work with victims and perpetrators of bullying needed further development."

34. Only 55 per cent of young people said that they felt respected by staff. However the inspection team concluded:

> "The poor survey findings did not reflect our observations of consistently positive interactions between staff and young people during the inspection. It was notable that staff were familiar with the background of the individuals they were dealing with and had a good grasp of the developmental needs of young people in custody."

35. In 2008, the Inspectorate recommended that Residential Support Officers (RSOs) should be more involved in planning the care of the young people they are responsible for. (An RSO is an officer identified for each young person to support them and answer questions about custody. They provide more administrative support for young people, for example helping them to apply for courses or work. Personal officers are distinct from RSOs and

should provide young people with pastoral care and emotional support.) The Inspectorate's recommendation was still not achieved in 2010:

> "RSOs still did not often attend training planning meetings for young people they were responsible for and we were told that they were not invited to attend when the meetings were scheduled. This led to some breakdown in communicating the targets set for young people to staff on the residential units who were closely involved in helping them meet those targets".

36. The Inspectorate repeated a previous recommendation that RSOs and caseworkers should meet regularly to discuss and review the progress of the young people they were jointly responsible for.

Independent Monitoring Board (IMB)

37. Each prison and YOI has an IMB, unpaid volunteers from the local community who monitor day to day life to help ensure that those in custody are treated humanely and justly. The most recent annual report published by the IMB at Wetherby covers the period from June 2010 to May 2011. The Chair of the IMB referred to the young person's death and said it was the first death at Wetherby for about ten years. The Chair recognised that the year had been challenging as the number of assaults on staff had increased and violence across YOIs had increased. Despite this, the IMB reflected the Inspectorate's findings that young people said they felt safe, concluding that "there was considerable confidence in the ability and willingness of staff to sort it out when it came to their attention".

THE YOUNG PERSON

38. The young person was born in August 1993 and lived in the Leeds area. He was taken into care when he was 18 months old because his mother was unable to look after him due to mental health issues because she suffers from a bi-polar disorder. He lived in settled foster care until 2007. This placement broke down because his behaviour began to deteriorate. He was first convicted of an offence when he was 13 years old. He had one more foster placement which broke down in 2010. He spent periods of time living with his uncle or in a bed and breakfast or a hostel. He had been living in bed and breakfast accommodation in a notoriously high crime area before he was taken into custody. His social worker had been helping to find him some semi-independent accommodation at the time he committed a burglary in November 2010.

39. Until the burglary, the young person had been visiting his mother on a regular basis. He was particularly close to one of his older brothers and he had six other siblings. He was small for his age, five foot three inches, and weighed just 50 kilograms. His father died in 2010, but he refused to speak to anyone about how he felt about this, despite being offered bereavement support. Before his death, he had been starting to build up a positive relationship with his father and had started living with him, after not having contact for some time.

40. The young person left school in 2010 without any qualifications. After leaving school he was referred to vocational projects through the local authority, but he never really engaged. In November, he said he was motivated to start some form of education because he would receive money each week from Social Care as an incentive. He said he would like to get his Construction Skills Certification Scheme (CSCS) card which would have allowed him to work in the building industry.

41. The young person's key worker at Leeds Youth Offending Service (YOS, also known as a YOT) throughout his supervision in the youth justice system wrote a pre-sentence report in November in relation to burglary and attempted theft charges. She said:

> "He does not show his emotions to others and I believe that he has become adept at hiding his feelings, and that he also struggles to recognise these feelings".

42. During interview, the key worker said there were periods when the young person engaged more with staff at the Youth Offending Service than others. Her view was that he became more difficult to engage with as he got older. She said:

> "He often adopted a very non-committal, non caring attitude, almost defensive and sometimes he would … kind of look almost as if he was almost laughing at you but not quite. Often as if he was trying to portray an image that he was bigger and better than everyone else … it was

difficult to get through because you knew that there were lots and lots there for him underneath but he wouldn't open up and talk to you. He'd rather try and portray this image of who he was".

She said she tried to talk to him about the issues around him growing up or his father dying the previous year, but he would not talk about them.

43. The key worker noted the young person spent most of his time with his friends, none of whom were in employment or education and many of whom had criminal records. He told her they spent time walking around or in each other's houses, playing computer games or listening to music. He spent about £10 per week on cannabis and said some of his offending was to fund this substance use. After being found guilty of the burglary and attempted theft charges, he was given a Youth Rehabilitation Order (YRO) with Intensive Supervision and Surveillance Programme (ISSP) on 22 November 2010. (ISSP is the most rigorous alternative to custody for young people, involving a structured 25 hour weekly programme and the possibility of being monitored through electronic tagging.)

44. A Youth Justice Worker knew the young person during his period on ISSP. She said it was very difficult to get him to open up and talk about anything. She said he was not interested and therefore it was difficult to engage with him. She said one of his older brothers was very well known in the area and had a reputation for offending. She believed that he looked up to his brother.

KEY EVENTS

The young person's community supervision

45. The young person appeared in court twice in December 2010 for breaching his YRO. Both times the order was continued. On 13 December, he went to collect some clothes bought with money from a local authority organisation that helps young people leaving care. He reportedly asked for his clothes in a threatening and abusive manner and was challenged by the acting lead of the ISSP team. He began to kick and punch the reception inner door, which the acting lead opened to avoid him breaking the glass. He shoved the acting lead in the chest, and tried to shove him for a second time. YOT staff tried to restrain him, but he continued to try and attack the member. Eventually he was given his clothes and he left the building, shouting racist abuse at the acting lead. During interview, the acting lead said he understood that the young person had rowed with his friend before coming to the YOT. He said that the young person was not usually an aggressive person, and following this incident their relationship returned to normal.

46. When he went to the YOT two days later, the acting lead and another YOT worker spoke to the young person about his behaviour. A meeting was held on 23 December and a behaviour management plan was agreed. According to his YOT records, this was the only recorded incident of him being physically aggressive.

47. In January 2011, the young person repeatedly breached his ISSP order. The key worker explained to the investigator that he refused to go to most of the areas in Leeds he was required to, because people were after him. She said that she would often collect him from his accommodation and take him to his appointments so that he could avoid these areas. She said that she was not sure whether he was genuinely afraid, or just did not want to engage.

48. On 7 February a progress report was prepared for the court. The young person had missed 16 of his 43 appointments since 11 January and had been threatening and verbally aggressive towards staff. The key worker asked the court to consider revoking the order and re-sentencing him for the original offences. The next day Leeds Youth Court decided to continue the order. He continued to miss many appointments throughout the rest of February and March.

49. The young person was not complying with his supervision, so was not regarded as working towards reducing his risk of reoffending and the Youth Offending Team began to consider custody a possibility. The key worker had written three breach reports about him and their difficulties in trying to get him to engage. She felt custody was the next option because "ISS[P] is pretty much the highest order you can get". She thought the courts were only going to allow a certain number of breaches before they judged that the ISSP was simply not working.

50. The acting lead for ISSP met the young person on several occasions during his time under intensive supervision. He said,

> "A lot of the time when a young person starts at ISS they can be a bit guarded but as time goes on they open up a little bit and you get to know them. He always remained guarded, he was all so closed. I can't remember ever really having an off the cuff conversation with him. With a lot of young people I'll talk about what happened on TV last night and they will engage about football or just random normal silly things. He never did that … it was one word answers kind of thing all the way through".

51. A Youth Justice Worker at Court completed the first part of a "Placement Information Form" about the young person on 9 March 2011. He was due to appear at Leeds Youth Court on 9 March 2011 for continuing to breach his order. She noted in the box 'Expected Outcome – Remand'.

52. The key worker completed an Asset core profile about the young person on 9 March. She updated some of the information from the pre-sentence report she wrote in November. She noted that he recently had the opportunity to sign for a flat in an area that he liked but did not go to the appointment. She said he was seeing his mother occasionally. She wrote, "He is not motivated to attend education or find employment, despite the best efforts of ISS staff". He continued to smoke cannabis heavily and often went to the Youth Offending Team under the influence of cannabis. It was also noted that he had made discriminatory comments about people who were different to him. She said that he "likes to give the impression he is invincible in order to hide how he really feels". She felt he did not engage with staff in terms of addressing his problematic thinking skills or work linked to his offending behaviour. He was told by the magistrates that he was being given one very last chance and that a further breach would result in custody. He was told that he must comply with his curfew and not be even five minutes late.

53. The young person met a worker from the Leeds ISSP team on 16 March. He asked for his curfew to be put back an hour (to 8.00pm) so that he could get from Armley (where his mother lived) to the bed and breakfast accommodation where he was living. He was told this was unlikely. The two then went on to discuss his offending. He said he had not committed any burglaries since his older brother had been in custody. He said he looked up to his brother because he protected him, gave him money when he needed it and always looked out for him. He spoke about his past and said he wanted to change his offending behaviour. He was adamant he had not committed any more offences for a long time but said he was tempted sometimes. The two talked about his new flat and what things he would like in it. She noted that he "seemed happy about his future prospects and a new start".

54. On 17 and 26 March 2011, the young person allegedly committed two robberies. Both robberies involved him using a weapon. During the course of one of the robberies, the victim was verbally abused because it was thought he was homosexual. He was stopped by police on 26 March in the same area as where the second offence took place.

55. There is a note in the young person's YOT case diary (made on 5 April 2011) by the young person's social worker. She noted that he signed up for a tenancy in Armley for his own flat with the council on 28 March. However, as the council only keep flats available for three months, if he went into custody and was not released within this period he would be homeless again and emergency accommodation would have to be sought.

The young person's arrest and court appearance

56. The young person was arrested and interviewed by police on 29 March 2011. After the interview and an identity parade, he was charged with two counts of robbery with an offensive weapon and detained in police custody. He refused to speak to a solicitor or to be examined by a doctor but his wellbeing was checked every hour when he was in a police cell. The Person Escort Record (PER) form that accompanies a person when they move or transfer location was completed at a Police Station at 1.50am. The section on 'risk indicators' lists the following: "previous self harm by banging head on cell wall… spits through cell hatch… previous amphet[amine] use".

57. Attached to the list of people held in police custody overnight is a series of markers about suicide risk, self harm or other matters that need to be brought to court staff's attention. G4S run the custody suite at Leeds Magistrates' Court, where the Youth Court also sits. The young person arrived at the court from the adjacent police station at 7.35am on 30 March. He was put into a cell on the upper landing of the court custody suite, reserved for young people and women, to await his court appearance.

58. If something noteworthy is written on an individual's PER, the person who is drawing up the chart of risk factors will tell the Prison Custody Officer (PCO) who is looking after that person. A PCO who works for G4S, could not remember the entry about self harm on the young person's PER. He said he would have been told about the reference to him banging his head on the cell wall and this would have prompted him to speak to him about it. He could not recall specifically doing so (our interview took place in July 2011) but said that had he any concerns as a result of that conversation, he would have increased his observations to constant supervision and communicated his risk to other members of staff. G4S staff can open a 'Self Harm Warning Form' if they have concerns about someone in their custody and this form is subsequently handed over to prison staff if the person is remanded into custody. No such form was opened for him.

59. The PCO said he knew the young person well, having worked at the court for ten years. He said he had seen him on several occasions over the previous few years. During an interview with the PPO investigator he said he was confident that he would have opened up to him if there was anything bothering him.

60. The young person was checked by the PCO or another PCO about every 15 minutes throughout his time in court custody, as his age required. Some of

these checks are recorded as being done, but no officer's name is written next to the entry to confirm who carried out the check.

61. The Bail Information Officer on 30 March was a Youth Justice Worker based at the court. He spoke to the acting lead (from the Leeds ISSP team) about the young person. He understood the offence he had allegedly committed was serious. He remembered speaking to him in a secure interview room in the court cells area. He said he understood it was likely that he would be remanded into custody that day.

62. A Placement Information Form (PIF) is used to communicate key information about a young person to the Youth Justice Board's Placement Service in order to facilitate the most appropriate placement, should they be remanded into custody. The Youth Justice Worker explained that the first section of the PIF is completed when a young person is at risk of going into custody and sent via urgent e-mail to the Placement Service. The first section of the PIF notes down basic information such as the supervising YOT, personal details about the young person and their offence details. This part of the form was completed by him. It noted the names of the young person's social worker and his YOT officer. Next to the question "First time in custody?" is written "Yes". The rest of the form asks questions about health, suicide and self harm, learning and emotional issues, parenthood, risk of harm, other risk issues, welfare requirements, education and family culture. This should have been completed later by either the person who wrote the young person's pre-sentence report (usually their case worker) or in his situation (because he spent the night in police custody), the Bail Information Officer. The Youth Justice Worker said he would have completed the first part of the PIF before his court hearing.

63. The young person was taken up to the dock area at around 10.30am. His hearing before Leeds Youth Court was at 11.00am. By 11.06am, he was back in the cells area, after being remanded into custody.

64. After the court hearing the Bail Information Officer sees the young person again. He assessed the young person's response to custody, made sure he understood what happened and recorded the outcome in a Post Court Report (PCR). His Post Court Report (PCR), written by the Youth Justice Worker, detailed the robbery offences and the solicitor's details in the first section, that the emergency contact was his social worker and that his mother was aware he was in custody. Under the section headed "At risk issues" there are three questions. The first asks "How is the young person currently presenting?" The Youth Justice Worker noted that he said he expected to be remanded today and there were no concerns around self-harm. He said when he asked him if he had any thoughts of suicide or self-harm he laughed, shrugged and said he did not. The second question asks whether there are any significant family or personal issues. He recorded that the young person had been under the care of social services since he was 18 months old and that two settled placements had broken down as his behaviour deteriorated. The last question asks whether there is anything else the unit needs to know. He

recorded that the young person's father had died the previous year and that he had not spoken to anyone about how he felt.

65. The Youth Justice Worker explained to the investigator that the young person was fine and resigned to the likelihood of custody due to the seriousness of his alleged offences. He asked the Youth Justice Worker to get his mother's correct telephone number from his social worker. He did this and wrote the number on an orange envelope. This went with the young person to Wetherby. The Youth Justice Worker said he would have sent the PCR, Asset document and the Placement Information Form (PIF) to the Youth Justice Board's Placement Service via the secure electronic mailing system. However, the investigator found that he sent the PCR and Asset, but the completed PIF was never sent.

