

**Investigation into the death of a young person at hospital,
in January 2012 while in the custody of
HMP and YOI Hindley**

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

June 2013

This is the report of an investigation into the circumstances surrounding the death of a young person who was found hanging in his cell at HMP and YOI Hindley on 20 January 2012 and who died in hospital several days later. He was 17 years old. I offer my sincere sympathy to his family for their loss.

The local PCT appointed a clinical reviewer to review the care that the young person received in custody. HMYOI Hindley and Derbyshire Youth Offending Service (YOS) cooperated fully with our enquiries. This was a long and involved investigation. Because of its scale it has taken some months to complete the report and I apologise for the delay in issuing it.

The young person had had little previous contact with the youth justice system when he arrived at Hindley in early December 2011, and he had a number of characteristics which identified him as vulnerable. Not only was this his first time in custody, but he had also been diagnosed with a conduct disorder and Attention Deficit Hyperactivity Disorder (ADHD), he had a statement of special educational needs, and he had recently self-harmed. He had told his YOS officer that he had thoughts of killing himself. This information was passed to Hindley when he arrived, but he was not subject to monitoring as the YOS court officer had recommended.

The young person chose not to mix much with the other young people at Hindley and reported to a number of staff that he was being bullied by other young people, but no one acted effectively to protect him. Hindley's safeguarding procedures were not followed – even when his YOS officer very clearly wrote down her concerns after a visit with him at the end of December. When he appeared in court again on 13 January, the YOS officer recommended he should go to a secure training centre or a specialist unit at HMP and YOI Wetherby, but he returned to Hindley where he continued to report being bullied.

On 17 January, the young person self-harmed. He was then made subject to monitoring. A bullying referral was also made but no other action was taken. On the evening of 20 January, he was subject to abuse during the association period when he chose, as usual, to remain locked in his cell. Despite his now acknowledged and well documented vulnerabilities, the supervising officers did little to check the harassing behaviour of the other young people. He was not unlocked from his cell to make a telephone call before the association period began, as he had expected, and he was not allowed to make one afterwards. Later that evening he fatally self-harmed.

This is a disturbing story of failure to protect properly a young person with multiple vulnerabilities. None of the systems designed to protect children at Hindley worked effectively and there were many failures to share information. He was very vulnerable but it appeared almost as if no one heard what he was telling them or appreciated that his sometimes challenging behaviour might be a symptom of significant distress.

Tragically, this is one of three apparently self-inflicted deaths of children in custody my office has investigated this year. In each case, I have been concerned that too many of the systems in YOIs holding children replicate those in adult prisons. Once again, a number of our criticisms in this investigation repeat this theme. Accordingly,

while a large number of recommendations are made to learn lessons and address the specific failures identified in his case, there are also some broader recommendations to the National Offender Management Service and Youth Justice Board intended to ensure a more holistic and child focused approach to managing and safeguarding children at risk of suicide and self-harm.

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.

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Prisons and Probation Ombudsman**

June 2013

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SUMMARY

1. The young person was 17 years old when he was sentenced to a detention and training order to be served at HMP and YOI Hindley on 6 December 2011. He had had little previous contact with the criminal justice system and this was his first time in custody.
2. The young person had a number of factors which are recognised to increase the risk of suicide and self-harm in custody. These included learning disability, attention deficit hyperactivity disorder (ADHD), conduct disorder, the fact that it was his first experience of custody and that he had been convicted of an offence involving domestic violence. He had also recently self-harmed. Youth Offending Service (YOS) staff drew attention to this recent self-harm in a post court report and, because of his vulnerabilities, recommended that an Assessment Care in Custody and Teamwork (ACCT) suicide and self-harm monitoring procedure document should be opened.
3. Information about the young person's risk could have been flagged more effectively, but there was insufficient consideration of his risk when he arrived at Hindley, and the ACCT process was not implemented as the YOS officer had suggested. Too much reliance appears to have been placed on his physical appearance and demeanour when assessing his vulnerability.
4. Over the following weeks, the young person reported being bullied to a number of different staff at Hindley. Although some staff were concerned, this information was not shared effectively or acted on in line with Hindley's own anti-bullying procedures. There continued to be a lot of reliance on how he appeared to individual staff, with whom he was able to interact well, rather than an objective assessment of the information available. In particular, his YOS worker visited him at the end of December and was very concerned about his vulnerability. She noted her concerns about his risk of self-harm and provided information about him being bullied in a form she handed to visits staff. This was not appropriately acted on.
5. On 13 January 2012, the young person received a six month sentence for another offence. Some concerns about his vulnerabilities were identified at court. Following this sentence, his YOS officer recommended that he be moved to a secure training centre (STC) rather than serve the sentence at Hindley. If he did not go to an STC, the YOS worker indicated that a place at the Keppel Unit (a specialist unit at Wetherby YOI) should be considered. It is not clear what consideration was given to these options by the Youth Justice Board placements team, but he returned to Hindley where his behaviour began to deteriorate.
6. On 17 January, the young person broke his television and self-harmed. He said he had done this out of frustration because he was being bullied. An ACCT was opened and a safeguards referral was made for the first time.
7. The young person seemed to find it increasingly difficult to cope over the following two days. On 19 January, an operational manager who heard a

disciplinary charge against him for breaking his television was very concerned about his mental state and his account of being bullied. Some attempts were made to persuade him to move cell but he refused.