66. The Head of the YJB Placement Service said that on 30 March 2011, the YJB received the following documents from Leeds Youth Offending Service – Notification of Court Outcome, Placement Information Form (PIF) and Asset core profile. The PIF received had only the first section completed. There is no evidence that the updated PIF with the more detailed information had been received by the YJB before the young person was placed at Wetherby.

67. The Youth Justice Worker explained during interview that if a 17 year old is thought to be particularly vulnerable, the Bail Information Officer can request that they are sent to Keppel Unit at Wetherby. The referral form for the Keppel Unit can be completed by the duty officer at Court, but there was no such referral for the young person. He said he could see from his records that he had spent considerable time in children's homes and was used to institutions. He said he had no concerns about him coping in custody. He knew his brother had been in custody and thought he would know what to expect. He did not see his PER. The PER contained the information about him banging his head on the cell wall while he was in police custody. He said that he would have considered referring him to the Keppel Unit if he had seen the PER. There is now a system for court staff to ask G4S staff about what is written on the PER.

68. Once the young person's placement has been requested, a placement confirmation form is emailed to the secure inbox in the Youth Offending Team's office at Leeds Crown Court. Youth Offending staff pass the form to G4S staff in the court custody suite to liaise with escort staff. At 12.02pm a Placement Confirmation Form was created at the Youth Justice Board. The young person's placement was HMYOI Wetherby. Noted on the form was the fact that this was his first time in custody, that he was subject to a care order and was a potential victim of bullying. This information was gathered from his PCR and Asset. His next court appearance was scheduled for 6 April 2011 via video link. Just before 2.00pm, he left Leeds on his way to Wetherby.

69. The escorting officer recorded on his PER that he had been "banging his head on his cell wall". She did not indicate that he was at risk of self-harm.

Reception at HMYOI Wetherby

70. The young person arrived at Wetherby at 2.45pm on 30 March. His PER was given to Officer A in reception. She signed the front page to indicate that she had accepted custody of him from the escorting PCO. She said that when a new young person arrives at Wetherby, escort staff come into reception with the paperwork and the young person remains on the bus. She said she always expects a PER form, a warrant and also normally a placement confirmation. His placement confirmation highlighted that he had been a victim of bullying and that it was his first time in custody. She said the YOI receives the placement confirmation from the YJB via e-mail as well.

71. Officer A explained that when a young person comes into the reception area from the bus, she confirms that it is the right person by checking his name, date of birth, which court he has attended and what disposal he received at court and whether he knows when he is going back. She also asks whether he has any immediate concerns about being in custody and whether he had any problems at court. The young person is then given a rub down search by another officer and put in a holding cell, while the other young people on the bus enter reception, one by one.

72. She said the comment on the PER about self harm said, "previous self-harm by banging head on cell wall" but there is no date on it and therefore it could have been last week or five years ago. She said,

> "I think this is just what the police take off their computer. We'd probably go more on the placement authorisation, what information we get from G4S, because if they've got a concern about someone they send us what's called the self-harm warning form and that's actually in addition to the PER…".

73. The officer said it is not unusual to read about someone banging his head on a PER. However, if it was recent, she would expect a Self Harm Warning Form from G4S staff. If the young person comes in with this form she said,

> "I would generally ask them immediately when they came in ... Because I prefer to know there and then if an ACCT needs to be opened ... So I would probably question them on it because, say the other day we had one, a self-harm warning form that he said something in court. So I just want to confirm 'did you say that because you meant it or because' and a lot of the time the answer is 'because I was trying to stop a custodial', trying to stop being remanded into custody".

(Assessment, Care in Custody and Teamwork, known as ACCT, is the system used in prisons to identify and support prisoners at risk of self-harm or suicide.)

74. During her interview, Officer A did not specifically remember meeting the young person that afternoon and booking him into custody. She could not therefore remember whether she specifically asked him about banging his head on the police cell wall. She said she could not have had any concerns

about self-harm, because she would have opened an ACCT document. She said all of the paperwork, including the PER is passed to the nurse in preparation for their medical assessment.

75. Our investigator told Officer A that the young person had been banging his head while in police custody the night before. She said that if this were the case, he should have come with a self-harm warning form. However, even if he had come with a self harm warning form it would not mean that an ACCT document would be opened in reception – YOI and nursing staff make their own assessment based on relevant information (including previous self harm, mental health history, how the young person is presenting at the time).

76. The officer completed some basic details about the young person in his core record. This included information such as his height, weight, tattoos, next of kin (his social worker was noted here). His mother's details were noted in the section about who should be notified if there was an emergency.

77. The young person saw a nurse at 4.30pm for his initial health check. He told the nurse this was his first time in custody and that he had been in care since he was 18 months old, his mother had bi-polar disorder and his father had died the previous year. He said he smoked 20 cigarettes a day, had used cannabis in the previous month and had no thoughts of deliberate self harm. The nurse noted he had grazes to the knuckles of both hands. She wrote that he said he had sustained this injury two days ago from fighting. The nurse noted that he also had a graze on his forehead, but made no comment about his self-harm or previous amphetamine use, even though she saw a copy of the PER. The nurse recorded his height as 1.61m (5' 3"), his weight as 50kg (7st 12lb). She recorded that his ideal body weight should be 64.54kg (10st 2lb).

78. The nurse completed her section of the Cell Sharing Risk Assessment (CSRA). This form is used to assess the risk that a young person may pose to others, if he were to share a cell. It looks at their history of offending, particularly violent, racist or homophobic crimes. It is completed by an officer, nurse and countersigned by a manager. She ticked the box for 'low' risk and said there was insufficient evidence to give an opinion based on her medical assessment.

First Night in Custody Assessment

79. Once the young person's health screen was completed, he went to the First Night and Induction Centre (FNIC), known as Benbow Unit at Wetherby. Officer B was working on the unit that day. In interview with the investigation team, she recalled that six young people were due to arrive at the same time and she was asked to assist the FNIC officer by completing two or three of the interviews.

80. The officer explained that a young person's documents are sent to the FNIC officer in advance of his arrival on the unit, so that the officer can review the records and highlight any areas of risk or immediate needs. Before he arrived

at Wetherby, she read the young person's Asset, pre-sentence report (from November 2010) and post court report. She said that it is a pressurised situation, with only a short time to read a lot of information about each young person. Using the YJB Placements Confirmation form to make notes about his documents, she jotted down that his father had died the previous year and he used cannabis. The form highlighted under "Other risk factors" that he was subject to a Care Order and that he was the victim of bullying.

81. The officer completed a vulnerability assessment (known as a T1:V form), when she interviewed the young person. This form is completed for anyone under 18 years old to identify young people who are at particular risk in custody. She said he was "very quiet in interview" and that he "wasn't bothered about being here [in Wetherby]". She said she tried to engage him throughout the interview but he "didn't really want to give me any information" and did not fully answer her questions. When asked whether he gave her any cause for concern, she said she did not think he was at risk of harming himself. She told him that he would be safe at Wetherby and asked him whether he self-harmed. She said he "kind of laughed and shrugged his shoulders… you know, like why would you want to do that".

82. Section one of the vulnerability assessment asks questions to determine whether being in custody has increased the young person's risk of self-harm or suicide. The officer recorded that there was no evidence of him being a risk to himself in his Asset. She wrote "PER stated that he banged his head on cell wall. He has denied this happened and has stated he has no thoughts of self-harm or suicide". It was noted his father died approximately a year ago and that he tried to hide his true feelings about it from YOT staff. "He has confirmed during interview that there is nothing at present that would upset him or make him vulnerable".

83. The second section is to assess whether the young person might be a potential victim. Officer B recorded that there was an "isolated incident" while the young person was in foster care, when he threatened another young person with a kitchen knife. The officer also wrote that he had pushed a YOT worker during his intensive supervision. She indicated that the YOI was not experiencing problems of bullying or victimisation at that time. She noted that his Asset said he was being threatened by various people across Leeds. It goes on to list several areas of Leeds that he told her he had to avoid, although he said he did not know of anyone at Wetherby. Despite him highlighting the problems he was having in Leeds, as well as the note on the Placement Confirmation form, the officer recorded that he did not have a history of being bullied or victimised.

84. Section three is to assess whether the young person presents a potential risk to others. Section 3.1 asks:

> "Does the child/young person have a history of putting others at risk? (ie. racist behaviour, bullying). Officer B has crossed 'No' but then added a note, "However Asset states that the young person was discriminatory towards the victims of the burglary as they were different to him".

[3.2] “Does their offence indicate potential for harming others?”
Officer B has put ‘No’ and written “Domestic burglary” as the offence.

85. In response to the question, “Did they appear to have an overly aggressive/passive attitude during their reception interview?” Officer B marked “no” and wrote “He was calm and polite but quiet during interview”. In response to the final question, it was noted there was no history of family aggression.

86. Section four of the vulnerability assessment is headed, “Risk Management Plan”. Officer B recorded that Wetherby would explain the personal officer scheme, monitor the young person on leg one of the unit (cells nearest the office), provide a full induction, encourage skills and education, use of the gym and library and complete a healthcare assessment. She wrote under “action recommended”, CAMHS (Child and Adolescent Mental Health Service), personal officer and staff to monitor. (He had been referred to CAMHS in the community, although he had never engaged fully with their services.) She said during her PPO interview that he was very non-committal and unbothered and that she had to encourage him to agree to anything. She tried to make him see that this might be an opportunity for him to learn some new skills, such as bricklaying, painting and decorating. He eventually agreed to the gym and then cooking.

87. Officer B said she thought the young person was not especially slight or short compared to some of the other young people. She thought he was average size. She described him as “just an average young person that came in… neither aggressive or overly friendly”. She said he was polite and calm during the first night interview.

88. Although she is ACCT trained, Officer B guessed she had probably only opened about two ACCT documents over the year she had worked on Benbow. She told our investigation team that most ACCTS are opened in reception before a young person arrives on the first night centre. Nevertheless, she agreed that she could open an ACCT document if she assessed a young person to be at risk of harming himself. She said she did not think he was at risk, taking into account the information on his Asset, post court report and pre sentence report, as well as his presentation that afternoon.

89. Once the vulnerability assessment was completed, Officer B went on to complete sections one and two of the CSRA. She ticked ‘yes’ in answer to the question “Has the prisoner been convicted of a homophobic crime?” The young person denied that the street robbery was homophobic. (He was on remand for the robberies.) She felt his CSRA should be assessed as high. She said during interview that she took into account his aggressive manner and his threats against other young people recorded in his Asset. She had originally jotted “Med” on his Placement Confirmation form (which included a first night alert as this was his first time in custody) when reviewing his documents. However, she changed her mind and wrote “high” on the form.

She said that the “high” related to his cell sharing risk assessment, not the level of risk she assessed him posing to himself. In her view, he was not at risk of harming himself at the time because he was dismissive at the suggestion of self-harm, but she thought he was a risk to others.

90. The young person made two separate phone calls that evening to his mother, but did not get any reply.

91. After Officer B had completed the first night interview, she took the young person to cell B14. She said the assessment interview usually takes 20 to 30 minutes but thought he took 10 minutes because he did not elaborate on anything. Because it was his first time in custody, he was located on leg one of the unit (the cells closest to the staff office), so that he could access officers more easily if he needed anything and so that staff could monitor him. His cell was the second closest to the staff office, approximately ten metres away. An officer described these cells as “safer cells” (a term for cells designed to have few ligature points) and explained that they have windows that do not open outwards, but have vents and the furniture is fixed, in order to reduce ligature points. The Governor told the investigation team that they are not official “safer cells”. The cells have been fitted with safer cell furniture but they do not meet the full safer cell specification. The Governor said young people who have not been in custody before are located on this landing for access to staff, but not as a way of managing a risk they might pose to themselves.

92. Once the young person was located in his cell, Officer B wrote the following entry in Benbow’s Observation Book, kept in the staff office: “New reception, cell 14. Had a very poor attitude on interview”. In the actions column, she wrote “staff to monitor”. This contradicts her description of him as “calm and polite but quiet”, as recorded in the vulnerability assessment. In his electronic case notes, she wrote that he was compliant during his interview.

93. No young people share a cell at Wetherby. The CSRA assessment did not therefore affect the young person’s location. It is completed in case the young person moves establishment when it would be useful for the receiving establishment to see how the young person was initially assessed.

Benbow Unit (30 March – 4 April)

94. On 31 March, around 10.00am, the young person saw a doctor. The YOI doctor recorded that he was calm and relaxed, had no suicidal thoughts, was a smoker and had a history of using cannabis. He noted that he was not on any medication appeared to be in good health, with no physical or mental health history. He made a note that he, “appears to be average weight”. He did not want nicotine replacement patches. (Wetherby has a no smoking policy and young people are not allowed to smoke.) A nurse noted at 11.10am that he did not want any vaccinations - for tetanus, meningitis, polio or diphtheria. She told him about the importance of immunisations and advised him to think it over and let healthcare staff know if he changed his mind.

95. Following Officer B's referral during the first night interview, a mental health screening form was completed by Healthcare Assistant (HCA). In response to a question from the nurse, the young person denied that his alcohol use or drug use took over his life. He told her that he did not feel miserable and he was not experiencing flashbacks or powerful memories connected to traumatic events. The nurse recorded that he was not experiencing panic attacks, or thinking of harming himself. The nurse assessed whether his observations were indicative of psychotic symptoms or hyperactivity. This screening form can lead onto a full interview if there are concerns. He scored a '0' for all of the questions. The person completing the form wrote "No concerns" on it. There was therefore no referral for further mental health assessment.

96. The same day, Officer C introduced herself to the young person as his caseworker, responsible for remand planning. During interview for this investigation, she explained that a caseworker sees all young people who have been remanded to Wetherby within 24 hours. She explained the purpose of the meeting is to see how the young person is settling in, their thoughts about being remanded and if they have any immediate needs that the caseworker can help them with. She said the caseworkers have access to the vulnerability assessment completed by the first night officers and usually the Asset. They also get the post court report written by the YOT officer based at Court.

97. Officer C said her impression of the young person changed in the short time he was at Wetherby. She said that when she first met him she thought he was over confident. She felt that this changed after he moved off Benbow unit. She felt she had quite a good rapport with him and said he engaged well during their meetings.

98. At their first meeting, the young person told her he had no concerns about his welfare and was coping well. He said he had been expecting to be remanded into custody. He had no current thoughts or intentions of self-harm. The officer said he seemed perfectly happy about being in Wetherby. He told her he had two brothers serving custodial sentences. A record of this meeting was entered in his electronic case notes.

99. All young people who arrive at Wetherby undergo a two week induction programme on Benbow unit. Those who have been in custody before are fast-tracked and might only stay on the unit for two days. Young people like the young person, who have not been in custody before, generally remain on the unit for five to seven days, while they undergo the majority of the induction programme.

100. The young person attended Stage One of the induction programme in Grenville College (Wetherby's Education department) on 31 March. He learned how to load telephone numbers onto his personal telephone account and how to complete visiting orders. He was also told about the rules and regime at Wetherby. The Imam from the chaplaincy department met him.

General details about where he came from and confirmation of his religious status were noted down.

101. The following day a Senior Officer (SO) recorded in the young person's electronic case notes that he had been warned about his "lewd, rude and disrespectful comments" made towards staff and the consequences on his entitlement to privileges while in custody if that behaviour continued. During induction that morning one of the nursing staff had complained to the SO that he (and some other young people) had been rude (using sexually inappropriate language) in healthcare. The SO told her he would speak to him and challenge him about the correct way to speak to staff. The next day, 2 April, he attempted two calls to his mother at 10.04am and 10.06am but did not get any answer.

Sunday 3 April

102. The young person tried to call his mother three more times on Sunday 3 April, Mothers' Day, but there was still no reply. Senior Officer 1 was in charge of Benbow unit. Officer D was locking up young people after tea (the young people all eat together on the unit). When she got to the young person's cell she said his door was unlocked but closed to. She thought he must have gone back to his own room and shut the door. She said she always likes to check a young person is in and ask "Are you okay?" She said she opened the door and said "Are you alright?" He said he had not been out for his dinner. She told him his door had been opened. He said he had closed it to go to the toilet. The officer explained that once you have done this, you cannot open the door again from the inside. She said there was still food available as leg two of the unit were still eating and told him to go and get something. He became abusive towards her and said he was not eating "sloppies", to which she responded that he would not eat unless he collected his dinner then. She said he came to the door, threw it shut in her face, swore at her and called her a slag. She then locked his cell and went to talk to the SO.

103. The SO decided to go and speak to the young person about what had happened and take a tray of food for the young person. She went to his cell and Officer D stood behind her at the cell door. She said that as soon as he saw the officer behind her, out of nowhere he ran straight at the door. She just managed to shut the door in time before he got there. She described him as being very aggressive. She thought he swore at the officer. The officer said he threatened to "snap her jaw". The officers said they were quite scared because he was so aggressive and threatening.

104. Three officers were present. One officer said the young person went on to flood his cell, banged on the door and shouted abuse. She heard him threaten to break Officer D's jaw. The SO made a note of the incident on his electronic case notes. Officer D also made a note about him using "foul, abusive and threatening language" towards her and that he was being placed on report. He was charged with an offence against YOI rules, "Uses threatening abusive or insulting words or behaviour".

105. The young person's television was temporarily taken out of his cell in order to stop him breaking it. His trainers were also removed so that he could not kick the cell door; he was 'flooding' his cell so the water supplying the taps in the sink was turned off. He used the toilet water to flood the cell. Officer D said he might have urinated on the floor of his cell, although she was not certain. Other young people on the unit at the time told the investigator that he had urinated out of the vents of his cell door into the corridor. Officer D said during interview that she felt he was okay with the male members of staff but not the female officers. She wondered whether he had behaved this way deliberately in order to get a move off the unit.

106. SO 1 rang SO 2, who was the orderly officer (operationally in charge) in Wetherby that evening. SO 1 told SO 2 that she was concerned about the young person. He had been making threats towards staff, he was not speaking to any of the staff and he had blocked his observation panel on the door. SO 1 did not want to go straight into the cell because of all the threats that had been made.

107. When he arrived on Benbow unit, staff briefed SO 2 and he went to the young person's cell on his own and spoke to him through the door. He ignored him to start with but after a while he unblocked his observation panel and sat on the bed. He then started talking to him. He said things like, "the staff haven't let me out for my tea" and "they're stitching me up". He agreed that the SO could go into the cell for a proper chat and so with another officer present at the door, it was unlocked and the SO went in. The SO told him that he had spoken with the staff and that they said he was unlocked and that later on he was offered a proper meal and that it was not the "scragg ends". He disagreed and said that his brother had told him the staff hated him and that they would hate him too. The SO said staff were not here to do things like that. He said "they are going to have me on here all the time". The SO told him Benbow was only an induction unit and that he would be moved onto another unit when his induction was finished. The SO said he was calm and not threatening during their conversation. He said he asked him if he had any feelings about harming himself and he said he did not. He agreed to keep his observation panel unblocked so that officers could make sure he was safe.

108. At 5.20pm, SO 1 summarised the incident in Benbow unit's observation book and recorded the following outcomes:

> "Placed on Governor's report;
> C Nomis [electronic contact record] updated;
> To move units;
> History of staff assault."

There was no evidence that the young person's mental health or vulnerability were discussed or considered, despite his extreme behaviour.

109. A Senior Officer recalled during interview with our investigator that he had gone to see the young person with another Senior Officer. He had not previously met him. He said the young person felt the staff had deliberately

'stitched him up' and not let him out of his cell for his tea. The SO said he was understandably upset about this,

> "It was explained to him that staff had forgotten to unlock him, they apologised, but the dinner was still on and they unlocked him at the end. On B wing… there's always plenty of food".

110. The young person was still upset at this time and said his brother told him that because of the family name the staff were going to do things like this. The SO felt this had made him a bit paranoid and that he thought staff had done it on purpose.

111. An officer made an entry in the young person's electronic case notes that he was given some toast at 8.00pm.

112. SO 1 requested that the young person was moved off Benbow unit the next day because Officer D was an induction officer and that she was down to take the induction programme for the next day or two. The SO felt that in order to protect the officer from what she perceived to be a serious threat of assault, it was right that he move onto a different unit. The SO told him that he could have a fresh start on Drake unit.

Drake Unit (4 April – 18 April)

113. The young person moved onto Drake unit on Monday 4 April. The following day, he saw a worker from the Young Persons Substance Misuse Service (YPSMS), to discuss his use of cannabis. She said the main theme throughout her discussion with he was that he did not want to engage or say anything much at all. He refused to sign his care plan because he did not agree with it, saying that he did not have a problem and could stop if he wanted to. He used cannabis daily but said he had not experienced withdrawal since being in Wetherby. He was offered a place on a half day course looking at alcohol, stimulant or cannabis use but declined it. She said he did not seem vulnerable and she did not consider him to be at risk of suicide or self-harm. His targets were to gain knowledge of the health, social and legal effects of drugs and alcohol use.

114. A governor was carrying out adjudications on 5 April. (An adjudication is a disciplinary hearing by a governor, when a young person has allegedly broken YOI rules.) The young person had been charged with "Using threatening, abusive or insulting words or behaviour" towards Officer D. The evidence was read out –

> "… whilst locking trainees away after tea trainee he became abusive to myself – he proceeded to flood out his room – when visited by the SO he became aggressive leaping off his bed and made threats towards myself – stating he was going to snap my jaw and continued to call me a slag".

115. The young person pleaded guilty. He had made a written response to the charge. He wrote:

> "I was not let out for my tea as Officer D must have forgotten about me. When putting other inmates back in their cells I stated to her that I was not let out for my tea. She told me to quickly run down and get something to eat. I said to her 'What go get leftovers. No don't think so', being in not a very good mood to start with I called her a slag and she replied by saying 'Just like your mother then'. Which I didn't take kindly to and threw my kettle at my door which was full of water and went all over. Then when the SO came to my door and I seen her again I threatened to break her jaw in anger because of what she replied about my mum and with it being Mother's Day and not being able to get in touch with my mum since I came in… I was very upset and angry and shouldn't have been threatening and abusive to staff".

116. The governor asked the young person what had happened to make him so angry and abusive. He agreed that he should not have reacted as he did, but he was angry about the food. She wrote that from the evidence and from his own admission, she found the charge proved. She said that there did not seem to be any question about the evidence, that his account and Officer D's account tallied, so she did not speak to the officer. The governor made no additional enquiries beyond their written representations and did not investigate the allegations he made about the officer.

117. The investigators asked Officer D whether anything she said to the young person could have come across as insulting to his mother and she said that could not think of anything that could have been interpreted in this way. She recalled trying to calm him down, by saying:

> "Don't swear at me, I'm not swearing at you, I've got kids your age. Would you like someone swearing at your mum".

She said he was not taking anything in because he was really angry. She said she had never encountered a young man being like that before.

118. The governor explained why she found the charge proved and the reason that she gave the punishment. She said the young person was not interested and just shrugged his shoulders. She said he showed no remorse or any kind of regret for what he had said or how aggressively he had acted. She said that she followed the tariff (guidelines as to what a reasonable/typical punishment would be for each type of offence against YOI rules). He lost his entitlement to association with other young people, he had to eat in his cell, not have use of the gym and no television in his cell, all for a period of seven days, until 11 April.

119. In the afternoon, the young person had a second remand review meeting with Officer C. His YOT officer and social worker were there. Officer C explained the purpose of the meeting was to gain a wider perspective of the people involved with him in the community. It was also an opportunity for him to see some familiar faces, people that he knew and who could answer questions he

might have had about his court case or housing issues. Objectives and targets were also agreed upon.

120. Under 'Assessment Information' on the New Remand Form (completed by Officer C) she noted the young person had no history or current risk of self harm, no risk to or from others and no victim issues. She added a short note, "says he [the young person] has people 'in mind' that he wants to have conflict with ie trainee. Not named". The officer wrote,

> "First time in custody. Feeling quite settled, is what he expected. Feeling more settled now on Drake, says it's 'like a holiday camp'".

121. During the remand review meeting the young person said if he saw Officer D he would "snap her jaw", which Officer C wrote in a security information report after the meeting. The discussion centred on his behaviour on 3 April and encouraged him to work with staff rather than against them. They discussed the fact he had lost his television as a punishment. He said he was not bothered but the staff said he might feel differently in a few days time, as it had only just been removed.

122. This was the only occasion the young person's key worker saw him when he was at Wetherby. She said her impression of him in custody was that he was the same as when she met with him outside of YOI. She described him as being "very defensive" about his feelings. She said he had a "smirking type smile" during the meeting and just kept saying he was fine. She said there were concerns that he was already at risk of being put onto the Red regime, the lowest privilege level, because of his behaviour. She said she did not remember him saying during that meeting that he had problems with any of the other young people at Wetherby.

123. The first objective on the young person's remand plan related to 'thinking and behaviour' and the target was to remain on Silver level of the Incentives and Earned Privileges Scheme. (IEPS is a scheme that rewards positive behaviour with additional privileges. At Wetherby, it has been deliberately designed to be understood by young people and is made up of Red - the most basic level of privilege, Silver – the standard level and Gold – the highest level.) The second objective related to education, training and employment. He was to complete the full induction course, attend and engage with education. The third target was about substance misuse. He was to attend one to one or group work sessions. The final target was about maintaining links with family and friends via letters, visits or phone calls. Officer C felt these targets (apart from the substance misuse ones with which he did not want to engage) could all be achieved quite easily.

124. Officer C made an entry in the young person's electronic case notes about the meeting. She wrote:

> "He had adopted a very negative attitude towards custody; including being threatening towards staff and suggesting that he already has intentions to

fight with other trainees from E and F wings … He states that he currently has no concerns or issues with coping in custody".

125. The next day, 6 April, the young person tried to telephone his mother at 10.03am and 10.04am but got no answer. He appeared in court at 1.45pm via video link. The case was referred to Crown Court and he was remanded until 8 April.

126. Officer C explained that caseworkers go to the units to help with mealtimes and she happened to be assigned to Drake unit. She therefore saw the young person regularly. She remembered giving him the addresses for two of his brothers (who were in prison at the time) so that he could write to them.

127. On 7 April, the young person went from Wetherby to the Police Station in Leeds. He had indicated that he wanted to talk to officers about other offences so that they could be taken into consideration. Noted in the police request to come and collect him was written "… has risk markers in relation to violent behaviour by way of spitting at police staff; he has also banged his head against the cell door while previously in custody". He was with the police for most of the day. After his return to Wetherby at 4.55pm, he saw a nurse. He wrote in his medical record, "Seen after return from police production no change in health status no thoughts of dsh [deliberate self harm] or suicidal idealisation".

128. The young person's cousin was also at Wetherby at the time, although on a different unit. (YOI staff did not know they were cousins.) On 7 April, his cousin attempted to hang himself after being shouted at by other young people. He was taken to hospital and returned the same day, but he was transferred to Keppel unit on his return. A review of this serious self-harm incident was completed and made available to the investigation team.

129. The following day the young person had his court appearance. The PER noted that his charges involved violence, aggression and threats. He was remanded for a further period until 4 May. The YJB confirmed he would return to Wetherby and he got back in the afternoon. He was seen by a nurse, who noted there were no concerns regarding his health or wellbeing. He tried four times (shortly before 4.00pm) to telephone his mother, but again did not get through.

130. An officer wrote in the young person's electronic case notes on 8 April that he had not come to the attention of staff that week and seemed to be settled on Drake unit. He hoped this level of behaviour would be maintained. He went to the Roman Catholic service on 9 April and was recorded as being very quiet when he was there.

131. On 10 April, the young person rang his mother at 2.00pm. The call lasted one minute and six seconds. He asked his mother to come and visit him in Wetherby. She said she would not because she did not visit the family when they were in prison. He asked her to tell the police he had been at home when his offence took place and she replied that she would not lie in a court

of law. The conversation ended with him saying he would telephone her later in the week.

132. The young person's adjudication punishments of no television, no association, no gym and eating in his cell all ended on 11 April. On 12 April he went to Grenville College for education assessments as part of his induction programme.

133. On 13 April, the young person was interviewed by a Connexions worker. (Connexions is an independent organisation who support young people with education and employment.) She completed an Individual Pathway Plan for him. They had a discussion about the courses available to him at Wetherby and she asked him to make a selection from what was on offer. She tried to get him to think about what he would like to do in the future, once he was released from custody.

134. The young person had no clear ideas but liked the idea of working in a warehouse and getting his fork lift truck licence. The Connexions worker said he had been given a high risk assessment in terms of the activities he would be able to do in Grenville College. She explained how some of the activities use tools like chisels. She thought the assessment took into account the offence the young person is in for and whether that involved a weapon. The risk level is reviewed every two months and so the activities that the young person has access to can also change. Because of the high risk restriction he could only choose from a more limited range of activities. She said he was not very interested in many of the choices and in the end they agreed that he could try cleaning. They also looked at other choices for the future. His first preference was for art and design. He also expressed an interest in painting and decorating, radio production and chef academy. The form was sent to the Allocations Team who put students onto the courses that are available or onto the relevant waiting lists.

135. She said the young person mentioned his brother. She had worked with him when he was in Wetherby. He told her that if he was sentenced he would like to go to the same prison as his brother when he was 18 years old.

136. On 14 April, an officer recorded in the young person's electronic case notes that there had been no issues over the week. He finished his induction in Grenville College.

137. A chaplain spent some time talking to the young person in the social time at the end of Saturday morning mass on 16 April, and he assured him that he was alright. The chaplain noticed during mass that he seemed unfamiliar with the religious practice and so asked him if he was a Roman Catholic. He said he was not, but that he wished to be baptised. Arrangements were made for a nun to visit him during the afternoon to begin baptism preparation. She went to see him and the two had a brief conversation.

138. During weekends there is no work or education. Young people have association time for part of the day (a morning or afternoon) – when they can

make telephone calls, spend time with other young people, play table tennis, have a shower or play computer games. The young people are able to have time outdoors for the other part of the day. Tea time is around 5.00pm and the young people eat their meals together. Afterwards, around 5.20pm, they are locked in their cells. There is a roll count at 5.30pm.

139. An officer was working on Drake unit on 17 April. During interview he said that he sat quite close to the young person on Sunday afternoon and remembered him sitting on the sofa with a group of five or six young people, having a laugh and a joke.

140. A Senior Officer was working on Collingwood and Drake units on the evening of Sunday 17 April. It is not the unit he normally works on. Within a short time of him arriving on the unit, probably around 6.10pm or 6.15pm, a member of staff told him that all the power was out. The SO felt it was important to tell the young people what was happening and so he and the officers on duty went round to every cell. An officer went down leg four of the unit to tell the young people what was happening. He had a brief conversation with the young person and said he seemed fine with the explanation about the power and how they were trying to fix it. Eventually, power was restored.

The night of 17 April and morning of 18 April

141. Senior Officer (SO) 3 was the night orderly officer in charge of Wetherby between 8.00pm on 17 April and 7.30am on 18 April. Officer E was the sole officer based on Collingwood and Drake unit. During the time the establishment is in night patrol state staff are required to undertake specific checks throughout the night. (Night patrol state is when all young people are locked in their cell and there are reduced staffing levels.) These include roll checks of all young people, one between 8.30pm and 9.00pm and a second around 6.30am. In addition the night staff must undertake regular general security patrols and checks on young people who have been placed on an ACCT.

142. Prisoner A was on an ACCT two cells away from the young person. Officer E had to check on him hourly. The officer said during interview that there were no issues with either the young person on an ACCT or the young person during the night. He made entries in the young person's ACCT document at least once an hour, including an entry at 6.25am.

143. For the first few hours of his shift Officer E said the wing can be a bit noisy, with young people shouting out to each other or pressing their cell bell to ask for a toilet roll and such like. He said that if he hears young people shouting through their windows when he is walking around the wing then he will tell them to stop. He said they have specific young people who they keep an extra eye on regarding shouting out – either because they have been identified as bullying others or because they are being victimised. The wing calms down between midnight and 1.00am and it is unusual for cell bells to ring after this time.

144. Prisoner B was in a cell about five doors away from the young person and wrote a statement for the police about the night of 17 April. He said he did not know him before he moved onto Drake unit and for the first week the young person was on 'lock down' so they did not speak (he was undergoing the adjudication punishment until 11 April). When he was out and about again the prisoner spoke to him quite a lot and gave him some shower gel. The prisoner told police that the young person never said he was going to hurt himself. In his statement, he said:

> "During his time on the wing I never had any arguments with him, never threatened him and I never saw him being bullied by anyone, in fact he was from Leeds and I wouldn't let it happen".

145. During the evening of 17 April, after lock up, Prisoner B said the young person was talking out of his cell window to quite a lot of people. He said he heard him arguing with another young person (he did not want to give this young person's name). He heard him say to this young person, "I'm going to stab you in the morning", but the prisoner said such arguments take place nearly every night over minor things. He did not hear him say anything about harming himself.

146. Prisoner C had known the young person for about five years and he said they sometimes went around together. In his police statement, he said he was in a nearby cell on Drake unit. He said he spoke to him the first day that he arrived on the wing and that they spoke all the time once he had served his adjudication punishment. The prisoner said "I never threatened to hurt him because I knew him". After lock up on 17 April the prisoner said he was talking out of his window to Prisoner B. He said "It turned into a little argument but we were having a laugh". Then he heard the young person say:

> "Something about my mum, so I started saying stuff back to him about his mum. This continued for a while then he shouted, 'I'm going to stab you in the morning' so I said, 'I've known you for ages and don't want to fight you but if you try and stab me I'll fight you'. The young person kept on saying 'Wait till the morning' and we kept on arguing for about 30 minutes".

147. Prisoner C told the police that he pressed his cell bell to tell an officer what the young person had said and that an officer came to his door, but he could not remember which one. The prisoner said he never heard him say he was going to hang himself. He said he fell asleep about 11.30pm. There are no cell bell records at Wetherby. Officer E did not recall speaking to the prisoner about the young person that night.

148. After the young person had died, Prisoner D in the cell next to the young person told two officers that during the night the young person had asked him and someone else to "string up together". The prisoner said he told him that all would be all right in the morning and to get a good night's sleep. He told the officers that the young person was getting bullied by Prisoners B and C. He recalled that they had threatened to "stab [him] up".

149. Prisoner D also spoke to a chaplain after the young person's death and said that the verbal taunts had been about the young person's father who had died and his mother. The prisoner said he was very upset and crying. He spoke to a prisoner about wanting to kill himself. The prisoner said that around midnight the young person asked him to press his bell for him because he "was going to do it". After this things went quiet. Both prisoners thought he had gone to sleep. He told the investigator that he had received two warnings and if he had a third he would lose his television. If he had pressed his cell bell for no reason, he would have incurred the third warning, and he did not believe that the young person would harm himself, so he did not press the bell.

150. Another prisoner asked to speak to an officer on the morning of 18 April. He told the officer that some lads further down (he would not give their names) had been threatening to make a "shank" and "stab him [the young person] up" late last night. A short time after, he shouted out that he was going to "string up". The prisoner also spoke to a chaplain and said that the young person had not been himself at tea time and said he was being bullied by other young people about his family. At about 11.00pm, he said the young person got very upset and started to shout for an officer but he did not know whether he pressed his cell bell.

151. A prisoner in the Care and Separation Unit (CSU) opposite Drake unit told staff that the young person had shouted out to him that he had made a shank and showed it at the window. He said he was going to stab Prisoner B, who was allegedly threatening him. He also said he heard Prisoner B say he was going to run into the young person's cell in the morning and stab him. He thought all the shouting out had started by the young person calling Prisoner B a "prick".

152. Officer E said the young person did not use his cell bell during the night and there were no incidents on the unit. There is a 'shout out log' on each unit for staff to record if young people shout through their windows. If a young person shouts out more than three times, he becomes subject to additional monitoring and could lose his privileges. There were no entries in the shout out log on the night of 17/18 April. The SO walked around the YOI several times as part of his night duties. He told the investigators that he had not heard any threatening shouts about the young person that evening.

Observations and roll checks overnight

153. The investigation team viewed the Closed Circuit Television (CCTV) footage of Drake unit from 1.00am through to 9.00am on 18 April. The three cameras located on Drake do not give a direct view of the young person's cell but give a clear indication of the movement to and from that part of the landing. A separate internal investigation was conducted (by staff from the NOMS Young People's Team) into the roll checks on 18 April at Wetherby. They identified a discrepancy on the time shown on the CCTV footage and the actual time. Initially they thought this was because some units had adjusted for British

Summer Time and others remained on Greenwich Mean Time. However, further investigation and a time check showed that the delay was different on each wing. The time differential on Drake unit was evidenced to be the time shown on CCTV plus 54 minutes, 52 seconds. The footage showed the following:

Actual Time	Footage shows
1.00am to 2.00am	No checks undertaken
2.10am	Officer E patrols landing near the young person's cell
3.16am	Officer E patrols landing near the young person's cell
4.30am	Officer E patrols landing near the young person's cell
5.45am	Officer E patrols landing near the young person's cell
6.00am to 7.00am	No checks undertaken

154. A roll check should have been carried out around 6.30am. Officer E was asked for a roll count for Collingwood and Drake units by the Communication Department (via the telephone) between 6.00am and 6.15am. He had not done the roll count and so gave the numbers from the recorded roll (in the office). He did not carry out a roll count to confirm the numbers he had given to the Communication Department.

155. The evidence from the CCTV footage shows that Officer E did not conduct the required early morning roll check around 6.30am on 18 April. The CCTV also calls into question the accuracy of the timings of the recorded ACCT checks during the night. It is unlikely that the last recorded ACCT check at 6.25am took place at all. We look at these serious matters further in the issues section of the report.

156. An Acting Senior Officer (A/SO) explained at interview that on weekdays the young people are woken up between 7.15am and 7.30am and, once the roll has been confirmed as correct, the young people are unlocked for fresh air. This is usually around 7.40am though the time may vary by a few minutes dependant on the number of staff on the wing. The young people have half an hour in an open air courtyard then get breakfast around 8.15am.

157. The A/SO recalled that on that Monday morning he came through the gate at 7.05am. He met Officer F (who had walked Officer E back to the co-ordinator's office after his night shift). The two men walked back to the wing together and then the A/SO said he would have put the kettle on to make tea/coffee for them both while Officer F went to check on the young person on the ACCT, two cells away from the young person. The A/SO said:

> "I put Officer F's name in the daily log as having counted each leg because I expected him to do it because he was the first officer on the wing. He then came back from having checked the ACCT lad and made an entry in the ACCT document at 7.15am. I then countersigned that …"

158. Officer F initialled the roll count to say that he was happy with the roll. The A/SO phoned the roll through to the Communication Department at about 7.35am. Once the roll was confirmed from all of the units at Wetherby the young people were allowed out for exercise. During interview, Officer F said,

> "… at approximately 7.30am I counted downstairs [that is, legs 1 and 2 of the unit]. I've spontaneously signed for legs 3 and 4 when I didn't mean to."

159. Officer G said during his PPO interview that the roll as far as he was aware had been confirmed when he got on to Drake Unit that morning. He would have thought this either because the signed roll check paperwork was on the desk or someone was on the telephone reporting the roll into the Communications Department. He thought it was time to wake the young people up. He said he walks around the wing and bangs on the doors to wake the young people up, asks them if they want exercise and check they are getting dressed. He said he went around legs 3 and 4 doing this.

160. The footage of the CCTV shows no activity on Drake until 7.33am when Officer G can be observed walking down legs 3 and 4 and tapping on the observation hatch of each cell. He does not open the observation flaps and look into the cells. Officer F can be observed at the same time looking into the cells on legs 1 and 2 of Drake. Shortly after his roll check, Officer F left the wing on escort duties. No roll check had therefore been carried out on legs 3 and 4 of Drake unit since 8.30pm the evening before.

161. Officer G got back to the office and then heard the roll come in over the radio (meaning that every wing had put in their roll and all young people were accounted for). This also meant that young people could be unlocked to go outside for some fresh air, so the A/SO instructed two officers to start unlocking. He thought the time was around 7.45am.

162. Just before 7.55am, Officer H was unlocking cells on leg 4. On reaching the young person's cell, the officer unlocked the cell door and asked him if he wanted to have morning exercise. He did not answer and the officer noticed that he was kneeling down, facing the cell window with his left arm on the back of the bed with the curtains closed. The officer asked him twice more if he wanted to go on exercise. Still there was no response, and so he went into the cell. He touched his arm, saw that his body was white and there was blood on the floor. He immediately came out of the cell and shouted across the landing for assistance.

Emergency Response

163. Officer G heard Officer H's call for assistance and ran over from the opposite leg of the wing (cell 44) to the young person's cell. On entering the cell, Officer G saw that the young person had a strip of bed sheet around his neck the other end of which was tied to the top of the bed. He then came out of the cell, leant over the railing and shouted as loud as he could, in the direction of the wing office, "Staff, staff". He went back into the cell, got out his anti-ligature knife, put his arm around the young person and cut the sheet. He started to lay him on his back. In doing, so he saw that his skin was cold and his limbs were stiff, in particular his left arm stayed in a fixed position. There was some blood on the floor that had come from his nose. He tried to put his head to his chest to check if he could hear or see any breath sounds. His arm would not move. He removed the ligature (made from bedding) from his neck and remembered seeing an officer on the radio. This officer had heard the calls for assistance. When he got to the cell he used his radio to request urgent assistance from healthcare staff.

164. Very soon after, the A/SO got to the cell. He said he called a code blue over the radio (a code blue is used to indicate that the emergency involves breathing problems or asphyxiation). He asked both officers to leave the cell because he saw the two nurses coming down leg 4 towards the cell. He told officers to lock up the other young people who were on the wing.

165. Two nurses had been walking up the corridor that leads to Collingwood and Drake around 7.45am when they heard the Communication Department radio for any hotel call sign (hotel is the call sign attached to members of staff who work in healthcare). Nurse A replied "send", meaning send through the message. The Communication Department asked whether they needed further assistance, but the two did not yet know what they were being asked to do. The two nurses got to the gates on Collingwood and Drake and at this point, an alarm sounded and the Communication Department radioed "Assistance required on Drake unit". This could have meant any incident on the unit, such as a fight, so the nurses stood back to allow the arriving officers through first. Then Nurse B said she heard someone shout "code blue". The two nurses ran onto the unit, up the stairs and into the young person's cell. Nurse A told the investigators that it was not until he got to the cell that he was told by the A/SO that it was a code blue emergency. Within one minute of the radio call from the officer, the two nurses were at the cell.

166. The nurses found the young person on the floor with his left arm in the air, his back arched and his knees bent. Nurse A found no signs of breathing and said his body was very cold to the touch. Nurse B felt his hand and described it as being bluey grey in colour and obviously stiff. Nurse A requested an emergency ambulance and began cardiopulmonary resuscitation (CPR) assisted by the A/SO. Nurse B went to get the emergency equipment bag from the treatment room (back on the Collingwood – Drake link corridor). The orderly officer arrived. He asked the control room to call an ambulance and took over looking after the unit, while the A/SO continued assisting the nurses with CPR. The orderly officer updated the duty governor over the telephone.

167. Nurse B returned in 46 seconds with the resuscitation equipment and oxygen cylinder. The A/SO held the mask over the young person's mouth while Nurse B squeezed the bag. Nurse A was doing chest compressions. The Deputy Healthcare Manager arrived and took over from the A/SO. She looked at her watch and noted the time as 7.55am. She attached oxygen to the ambu bag and made sure a defibrillator was on its way (a defibrillator monitors the heart rhythm and administers shocks to the heart to restore the normal rhythm if advised to do so.) It is kept in the treatment room on the Collingwood – Drake link corridor. A nurse went to fetch it, taking a minute to do so. Nurse A rotated doing the chest compressions every couple of minutes with the officers who were there (the A/SO and an officer).

168. Nurse A applied the pads of the automatic external defibrillator (AED) to the young person's chest. The AED advised that there was no shockable heart rhythm after each cycle of CPR. CPR was therefore continued. The Deputy Healthcare Manager described trying to get an airway tube inserted into his mouth but said she could not, because it was clenched shut.

169. Staff continued with CPR until the paramedics arrived at the cell at 8.18am. They transferred the young person into the ambulance, maintaining CPR. He was taken to a hospital nine miles away. He was pronounced dead by a hospital doctor at 8.46am.

170. Nurse B said at interview that rigor mortis had clearly set into the young person's body by the time the alarm was raised, which indicated to her that he had died. She went on to say that she and Nurse A had not taken any emergency equipment to the cell as the radio communication had not said it was an emergency. Nurse A said, based on his medical experience, including working in accident and emergency departments, his assessment was that the young person had died. The Deputy Healthcare Manager, a nurse with many years experience, said she felt that they would not be able to bring him back. She said the position of his raised arm and fixed knees meant that rigor mortis had set in.

171. Nurse B said the paramedics felt the young person had died but that their guidelines were to continue CPR until he arrived at hospital and was pronounced dead by a doctor.

172. A debrief for staff involved in the emergency was held at 9.00am. Members of the care team were available to support staff.

173. Following the young person's death other young people were offered support from the chaplaincy, IMB or members of staff. All of the young people at Wetherby who were on ACCT monitoring, or who had recently been taken off monitoring were reviewed to assess whether his death had increased their vulnerability.

Informing the young person's family of his death

174. An officer was appointed to be the YOI's family liaison officer and contacted social services at 8.25am. At 9.11am, he spoke to the young person's social worker's supervisor and told him that he had been found hanging and had been pronounced dead at hospital.

175. At 9.33am, the supervisor gave the officer the address and contact details of the young person's mother and explained the social worker was being called back from a training event and that she would go with them to break the news to his mother. The initial plan was to collect her from their offices (just a few miles from the family home) and for both YOI staff and social services staff to be present.

176. The officer also spoke to the police liaison officer based at Wetherby, who advised staff to wait until the police arrived at Wetherby before going out to see the young person's mother.

177. The officer called the supervisor at 10.50am to say the YOI staff would be going a little later because they were waiting for a police officer to accompany them. At 11.30am, the officer confirmed with the supervisor that arrangements had been made for staff from Wetherby, the police and a social worker to meet at the Social Services offices at Hunslett Hall, Leeds at 12.30pm.

178. A manager at Wetherby and an officer accompanied the prison family liaison officer for the visit. They left Wetherby at 11.45am. When they arrived at the offices, the social worker had decided not to go to meet the young person's mother because she thought she might make the situation worse. This last minute change was frustrating because the family liaison officer and his colleagues had been waiting for the social worker's return from a training event as they were told.

179. Shortly after staff had left Wetherby, the Deputy Governor received a phone call from the young person's mother. She was understandably very distraught and told the Deputy Governor that her brother's step-son, who was also at Wetherby, had telephoned to tell his family that her son had died. Her brother had gone to visit her straight away to inform her of her son's death. The Deputy Governor told her that YOI staff were on their way to see her now and that she was very sorry she had found out in this way.

180. The Deputy Governor said at interview that the information about the family connections between the young person and his cousin had only come to light shortly before she received the phone call from his mother. She explained that the only way to have prevented a young person from contacting family or friends outside the establishment would have been to block all outgoing phone calls.

181. After the call from the young person's mother, the Deputy Governor contacted the supervisor to inform her that the news of the young person's death had

already reached the family. She wanted to know how long it would be before they arrived at his mother's address. She said she was aware that the family liaison officers were following advice and protocol but found it very frustrating that they had not arrived at the mother's address sooner.

182. The police support had not arrived at the social services offices. The prison family liaison officer contacted the police who then made a further arrangement to meet at HMP Leeds in Armley. (This was a short distance from the young person's mother's address).

183. The YOI staff finally arrived at the young person's mother's home at 1.25pm, nearly five hours after he had died. Her brother and other family members were present. The staff offered their condolences for his death. The family liaison officer gave her a mobile telephone number that she could use to contact him and a booklet containing some further information.

184. In the days that followed the family liaison officer maintained contact with the young person's mother and offered support and financial assistance towards the funeral expenses. This included arranging for her to visit Wetherby to meet the Governor, chaplain and staff on Drake unit, to see his cell and collect his belongings.

ISSUES

Clinical issues

185. A clinical reviewer was appointed by NHS Airedale, Bradford and Leeds to carry out a review of the clinical care that the young person received while he was at Wetherby. He concludes that the care that the young person received was equal to that which he could have expected to receive in the community and he makes no recommendations.

186. The PCT carried out a Post Incident Review, which raised concerns about the quality of the first reception health screen. The review had identified that the young person's father had committed suicide the previous year, and this was not recorded on his health screen. In fact, his father's death was through natural causes and this was well documented in his Asset, which was in the records sent to Wetherby. As a result of this review, the deputy healthcare manager said Wetherby has changed the system so that mental health nurses now do reception screening.

187. The clinical reviewer found that:

> "Unfortunately, with existing screening procedures, nothing could have identified the young person as a risk of imminent suicide. His death could not have been prevented or anticipated. Although most suicides in prison happen within the first few weeks of incarceration, and within a few weeks of seeing a GP, no subtle signs were identified and no significant indications were missed."

188. Following the first night vulnerability assessment, an officer referred the young person to CAMHS. As a result, he was assessed by a HCA the next day using a mental health screening tool, and was found to require no further mental health intervention. The assessment was a series of questions about the extent of his substance misuse and how he was feeling. It did not have the benefit of his health records but relied on his own account of his previous engagement with health services.

189. The clinical reviewer describes the mental health screen as "the standard questionnaire as set out by the healthcare department [that] is not significantly different from other prisons' initial health screen". He concludes that the mental health tool was completed accurately by the nurse, given that she relied entirely on the young person's self-reporting. The clinical reviewer comments that any criticism of the mental health assessment is a criticism of the tool and not the nurse.

190. The young person was referred to see CAMHS because the YOT had previously identified that he needed mental health support, but he refused to engage in the community. In order for him to have qualified for further mental health assessment and support as a result of the mental health screen, he would have had to identify his own mental health needs. It is difficult to understand how a young person can make such a complex judgement. While

we agree with the clinical reviewer, that the nurse did not complete the assessment inaccurately, his account of his own needs was very inaccurate. Information from his Asset was not used to inform the assessment, and it does not appear that the assessment allows for the nurse to take into account her own judgement of a young person's mental health needs.

191. The young person had been involved in substance misuse, suffered a significant bereavement and had been referred to CAMHS by YOT staff in the community. He might well have benefited from the additional support of the mental health team but this was not identified by the mental health screening tool.

The Head of Healthcare should ensure that the mental health assessment appropriately identifies young people's mental health needs on arrival.

Person Escort Record (PER)

192. The PER was initiated while the young person was in police custody overnight on 29 March. The risk indicators listed, "previous self harm by banging head on cell wall, spits through cell hatch and previous amphet[amine] use". G4S staff in the court custody suite said that if someone comes in to court with a marker for self harm on the PER then a note is made on a chart in the cells area so that they are checked every 15 minutes. He would have been checked every 15 minutes anyway because of his age (all under 18 year olds are checked every 15 minutes).

193. Some of these checks were recorded as having been done by two PCOs. However, there are several checks that are recorded as having been done, but with no PCO's name alongside to indicate who actually carried out that particular check. These are the checks logged at 11.15am, 11.30am, 11.45am, 12pm, 12.15pm, 12.30pm, 12.45pm, 1.15pm, 1.30pm and 1.45pm (the young person left Court on his way to Wetherby at 1.57pm). It is poor practice that no PCO's name is recorded next to these checks. Unlike the checks with an actual PCO's name alongside the entry, they are at exactly 15 minute intervals.

The Youth Justice Board should seek assurances from the manager of the custody suite at Leeds Crown Court that custody officers who conduct checks of young people detained in court cells record both the time of the check and the name of the member of staff who carried out that check on the PER.

194. The PCO could not remember the entry on the young person's PER about banging his head in police custody but told the PPO he would have spoken to him about it. The PCO said that if he had any concerns as a result of that conversation, he would have increased his observation level to constant watch and told other members of staff about his risk.

195. The Bail Information Officer at court who completed the young person's Placement Information Form (PIF) and post court report (PCR) is part of the YOT team and is therefore not based in the court custody suite. He did not see the PER and was unaware of the reference to self-harm, about him banging his head in police custody. He told the investigator that if he had seen the PER he would have known that he was unhappy. He said he would have considered referring him to Keppel Unit had he seen the self-harm risk at the time of his remand and he would have spoken to him about what had happened in police custody.

196. The youth team at Court now ask G4S staff in the court custody suite if there is significant information or indicators on the PER form. We are pleased to note that this improvement on information exchange has already been implemented, but it is a matter of concern that the PER, a form intended to communicate risk to all agencies who come into contact with a young person, was not available to the youth justice workers at court.

The Youth Justice Board should ensure that youth justice workers review PERs to inform their assessment of a young person's risk factors.

197. When the young person arrived at Wetherby, an officer signed the PER at 2.45pm to acknowledge taking custody of him from G4S escorting staff. She said she might have thought the information on the PER about him banging his head was historical and not current. She said if it had happened the previous night, she would have expected him to have come in with a suicide and self-harm warning form from G4S.

198. In any event, Wetherby staff would have made their own assessment as to whether the young person was at risk of self-harm or suicide when he arrived. No one that the investigation team spoke to felt that he was at risk on his first night in custody. In the context of his banging his head, there was probably insufficient indication for an ACCT document to be opened, but someone should have talked to him about this and recorded his explanation and response. If there are clear markers of self-harm on a young person's PER, there should be a documented decision not to start self-harm monitoring procedures:

The Governor should ensure that staff consider all self-harm markers on PERs and record subsequent decisions about self-harm monitoring.

Custodial placement

199. A Bail Information Officer at court explained that if a 17 year old is remanded into custody, current legislation means the young person must go to YOI accommodation. If the Bail Information Officer is concerned that a 17 year old is very vulnerable, they can recommend that the young person is sent to the Keppel Unit at Wetherby, which takes particularly vulnerable young people. Referrals to the Keppel Unit by Leeds Court staff are not made often and there was only one in the period April to July 2011

200. The Head of the YJB Placement Service confirmed that due to the young person's age, the only custodial remand option was to a YOI. The closest establishment was Wetherby YOI. The Youth Justice Board website indicates that Wetherby would be the usual placement for a young person appearing before Leeds court.

201. We do not find it surprising that the young person was remanded into custody on 30 March 2011. He had already been given several chances to complete his ISSP Order by the Court, despite breaching it on three or four occasions. He himself did not seem to be surprised by the decision. Because he was 17 years old, he could only have gone to a YOI. His allocation to Wetherby was reasonable and appropriate.

YJB and Leeds Court placement procedures

202. There was a pilot placement system operating at Leeds court at the time of the young person's remand into custody (it is still considered a pilot at the time of issuing this draft report). The pilot replaced Placement Alert Forms with Placement Information Forms (PIFs). The Head of the YJB Placement Service said that when they reviewed the papers at the YJB, the PIF had not been fully completed and contained no detail about risk. The first section of his PIF was completed by the Bail Information Officer, but the sections covering the more detailed information about him and his background were not. Therefore the Placement Service made their decision based on the information contained in the Asset.

203. When the investigator visited Leeds YOS, a copy of the completed PIF was provided to her. This had been attached to the young person's YOS file, but not passed to the Placement Service on 30 March. The completed PIF incorrectly suggested that it was not his first time in custody. As this was not sent to the Placement Service, this mistake did not affect his allocation placement, but it has been the subject of an internal investigation.

204. The Bail Information Officer explained that he had partially completed the PIF before the young person's court appearance and sent it to the Placement Service in preparation for the likely remand. He said he updated the PIF after his court appearance, when he completed the post court report. There is evidence that the post court report was sent to the Placement Service, but it was not accompanied by the updated PIF. He suggested that if he was busy, another member of the team might have sent the paperwork on his behalf. He said that the secure email exchange between the court team and the Placement Service had not always worked efficiently and there could have been a technical difficulty. As Leeds YOS court staff were piloting a new approach to placement information exchange, the system was not sufficiently developed to provide the investigator with evidence of who sent the post court report. However, the responsibility for ensuring that the Placement Service receive all of the information required to place a young person must remain with the person completing the form. The Bail Information Officer should have

taken personal responsibility for sending the forms he had completed to the Placement Service.

205. There is no e-mail evidence that the PIF was sent through to the YJB's Placement Service from Leeds Court. Had the YJB received it, there would be an auditable trail. The Placement Service should have chased up the missing sections on the PIF to ensure a fully informed decision could be made about the young person's placement. We accept that in his case there is nothing to indicate that this led to an incorrect allocation to Wetherby which we are satisfied was appropriate.

206. Since the investigator fed back her concerns about the PIF system to the YJB, the Board has assured us that the information exchange between court staff and their Placement Service is now more accountable. The YJB reported that it has also reinforced that a young person should not be placed without completed placement information, unless in exceptional circumstances. Nevertheless, we make the following recommendation:

The Youth Justice Board should ensure the Placement Service has all relevant documentation before allocating a young person.

First Night Centre

207. There were some inconsistencies in the completion of the vulnerability assessment and CSRA by Officer B. She used information in the Asset, Placement Confirmation Form, PER, pre-sentence report and post court report to complete her paperwork.

208. The officer said,

> "You can get an Asset file which comes from the Youth Justice Board … [with] up to 40 pages to read and you can be really under pressure… to reassess the young person's history, his family history, who he lives with, is he a looked after child, what his crime is, is he on remand, has he got any issues, is he violent, there are all sorts of things to read".

209. One officer may be responsible for completing assessments for no more than four new young people in one evening.

210. Despite evidence on the Asset, Placement Confirmation Form and from the young person himself during their discussions about his history of being threatened by various people and avoiding parts of Leeds as a result, Officer B considered that he had no history of victimisation or being bullied. This did not fit with the information available.

211. The officer considered that the homophobic element of the current charge, the previous derogatory comments made by the young person towards people from another country (noted in the pre-sentence report for the burglary) and describing himself as a person who gets angry or frustrated easily led to a high CSRA. This assessment is not compatible with section three of the

vulnerability assessment where all the questions to ascertain “Does the young person present a potential risk to others” were all answered “No” by her.

The Governor should ensure that assessments completed in the first night centre accurately reflect the information available.

Remand management

212. Remand management for young people under 18 involves two distinct functions, a remand review and a remand planning meeting.

213. A remand review should be undertaken within five days of initial remand to determine whether a bail supervision and support programme or other relevant placement could be offered in support of a bail application at the next court appearance.

214. Officer C introduced herself to the young person on 31 March on Benbow unit. She said the purpose of that meeting was to see how he was settling in and his initial feelings about being in custody.

215. The first remand planning meeting should take place within 10 working days of the initial remand to custody, to consider the needs of the young person. Using information sources, a remand plan should set out the programme of work offered by the secure establishment and the YOS during the period of remand. The secure estate should provide programmes to address young people's needs and, while not being able to address offence-specific issues, can address some issues related to the circumstances of the alleged offence. This meeting must be attended by the home YOS worker, secure estate staff, parents/carers, child or young person and other relevant parties.

216. The first remand planning meeting was held on 5 April, well within the timescale. The young person’s social worker and community YOS officer both attended the meeting at Wetherby. He was given some appropriate initial targets at that meeting which included completing the induction course, attending education and engaging with substance misuse targets. Ideally, his personal officer would also have attended this meeting. However, Officer C had some contact with him as she normally assisted Drake unit staff at mealtimes.

217. Officer C ensured that all of the requirements set out by the YJB, in terms of timescales and the facilitation of meetings were met. She was also the only officer who noticed a change in the young person’s behaviour when he moved from Benbow Unit to Drake Unit. She was able to describe meaningful conversations she had with him, unlike any of the officers on Drake Unit. This is the first investigation into the death of a child or young person where we have found the remand management arrangements operating effectively. His case worker took on the role of personal officer informally, because the personal officer scheme was not working well at Wetherby.

The role of personal officers and residential support officers (RSOs)

218. During their inspection of Wetherby in 2010, the Inspectorate commented:

> "RSOs still did not often attend training planning meetings for young people they were responsible for … This led to some breakdown in communicating the targets set for young people to staff on the residential units who were closely involved in helping them meet those targets".

219. A previous recommendation that RSOs and caseworkers should meet regularly to discuss and review the progress of the young people they were jointly responsible for was not achieved. The Inspectorate concluded:

> "there was little evidence of RSOs and caseworkers meeting to discuss the needs and progress of the young people... Use was being made of P-NOMIS to record and share information, but this did not provide a substitute for discussion."

220. Personal officers and RSOs are not the same thing. A personal officer is allocated about six cells on Drake unit and they become responsible for the young people in those cells. The officer identifies him or herself to the young person so that they know who they are. If the young person is new in custody, the officer can explain how things work, how the regime runs, ask if he has any problems, any family issues – whether he needs to make telephone calls. The aim is for the officer to build up an effective relationship with the young person. An officer said that once you know who your young person is, you find out a little bit about them – what they have done, how long they are going to be in custody for, where they are from, their age etc. If any problems have arisen they can be discussed and sorted out.

221. The RSOs have more of an administrative role for the whole of a unit rather than being allocated to a set number of young people. For example, if a young person wanted a book from the library or if he needs to see a nurse, he puts in an application form, which is processed by the RSO. The RSO opens the mailbox and sorts out the applications for that day, allocating them to the right department. The RSO also does a weekly file check. So on a Monday the RSO might be required to write up a note (in the electronic case notes) about how young people in cells one to 18 are progressing. The RSO does not meet the young person before making the entry, but reviews their case notes from the previous week.

222. There is evidence of RSOs completing write ups in the young person's case notes – an officer made an entry in his case notes on 8 April and said he had not come to the attention of staff that week and seemed to be settled on Drake unit. He hoped this level of behaviour would be maintained. On 14 April, his personal officer recorded in his case notes that there had been no issues over the week. However, these are observational notes which are not indicative of any interaction with him.

223. The personal officer explained to the investigator that he had introduced himself to the young person, and particularly remembered him because he had known one of his brothers. However, there is no corresponding entry in his case notes to demonstrate this. The officer said that he did not come to him for any particular support, although he said he remembered having a few conversations with him. He did not give the officer any cause for concern, although he recalled him having an argument with another young person on Drake unit. He said that he had not considered this to be bullying, just a misunderstanding and did not consider him at risk from others or to himself.

224. Sadly, this office has investigated four deaths of children or young people in custody, although this is the first death at Wetherby. Personal officer schemes have frequently been the subject of criticism. A personal officer should be a stable source of support for a young person, get to know his personal circumstances and actively help him with all aspects of life in the YOI, rather than waiting for the young person to contact him.

225. The officer did not contribute to the young person's remand planning, and neither did he make regular entries in his case file, as required by the personal officer policy. (He made one case entry, when he was performing RSO duties.) At Wetherby, the role of the RSO seems to confuse the responsibility of the personal officer. A weekly review of case notes and a corresponding entry should not replace meaningful interaction with a designated officer and regular entries about a young person's welfare.

The Governor should clarify the role of the personal officer and ensure that they introduce themselves to young people for whom they are responsible, actively get to know and support them and record regular interactions in case notes.

3 April and subsequent adjudication

226. On Sunday 3 April, Officer D said that she unlocked the young person for tea, but he must have closed the door in order to use the toilet. He was unable to open it again from the inside, which meant he did not go down for his meal with the other young people. His behaviour continued to deteriorate – he flooded his cell and kicked the door (so that his trainers were removed). His television was also taken away so that he could not smash it up.

227. Our investigators asked a governor what her expectations would be about recording the young person's behaviour over the tea time period. She replied, "I'd expect to see it in the Observation Book; I'd expect to see something on his NOMIS notes". She went on to say that if someone had done more extreme things such as urinating in their cell or smashing things that she would have expected the orderly officer to have recorded something in the management book that is kept in the coordinator's office.

228. A note was made about part of the incident on the young person's electronic case notes. Officer D wrote:

"He has been placed on a Governor's this evening for using foul, abusive and threatening language towards myself on B wing while putting the trainees away after tea".

229. SO 1 recorded the following in Benbow unit's observation book:

"Very aggressive towards Officer D at tea time, he has a history of being aggressive and he has been placed on a governor's report for this, he may find himself on level red if this type of behaviour continues as it is far from acceptable and he has already been warned".

230. This incident was not adequately investigated or documented. The case notes record only aggressive behaviour and foul language towards Officer D and the fact that the young person was charged with an offence against YOI rules. It does not give a clear description of what led to the incident nor what happened afterwards in terms of him continuing to be extremely angry and flooding his cell. The case notes do not show that the orderly officer was involved, and neither does the entry made by the SO in Benbow's observation book. His move onto Drake unit the next day because of this incident should also have been recorded in his electronic case notes.

The Governor should ensure that staff and managers record incidents in appropriate detail in young people's case notes and unit observation books.

231. As the IMB noted, the number of assaults involving young people had increased over the previous year. YOI staff told the investigation team that there had been a number of incidents in the preceding months where staff had been seriously injured as a result of assaults by young people. There was, therefore, a focus on staff safety but no one spoke to the young person about why he reacted in such a way. No consideration was given to referring him for a further mental health assessment. The orderly officer said that he did not consider him to have a mental health problem and Officer D said that he was just upset. However, Officer D, a very experienced officer, said that she had rarely observed such aggressive behaviour in a young person. Such extreme behaviour should have prompted consideration at least of involving the mental health team or some further consideration of the underlying cause.

232. More thought should have been given to providing the young person with ongoing support following this outburst, rather than simply moving him to another unit, and punishing him. There appeared to be insufficient recognition that in effect he was a disturbed and upset child. There is also a lack of clarity about how he came to be locked in his cell and could not get out to collect his meal. Officer D said the door had been unlocked and he himself had locked himself in. The SO said that he told him that staff had forgotten to unlock him. He believed that he would be victimised by staff at Wetherby because of the reputation of one of his brothers who had been at Wetherby previously and it appears that this incident fuelled those feelings.

The Governor should ensure staff treat disruptive behaviour as an indicator of potential vulnerability and that staff understand the need to take a child-centred approach when responding to such behaviour.

233. The young person's adjudication was chaired by a governor on 5 April. As a result of the adjudication, his television was removed for seven days and he had no association. At the time of the incident, his first time in custody, he had been at the YOI for only five days.

234. In his statement written for the adjudication, the young person admitted that he should not have been threatening towards staff and explained why he was upset. He also claimed that Officer D had made abusive comments to him about his mother. These allegations were never investigated by the governor, as she was required to do and she did not question Officer D to establish whether if true, this could have amounted to a defence to the charge or at least substantial mitigation. The circumstances which led to him being locked in his cell were not established. The governor was not aware of the subsequent deterioration in his behaviour because it was not documented in any of his records. She found him guilty of threatening a member of staff. She said that she gave him the lowest level of punishment in Wetherby's adjudication tariff book (which sets out suggested punishments for every breach of YOI rules). The investigation team reviewed the tariff book and confirmed that his punishment was at the lower end of the suggested scale which indicated that adjudicators could consider punishments of up to double the number of days' loss of association and television that he received. We do not consider that the circumstances of the charge against him were sufficiently investigated, and when the finding of guilt was reached insufficient consideration was given to mitigating circumstances. We consider the punishment was too severe and led to a newly arrived child being locked in his cell at all times for seven days, without a television or radio, and isolated from other young people unless he had an induction session to attend.

235. The young person's adjudication took place very soon after his arrival at Wetherby. The governor did not sufficiently investigate the incident, and relied solely on a child's admission of guilt. She did not give adequate consideration to his explanation for his behaviour (that he could not speak to his mother on Mothers' Day) and she did not question Officer D about her actions that evening, or otherwise investigate the young person's allegations: how he had come to be locked in his cell that evening was not established.

The Governor should ensure that adjudications are investigated thoroughly and conducted fairly, and that full account is taken of mitigating circumstances.

Bullying and shouting out of cells

236. Prison Service Instruction (PSI) 28/2009 on Violence Reduction says, "There are well documented links between violence, bullying, self harm and suicide". Violence reduction is an umbrella strategy that encompasses bullying and encourages all establishments to link their violence reduction strategy with suicide prevention and self harm management.

237. Each year the Inspectorate publishes a document of the reported experiences of 15 to 18 year-olds held in YOIs. These reports provide an opportunity to compare young people's perceptions across establishments, and over time. The most recent published survey at Wetherby was in June 2010. Just over 50 per cent of young people there at the time completed the survey. 75 per cent of those held at Wetherby were sentenced. For 50% of young people it was their first time in custody. The figures in brackets are the 'young person's comparator' (average across all similar establishments). Responses from young people at Wetherby suggested that in general they did not feel as safe as young people at other YOIs.

238. Specifically in relation to safety the young people were asked,

> -Have you ever felt unsafe in this prison? 26% said yes (29%)
>
> -If you did tell a member of staff that you were being victimised do you think it would be taken seriously? 30% said yes (42%)
>
> - Is shouting through the windows a problem here? 57% said yes (40%)
>
> - Have staff checked on you personally in the last week to see how you are getting on? 28% said yes (44%)

239. The A/SO was not aware that the young person had any problems with any other young people. He said he was expecting him to be like one of his brothers, who had previously been on the wing and difficult to manage, but in fact he was not like him at all. Officer F said he knew the young person's brother from when he was in Wetherby and used this as a way of trying to "bond" with him. He talked to him about his brother and said he would smile and laugh about things. The officer said he had seemed to get on with a few of the other lads on the same leg of the wing. He did not think he had any problems with anyone on the unit.

240. The Child Protection Co-ordinator wrote a report into the serious incident of self harm by the young person's cousin. She wrote,

> "Shouting taunts and threats to [the young person's cousin] overnight on April 7th was clearly connected to his actions, although not the primary reason. Shouting out is monitored and may lead to disciplinary measures. Night patrol staff are expected to challenge unacceptable shout outs, but as there is only one member of staff patrolling two units overnight, it is impossible to hear everything that is happening. Increasing the presence

at night would not necessarily prevent verbal threats and bullying. Current procedures can only contain this unacceptable behaviour to a certain extent".

241. A young person who our investigators spoke to on Benbow said that shouting out at night was a problem and that it often stopped him sleeping. The young person said it depended who was at Wetherby at the time but, when we spoke to him in June 2011, he said there was a lot of shouting out of cell windows.

242. A SO said the "Shout Out" policy had been re-introduced a few months earlier because a lot of bullying had been evident from young people abusing each other out of their windows at night. He said the main problem was positively identifying who was responsible as young people would always deny it was them.

243. A re-launched "Shout Out" policy had been implemented at Wetherby the month before the young person's death. The policy stated that 'shout outs' can lead to many negative issues such as fights, bullying, self harm, abuse to staff, abuse to prisoners, abuse to visitors. The revised policy set out clear guidance for YOI staff to challenge shouting out of the window and record all such challenges in a log.

244. An officer who works on Drake unit said shouting out is discouraged. There is a shout out log on each wing, which was reviewed by the investigation team. There were very few entries in Drake unit's shout out log in the month before the young person's death. He was not mentioned in the log, and neither were the two young people who were alleged to have shouted at him. Officers told the investigator that names are rarely entered as in practice it is difficult to determine who is shouting out of the cell. At the time of the investigation, no adjudications had been held as a result of shouting out of windows, although the policy envisaged this would happen.

245. The officer said the idea was to "try and catch everybody that's saying things detrimental and challenge it straightaway". He said that can be really difficult because if the young people are locked in their cells you cannot always identify where the shouting is coming from because it can be an echo. Even from outside, you cannot see who is shouting if the young people stand back from the windows. So, unless you recognise that particular voice or accent, you often cannot identify the person.

246. A SO said during interview that the policy on shouting out had been revised in the previous few months and that generally speaking it had been successful. He said "people have said that they'd heard a big reduction in the amount of shouting out of an evening".

247. Officer E told the investigation team that he had not heard anything of concern that evening. He was working on Drake and Collingwood unit that night and spent some time in the staff office between the two wings. The young person was at the end of Drake unit, furthest from the staff office. The CCTV showed

that the officer patrolled the landing several times overnight, but not at the time other young people allege that he was threatened.

248. A SO was the orderly officer and therefore the only member of staff patrolling outside the wings overnight on the night leading up to the incident. He could recall that there was a lot of loud shouting out of windows that night. However, he did not remember hearing anything specifically being called out to him.

249. The SO facilitated a night visit for the investigation team. They observed young people shouting through their cell windows, but during this visit no shouts were threatening or abusive. Still, the shouts remained unchallenged, contrary to the shouting out policy implemented just a few months before. In the subsequent review of the shout out log, there was no reference made to the shouting heard by the investigation team.

250. The Inspectorate recognised that Wetherby's policies to tackle bullying were good, but identified that staff had not been adequately trained to implement those policies. Similarly, we found in this investigation that the written policy to tackle young people shouting out of windows was sound but there was little evidence in practice that it was implemented effectively, and more could have been done to challenge those responsible by more assiduous supervision.

The Governor should ensure that there is more effective supervision and challenge of young people who shout out threats to each other from the windows.

Was the young person trying to move to the Keppel unit?

251. Prisoner D in the cell next to the young person told the investigator that the young person had asked him to "string up" with him on the evening before his death so that they could go to the Keppel Unit. The prisoner did not believe that he was serious and did not alert staff.

252. Keppel unit is a dedicated enhanced supervision unit designed and commissioned to look after the most vulnerable young people in custody with behavioural, anti-social and self-harming histories. The main catchment area for Keppel Unit is the North East, North West, West Midlands, and Yorkshire and the Humber. Young men from outside the catchment area who meet the eligibility criteria are also considered as it is regarded as a resource for the whole of England and Wales.

253. Suitability for Keppel is determined by the fact that the young person is struggling to cope or unlikely to cope with the standard regime in a YOI. An assessment must be completed, evidencing that the young person is not or would not engage with the regime.

The characteristics of a young person who could struggle to cope may include:	**The list of observed behaviours which may indicate a young person will not cope well with a**

	standard YOI regime are:
Characteristics - Attention deficit hyperactivity disorder - Autism spectrum disorder - Conduct disorder - Difficulties with communication / social interaction - Dysfunctional family background - Emotional immaturity - History of multiple care placements - Learning or cognitive difficulties - Communications, speech or language difficulties - Recent trauma (eg loss of family member) - Physical disability - Small build/ physical immaturity	Observed behaviours - Requesting not to attend education - Non-participation in education due to an inability to cope with group interaction - Inability to participate in association due to being unable to cope with group interaction - Requesting not to leave cell due to inability to cope with group situation - Repeated loss of association - Requesting not to participate in other aspects of the regime - Periods of time in segregation for their own protection - Accommodation on healthcare requested for non-health related reasons - Self-harm or suicide attempts

254. Although it could be said that the young person had one or two of the characteristics that might make it difficult for someone to cope in a YOI, we do not consider that he showed many (if any) of the observed behaviours. Officer G on Drake unit described him as follows;

> "Seemed quite happy, content young lad. He wasn't overly, he wasn't in your face as a lot of the trainees can be, thinking they'll big up their reputation by squaring up to staff but he wasn't hiding in his cell at all… he was out associating with the other lads, I believe he was out on the exercise yard, so like I said, there's nothing that would have stood him apart from any other trainee".

255. Another officer described how the young person "smiled and laughed" when they talked about his brother. The entries in Benbow and Drake's observation books and his electronic case notes do not indicate a young man who was struggling to associate with other young people. He did not tell staff that he was finding it hard to cope.

256. The young person's cousin harmed himself ten days before the young person died. He was saved by the actions of an officer in lifting him up and summoning help immediately. When he returned to Wetherby from hospital, it was decided to move him to the Keppel unit. In the review meetings afterwards, the young person's cousin told staff that he felt unsafe on Frobisher unit and wanted to move to Benbow unit, and did not suggest that he wanted to go to Keppel.

257. Not all young people who self-harm at Wetherby are moved onto Keppel. They have to be assessed as suitable, and the assessment must be approved by the YJB Placement Service. The young person met some of the criteria, but the criteria are broad. Only the Bail Information Officer who completed his post court report said that he might have considered him for Keppel had he known about him banging his head against a cell wall. No one else considered him to be suitable for placement on the Keppel unit. There are, therefore, no strong grounds to consider that he should have been allocated to the Keppel unit.

Early Morning Checks

258. The CCTV evidence obtained by our investigation team clearly shows there were failings at Wetherby in regard to the early morning roll checks on 18 April. When the investigation team began the investigation at Wetherby on 20 April, they were informed by the Deputy Governor that she had already commissioned an internal investigation into the issue.

259. The internal investigation was carried out by the National Offender Management Service, Young People's Team. The Governor has subsequently acted on the recommendations of that investigation.

260. That investigation found:

> "Officer E was under the mistaken impression that the 6.30am roll check should have been carried out for 6am. He was contacted by the communications department at about 6.15am or 6.20am asking for the numbers of young people. He provided… the numbers from the count the night before".
>
> The officer said as part of that investigation, "When I realised I hadn't done it I know I should have gone and done it… it just slipped my mind".

261. It is unknown how long the young person may have been hanging in his cell with a ligature around his neck. When he was found at 7.55am, all staff reported that rigor mortis had set in. Rigor mortis sets in approximately three hours after death, although this can vary depending on the individual and the temperature of the environment. It is likely that he was already dead at the time the roll check should have taken place. However, if Officer E had conducted the roll check at 6.30am there would have been an earlier emergency response.

262. While we accept it is unlikely that the outcome would have been any different for the young person, it was a serious failure and lapse of care by Officer E not to conduct a roll check at 6.30am as he was required to do. We are not persuaded that such an important check could have "slipped his mind" or that he had intended to carry out a roll check at all that morning.

263. Although an ACCT was signed to indicate that a young person assessed as at risk of self-harm was checked at 6.25am near the young person's cell, CCTV showed that there was no officer near that cell at that time. Not only is this a serious lapse in the care of a young person assessed to be at risk, it is also deliberately misleading record keeping.

264. Officer G did not look into each cell around 7.30am (as CCTV footage confirmed) - he only tapped the observation flap. He explained this as being a way of waking up the young people and that he would do this if the roll count was already in. The internal investigation found his explanation for this 'wake up round' to be confusing, particularly as to when it would happen and how he would know that a roll check had already been done. Other officers who were interviewed as part of that investigation said there is neither the time nor the resource for doing a separate 'wake up round' and that they wake up young people at the same time as conducting the roll check. The entries made by the A/SO detailing Officer F's name next to each leg of the unit may have led Officer G to believe a roll check had been completed. However, the internal investigation felt it would be fair to assume the young people would be awake already, if a roll check had been done. It is unclear exactly why things happened the way they did that morning, but whatever the reason, 7.30am was yet another missed opportunity when the young person should have been found.

265. During interview, Officer F said:

> "… at approximately 7.30am I counted downstairs [that is, legs 1 and 2 of the unit]. I've spontaneously signed for legs 3 and 4 when I didn't mean to."

266. He thought that another officer was counting upstairs (Officer G). The A/SO said:

> "I noticed Officer F had actually initialled the roll count to say that he was happy with the roll, so I then probably around 7.30/7.35-ish would have rang the actual roll on D wing as being correct…".

267. The footage of the CCTV shows no activity on Drake unit until 7.33am when Officer G can be observed walking down legs 3 and 4 and tapping on the observation hatch of each cell. He does not open the flap and look into the cell. Officer F can be observed at the same time looking into the cells on legs 1 and 2 of Drake unit.

268. The A/SO countersigned the roll count check based on the assumption that Officer F had correctly completed the full roll check for Drake unit, when in fact he had only counted legs 1 and 2. The officer assumed Officer G had completed the roll check on legs 3 and 4. He should not have signed for legs 3 and 4 without at least asking the officer whether he had counted and checked them. There was no dialogue between the two officers to make clear who had done what that morning.

269. The internal investigation said:

> "The A/SO did not ensure that his staff were designated specifically to carrying out the roll check, with an assumption that Officer F would do the roll check on legs 3 and 4 when checking a young person on an ACCT. The investigation team believe this contributed to the confusion as to which members of staff counted which legs and, as a result, no roll check was carried out on legs 3 and 4".

270. The internal investigation made 16 recommendations particularly that the Governor should ensure that staff carry out roll checks when required and reinforced the role of the senior officer in managing accurate roll checks. The investigation recommended an improvement in the use and accuracy of CCTV cameras. We endorse these recommendations:

The Governor should ensure that the recommendations from the internal investigation into the supervision of Drake unit on 18 April are fully implemented and regularly checked.

Emergency Response

271. The local guidance to staff at Wetherby details what action to take if they find a young person hanging in their cell. It states:

- "Summon help and request emergency medical assistance and first aid equipment.
- Enter the cell as soon as possible, following the local strategy for doing so.
- Support the body to reduce constriction. Staff should be aware of the potential for injury to themselves for such a process, and should consider utilising any alternative methods of support, such as items of cell furniture.
- Cut the person down using paramedic shears or 'The Big Fish' (ligature knife). Then cut and then release the ligature immediately, preserving the knot if possible.
- Place the trainee on his back on a flat, solid surface.
- Check for signs of life, ie. breathing, chest movement/any movement of the body, pulse. If no signs are present, open airway and attempt resuscitation, using a face mask with a non-return valve, unless rigor mortis of the limbs has clearly set in. (Rigor mortis is a condition of extreme stiffness affecting the arms and legs after death, making it virtually impossible to bend the wrists, elbows or knees.) After application of the face mask, you must check that the jaw is held in an upright position to ensure that there is a patent airway from mouth/nose to throat to enable oxygen to reach the lungs."

272. Officer H was the first officer to discover the emergency. He had a radio with him, but came out of the young person's cell and shouted for assistance. Officer G arrived within a few moments. When another officer arrived he used his radio to summon assistance from healthcare staff. He did not use the 'code blue' emergency response code. The purpose of an emergency code system is to alert staff to the nature of the incident, so that they can bring

appropriate equipment to the scene. This meant that the two nurses were not aware of the nature of the situation they were responding to. The A/SO said he called a 'code blue' over the radio when he got to the cell. Nurse B said she heard someone shout that it was a 'code blue' but Nurse A said he did not know until he got to the cell. Because of the confusion about the codes, emergency equipment was not immediately taken to the cell.

273. A defibrillator was not brought to the young person's cell until the Deputy Head of Healthcare arrived and requested one. It is not clear why this was not brought when Nurse B had gone to collect other emergency equipment. The emergency response is not a key factor in this case because it is evident that the young person had been dead for some time and it would not have been possible to resuscitate him. However in many emergency situations the speed of getting emergency equipment including a defibrillator to the scene of an incident is crucial for a successful resuscitation.

The Governor should ensure that all staff understand and use emergency codes accurately, so that a defibrillator and other emergency equipment are taken swiftly to the scene whenever there is a life-threatening incident.

274. When the young person was discovered, Officer G, assisted by Officer H, supported his body, cut and then removed the ligature from around his neck and laid him on his back. At this point, both nurses arrived; Nurse B ran to get the emergency equipment and Nurse A requested an emergency ambulance. Both nurses acted swiftly and professionally in conducting and continuing with CPR until the paramedics arrived and took over the young person's care.

275. The clinical reviewer describes the emergency response on 18 April as "correct" and that there was little delay in getting the resuscitation equipment which was in good working order. NHS Airedale, Bradford and Leeds Post Incident review considered whether it was appropriate to attempt to resuscitate someone when rigor mortis has set in. The review suggested that there was a difference between the resuscitation of a child and an adult, echoing the thoughts of the Deputy Head of Healthcare. She said that she did not feel that staff could "give up" on the possibility that he could be resuscitated given his young age, despite clear signs that he had been dead for some time.

276. Prison Service Order (PSO) 2700 was in force in April 2011, and set out the requirements for the management of suicide or self-harm in prisons and YOIs. The PSO instructed that where rigor mortis had set in, resuscitation should not be attempted. The Post Incident review identified the difficulty that nurses had making the decision to pronounce death and stop resuscitation, despite the presence of rigor mortis, and suggested a review of procedures where they apply to the life of a child. The PSO is clear that resuscitation should not have been started. The staff involved did not follow this guidance because of the young person's age.

277. The clinical reviewer concludes that guidance to nursing staff is not sufficiently clear in these circumstances. He says that nurses should feel supported when making the decision about resuscitation, but in this case, they were in doubt. The clinical reviewer recommends that staff be informed of the outcome of the NHS review, and we make the following recommendation:

The Governor should ensure that YOI staff and NHS Airedale, Bradford and Leeds staff work to a common protocol that resuscitation should not be attempted where there are clear signs of rigor mortis.

Family Liaison

278. PSO 2710 'Follow up to deaths in custody' details the actions an establishment must take following a death in custody. PSO 2710 states "For juveniles, establishments must notify:

- The appropriate Youth Offending Team
- The Youth Justice Board
- Local and home social services (If there is a Care Order in place, parental responsibility may be shared by the parent and local authority).

"Governors/Directors of contracted prisons must have in place a local protocol explaining what support will be offered to a family bereaved by a death in custody. They must also:

- Arrange notification to the next of kin and any other person reasonably nominated by the prisoner as soon as possible in a suitable manner giving an accurate factual account of what has happened.
- Appoint a senior member of staff or a dedicated family liaison officer (and a deputy to cover absences) as a named point of contact for the family, to make and maintain contact with the family, beyond the inquest if necessary, and to provide information and practical support."

279. A Family Liaison Log was correctly opened by the prison's family liaison officer in which he detailed all the contacts he had with social services and the young person's mother. He did not, however, record any of his contact with the police and the advice that they gave. This meant that there was no record made at the time of the sequence of events which ultimately contributed to the delay in breaking the news to her.

280. PSO 2710 required that "Every contact with the family and their representatives should be recorded" to provide "an accurate and transparent record" which "is needed in case of any dispute later about what has been said". There was no record made of the telephone call between the young person's mother and the Deputy Governor. We appreciate the difficulty in handling such a distressing call, but a record should still have been made.

281. The young person's mother said she could not understand why it took so long for YOI staff to break the news of her son's death. His cousin contacted his father and told him of his death. Regrettably, this meant that she did not learn of his death first hand from YOI staff. Our investigation shows that the local death in custody contingency plan was correctly instigated by staff at Wetherby and family liaison officers were appointed in a timely manner. As he was the subject to a full Care Order, the family liaison officer followed the guidance and contacted social services and received advice from them about breaking the news to his mother.

282. While we fully accept that there was the requirement to contact social services the considerable delay in breaking the news to the young person's mother should not have happened. This occurred as a direct result of the protracted liaison between social services, the police and Wetherby staff. The Deputy Governor was concerned about the delay but in our opinion, should have used her authority to address the situation sooner and to get staff to the mother's address more quickly.

283. YOI staff were unaware that the young person was related to another young person at Wetherby. His cousin contacted his step-father, his uncle, by telephone, when he found out that the young person had died, who in turn told his sister before YOI staff arrived. This underlines the need for families to be contacted quickly.

The Governor should ensure that in an emergency situation there is a properly coordinated and recorded approach to contacting families to avoid undue delay.

284. In the days that followed the young person's death, Wetherby appropriately followed the guidance in PSO 2710 by maintaining contact with his mother, offering support, facilitating a visit to the establishment and offering financial assistance towards funeral expenses. When the investigator and one of the Ombudsman's family liaison officers met his mother, she said that she felt well supported by the YOI in the weeks after his death, and particularly appreciated the memorial service.

FAMILY CONCERNS

285. *The young person's mother wanted to know whether he was offered any bereavement counselling after his father's death.*

The young person's YOT caseworker said he was offered some bereavement counselling with their nurse. She said she was not certain whether it would have been specific bereavement counselling, but said he was certainly offered some appointments to speak to the nurse about how he was feeling and emotional issues after his father died. She said he was not interested in attending this sort of meeting. Later the YOT manager reviewed his records and informed us that he had been referred to bereavement counselling after his father's death, but had refused to attend.

286. *No one from Wetherby arrived until 1.30pm. By this time the young person's mother had been told of his death by her brother.*

The reasons for the delay in staff arriving at the young person's mother's house are detailed in paragraphs 165 – 175 and discussed in paragraphs 271 – 274. We consider that the delay was unacceptably long.

287. *At her first meeting with YOI representatives, the young perso 's mother was told that when he was found, rigor mortis had set in. However, in a differing account she was told that resuscitation was attempted. She wanted clarification on how he was found. She wanted information on when observation checks were due to be made and whether those checks were actually completed.*

Rigor mortis had set in to the young person's body when he was found, which would indicate he had been dead for some time. However, resuscitation was still attempted by medical staff and continued until he was formally pronounced dead in hospital. A detailed description of the sequence of actions when he was found are in paragraphs 154 – 164.

288. There was no requirement for observation checks during the night. A roll count was carried out at 9.00pm on 17 April as required. The next roll count of the unit was due at 6.30am on 18 April and this was not done. The next roll count on Drake unit should have been at 7.30am and half of the unit including the young person's landing was not counted. More details about the roll counts are in paragraphs 144 – 152 and 260 – 267.

289. *The young person's mother had heard that two young persons at Wetherby had been shouting and threatening him during that evening/night. She added that there was apparently only one member of staff on duty for two units throughout the night and questioned why this was the case.*

After the young person died, information was passed to staff at Wetherby that two young people had been shouting out the windows with him on the night of his death. Paragraphs 135 - 142 give more detail.

290. During the night there is one officer covering Drake unit and Collingwood unit (next door). The officer is responsible for patrolling both units during the night, answering cell bells, conducting the roll checks and ensuring any young people regarded as at risk of suicide or self-harm are monitored according to their assessed need. Another officer patrols the grounds. Paragraphs 226 – 238 look at the problem of shouting out in more detail, with associated recommendations.

291. *The young person's mother thought he had had three assessments completed after intentionally banging his head while in police custody. Two assessments were marked as low risk and one as high risk. The most recent being high risk. If he was assessed as high risk then he should have been monitored.*

The Person Escort Record (PER) that accompanied the young person from the police station, to Leeds court and then to Wetherby indicated that he had previously banged his head on the cell wall. G4S court staff did not increase the observations of him above the routine level of once every 15 minutes. They indicated that if they had had any concerns about him, they would have increased his observations to constant and opened a Suicide and Self Harm Warning Form. When he arrived at Wetherby he was seen by reception staff, a nurse and the first night custody officer. None of these staff considered that he was at risk of suicide or self-harm. All assessed him as low risk.

292. A Cell Sharing Risk Assessment (CSRA) was completed when the young person arrived at Wetherby. The form is completed by the nurse in reception, then the officer on the first night centre and finally countersigned by a manager. The nurse assessed him a low risk of causing harm to others. Because of information about the circumstances of the charges the officer on the first night centre reassessed this as high. This risk assessment is about risk to others if sharing a cell, not whether the young person is a risk to themselves. Paragraphs 68, 79, 83 and 197 - 201 cover the CSRA process.

293. *The young person's mother described him as a very small young person and therefore an easy target. She felt there would have been a lot of people after him at Wetherby. She wondered if he was so desperately scared that he resorted to doing what he had.*

Although YOI staff were aware that the young person felt the need to avoid certain parts of Leeds, he had not given them any indication that he felt at threat from other young people at Wetherby. During his remand review meeting on 5 April he told Officer C that he had young people in mind that he wanted to have conflict with, but not that he was in fear of anyone. He told the officer, his social worker and YOT officer that he felt settled on Drake unit.

294. Although we accept that this might have all been 'bravado' on the young person's part and not what he was feeling underneath, he seemed unable to open up about his true feelings to any members of staff. None of the YOT team, who had known him for longer, felt he was willing to let anyone in below

the surface. His YOT caseworker said he “was adept at hiding his feelings and that he struggled to recognise them”.

295. There is no indication from the young person’s behaviour on Drake unit that he was afraid of mixing with the other young people. Until the evening before he was found, there seemed to have been no problem with others. However, the accounts of other young people near to his cell indicate he became very upset during the course of the night because of the shouting. A threat was made that he would be ‘stabbed’ the next day. He may have decided to hang himself when he was very distressed about the shouting.

296. *The young person’s mother said he had written to his brother in a different prison. He had made reference to being frightened.*

Mail to and from young people is not routinely monitored by YOI staff. Staff would not therefore know whether the young person had written to anyone in his family telling them that he was worried or frightened. He did not speak to YOI staff about having any concerns for his safety or that he felt frightened and hence no additional support or monitoring was put in place.

CONCLUSION

297. The young person was at Wetherby for less than three weeks. A reference to self-harm by banging his head in the court cells on his PER was insufficiently explored by escort and reception staff. The first night vulnerability assessment was confused and we consider a subsequent mental health assessment was inadequate.

298. After the young person threatened an officer on Mothers' Day, a poorly investigated adjudication resulted in him losing his television and the opportunity to associate with other young people for a week. He was also moved off the induction wing. Nothing was done by YOI staff to support him despite clear distress at the time. The incident was badly recorded. With the exception of his remand management key worker, officers did not know him well and some did not recall his adjudication punishment.

299. The night before the young person died he was involved in an argument with other young people conducted through the windows of cells when they were locked up. A policy to challenge young people shouting out of windows was ineffectively implemented. The morning that he was discovered hanging in his cell, two roll checks were not completed and he was not found until his cell was unlocked. Despite clear signs of rigor mortis, nurses and officers attempted resuscitation. It took an unacceptable amount of time for YOI staff to break the news of his death to his family.

300. During his time at Wetherby the young person exhibited few signs of vulnerability. We are satisfied that Wetherby was an appropriate allocation. However, it is a concern that there appeared to be an insufficiently child centred approach to his management: his poor behaviour resulted in a severe disciplinary response with little examination of the underlying reasons or whether he needed additional support, there was scope for mental health support and there was no structured personal officer work to befriend and support him. On the night of his death there he appears to have suffered taunts from other young people which went unchallenged by staff. He appears to have hanged himself during the night following this incident, but we conclude it would have been extremely difficult for YOI staff to have identified the extent of his vulnerability.

LIST OF RECOMMENDATIONS

1. The Head of Healthcare should ensure that the mental health assessment appropriately identifies young people's mental health needs on arrival.

   Accepted. A Comprehensive Assessment Tool has now been implemented across the children and young people's estate, so all young people arriving at Wetherby have a full mental health assessment within 72 hours.

   Wetherby now requests GP records for all young people arriving at the YOI, subject to consent, so staff do not rely solely on the young person's account of his physical or mental health history.

2. The Youth Justice Board should work with NOMS to seek assurances from the manager of the custody suite at Leeds Crown Court that custody officers who conduct checks of young people detained in court cells record both the time of the check and the name of the member of staff who carried out that check on the PER.

   Accepted in principle. The Youth Justice Board agreed with the recommendation, but responded that they would have to work with NOMS as the organisation responsible for PERs, to implement it. A joint working group has been set up to oversee the implementation of actions arising from this report.

3. The Youth Justice Board should ensure that youth justice workers review PERs to inform their assessment of a young person's risk factors.

   Accepted in principle. The Youth Justice Board will seek to contribute to NOMS' ongoing review of the PER to enable YOT workers to meaningfully contribute to PERs.

4. The Governor should ensure that staff consider all self-harm markers on PERs and record subsequent decisions about self-harm monitoring.

   Accepted. The Governor has introduced a system to ensure that staff consider all self-harm markers on PERs and record subsequent decisions about self-harm monitoring, with staff guidance and random checks by the safeguarding team.

5. The Youth Justice Board should ensure the Placement Service has all relevant documentation before allocating a young person.

   Rejected. The Youth Justice Board agreed with the recommendation in principle, but responded that there would always be exceptional circumstances when a young person will have to be placed without the require documentation.

6. The Governor should ensure that assessments completed in the first night centre accurately reflect the information available.

Accepted. The Governor introduced additional training for first night centre staff to improve the accuracy of the first night assessments, provided staff guidance and has a system of ongoing management checks completed by the safeguarding team.

7. The Governor should clarify the role of the personal officer and ensure that they introduce themselves to young people for whom they are responsible, actively get to know and support them and record regular interactions in case notes.

   Accepted. The Governor commissioned a review of the personal officer scheme. Personal officers will be required to attend or contribute to all case reviews, and follow up any actions emerging from case reviews jointly with the case worker.

8. The Governor should ensure that staff and managers record incidents in appropriate detail in young people's case notes and unit observation books.

   Partially accepted. NOMS responded that this recommendation was unrealistic. The purpose of the observation book is apparently to handover key information between shifts, and so detailed accounts of events would not be recorded there. However, the case notes should be more detailed and officers have been reminded of the importance of this as part of the personal officer scheme review.

9. The Governor should ensure staff treat disruptive behaviour as an indicator of potential vulnerability and that staff understand the need to take a child-centred approach when responding to such behaviour.

   Accepted. Staff have been reminded of the importance of a child-centred approach to managing disruptive behaviour and this was reinforced through national training.

10. The Governor should ensure that adjudications are investigated thoroughly and conducted fairly, and that full account is taken of mitigating circumstances.

    Accepted. The Deputy Governor reviews a sample of adjudications monthly, and adjudicating governors have been reminded to record any mitigation that they have taken account of.

11. The Governor should ensure that there is more effective supervision and challenge of young people who shout out threats to each other from the windows.

    Accepted. All windows at Wetherby were replaced by ventilated windows by April 2012, but this has not eliminated shouting out of windows. The management team has driven the implementation of the revised southing out policy.

12. The Governor should ensure that the recommendations from the internal investigation into the supervision of Drake unit on 18 April are fully implemented and regularly checked.

    Accepted. The recommendations were accepted and an action plan drawn up, which is subject to quarterly review at safeguarding meetings.

13. The Governor should ensure that all staff understand and use emergency codes accurately, so that a defibrillator and other emergency equipment are taken swiftly to the scene whenever there is a life-threatening incident.

    Accepted. Staff have been reminded about the use of emergency codes, and the Governor is confident that they are now being used effectively.

14. The Governor should ensure that YOI staff and NHS Airedale, Bradford and Leeds staff work to a common protocol that resuscitation should not be attempted where there are clear signs of rigor mortis.

    Accepted. A resuscitation policy was in place in April 2022, but not all staff were aware of it. Additional training has been run to increase staff's awareness of the policy, and reference to the policy has been incorporated into future resuscitation training.

15. The Governor should ensure that in an emergency situation there is a properly coordinated and recorded approach to contacting families to avoid undue delay.

    Accepted. Wetherby's contingency plans have been updated to reflect the primacy of contacting the young person's family and staff will be prompted to consider turning off the internal telephone system in the event of a death in custody.