8. On 20 January, the young person was very upset that he had not been let out of his cell to make a phone call before association began as he believed had been agreed. In frustration, he broke some of the furniture in his cell. CCTV footage shows other young people congregating at his cell door throughout the association time period. It is apparent that they were harassing him. Some were opening and closing his observation panel and hitting his cell door with table tennis bats. Although by this stage it was clearly documented that he was a victim of bullying and was being monitored as at risk of suicide and self-harm, there is little evidence that the officers who were responsible for supervising association intervened to prevent this behaviour and protect him.
9. At the end of the association period the debris from the broken furniture was removed from the young person's cell. He was not allowed out to make his phone call. A senior officer spoke to him and satisfied himself he was okay, but there is no documented evidence of consideration about whether his level of risk had increased, whether the frequency of observations should change or whether he should remain in the same cell.
10. Later that evening, at one of the twice hourly ACCT checks, the young person was found hanging. YOI staff responded quickly with cardio pulmonary resuscitation (CPR); he was transferred to hospital but he never regained consciousness. Sadly, he died several days later.
11. The investigation found that too little consideration appeared to have been given to whether Hindley was the appropriate place for the young person. Although there were some good safeguarding procedures and systems at Hindley, these were not used effectively. We believe that he should have been placed on an ACCT sooner in his time in custody. YOI staff did not seem to take bullying seriously enough and did not follow Hindley's own procedures. While some individual members of staff had a good understanding of him, too many opportunities to identify and deal with his vulnerabilities were missed. Ultimately, there was a failure to protect him.

THE INVESTIGATION PROCESS

12. An Assistant Ombudsman led the investigation. She and the investigator visited Hindley on 27 January. Hindley provided them with the young person's YOI record, including his medical file. They met the Independent Monitoring Board (IMB) and Prison Officers Association (POA). They also met the Governor, toured Hindley and saw the young person's cell. They interviewed three young people due for release, and the young person's friend and co-defendant.
13. Hindley provided recordings of the telephone calls the young person made, which we transcribed. The YOI also provided CCTV footage of the last day he was in the YOI. The format of the CCTV and the equipment needed to view it meant that the investigators were only able to watch the CCTV at Hindley.
14. Notices were issued to staff and young people informing them of the investigation and inviting anyone with relevant information to contact the investigators. No one came forward as a result. The young person's family identified another young person who might have had information and the investigators interviewed him.
15. The investigators interviewed 61 staff members from Hindley YOI, healthcare, Youth Offending Service and escort staff. They also interviewed ten young people.
16. The investigators observed safer custody and violence reduction meetings at Hindley and spent time on Fir wing, where the young person lived, observing movements and meal times, including evening association.
17. There were two people the team sought to interview without success. One young person had been released by the time he had been identified from CCTV footage. The team wrote to him at his home but did not receive a response. The team also sought to interview the Youth Justice Board (YJB) placements officer on duty on 13 January. However, she was on sick leave, and subsequently resigned. The team wrote to her twice offering her dates to meet but received no reply.
18. In September, Hindley provided a copy of a document previously unseen by the investigation team. This led to a further interview on 18 September.
19. The Assistant Ombudsman attended a meeting with the members of the Serious Case Review (SCR) panel in February 2012. The purpose of the SCR is to:
 - establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children

- identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result, and
 - improve intra- and inter-agency working and better safeguard and promote the welfare of children.
20. The Assistant Ombudsman subsequently corresponded with and met the chair of the Serious Case Review in June and August 2012 to share information.
 21. Greater Manchester Police conducted an investigation into the circumstances surrounding the young person's death. The team spoke to a Detective Constable and shared information.
 22. The local Primary Care Trust (PCT) conducted a clinical review of the young person's clinical care in custody. This was undertaken by a clinical reviewer and supported and approved by a clinical panel. He conducted joint interviews of clinical staff with the PPO investigators.
 23. The Assistant Ombudsman provided verbal and written feedback on the progress of the investigation to the Governor of Hindley, the Coroner, the Serious Case Review panel and Youth Justice Board, indicating emerging issues and preliminary findings.
 24. HM Coroner for Greater Manchester West District was informed of the investigation. A copy of the post mortem report was requested. This was received in August 2012. This report will be sent to the Coroner to assist her enquiries.
 25. One of the PPO's family liaison officers contacted the young person's family to explain the investigation process and offer the opportunity to ask any questions and raise any matters they wished to have considered as part of the investigation. The family liaison officer and the Assistant Ombudman subsequently met the young person's mother, father and step-mother, and their legal representatives. They raised the following matters:
 - Were staff at Hindley told that he had a learning difficulty and a statement of special educational needs?
 - What medication was he prescribed and at what time of day was it issued?
 - What treatment did he get for his tongue infection?
 - Why was no action taken to deal with the bullying that he experienced, such as requiring him to move to the Willow Unit?
 - Why was he not sent to HMYOI Wetherby after his court appearance on 13 January as he had been promised?
 - Why was nothing done to protect him despite his extreme vulnerability in the final days?
 - Was he told that his YOS worker would not be visiting him as scheduled on 20 January and, taking into account his distress on 17 January, why did a duty worker not attend instead?

- Why were his letters to his family not checked after the ACCT form was opened?
- Why was he not allowed to use the telephone on 20 January?
- What happened when he was discovered hanging?
- Why was the hospital told that his name was another name?
- What caused the markings on his body when he was at hospital?
- They found the behaviour in the hospital of one of the YOI escort officers disrespectful and insensitive.
- When Hindley's Governor visited the hospital he made a number of comments that the family considered to be distressing and inappropriate.
- When his family visited his cell after his death it had been cleaned and the bed made with fresh bedding, although they had asked to see the cell as it had been when he was found.

26. We address most of these issues in the report and some in separate correspondence. We are grateful to the young person's family for sharing the letters he wrote to them during his time in Hindley and allowing them to be used as part of the investigation.

THE YOUNG PERSON

27. The young person was born in June 1994 and lived in Chesterfield with his mother, sister and his sister's young child. He also had regular contact with his father and stepmother.
28. In 2007, the young person was diagnosed with conduct disorder and ADHD and had quarterly appointments with a community psychiatrist. He was on the maximum dose of medication for ADHD.
29. The young person found school difficult and when he was 12 he received a statement of special educational needs because of dyslexia and ADHD. He apparently displayed challenging behaviour in mainstream school and spent 12 months at a special unit. After this he attended college, spending time on literacy and numeracy as well as other skills. This appears to have made a real difference to him and his literacy and numeracy improved, as did his behaviour.
30. Before the young person went to Hindley, he had had little contact with the criminal justice system and the Youth Offending Service. He had been convicted of only one minor offence which had resulted in a referral order in 2009. He was then convicted of two violent offences in 2011, resulting in him going to Hindley. In his pre-sentence report, his Youth Offending Service (YOS) worker said that his offences were characterised by "ill considered decision making, impulsivity and poor emotional management". She went on to write "He seems to display low self esteem and confidence ... poor conflict resolution [skills] ... He has also told me he has thoughts about killing himself but has no intention of carrying this out, he tells me he feels worthless and depressed most of the time".
31. The young person was tall and well built. His mother said his mental ability was younger than his years. Because of his stature people tended to overestimate his abilities to cope and deal with situations. He was close to his mother and often spoke of being concerned about her health and wanting to talk to her. He also spoke a lot about his girlfriend and cared for her daughter. Thoughts of his family appeared to dominate much of his time at Hindley.

HMP AND YOI HINDLEY

32. Her Majesty's Young Offenders Institution (HMP and YOI) Hindley is in Wigan. It opened in 1961 and became a youth custody centre in 1983. In April 2009, Hindley became a dedicated centre for remanded or sentenced young people aged 15 to 18. It is the largest custodial establishment for children in the country, with the capacity to hold up to 500, although the Youth Justice Board has only ever commissioned a maximum of 440 places. On 20 January 2012, there were 333 young people at Hindley. On 20 January, in addition to the young person, there were eight other young people being monitored under suicide and self-harm protection procedures.
33. Hindley has nine residential units. Fir wing holds up to 96 young people on two landings. The wing is split in the middle by an area which contains the senior officers' room and an office. The two sides of Fir wing, Douglas (where the young person lived) and Noble, are self-contained units, so during association periods young people from each side do not have contact with each other.
34. The YOI also contains Willow Unit, a multidisciplinary psychology led unit that takes up to 11 young people with complex needs such as mental health problems, behavioural problems, educational deficits and problems with vulnerability. It aims to provide a behaviourally oriented environment with positive rewards for desirable behaviours. It uses a core set of staff to improve continuity for the young people on the unit. There is a higher staff to detainee ratio than elsewhere in Hindley. A young person can be referred to Willow from anywhere in Hindley. Their suitability for the unit will then be assessed by a member of the mental health team and a member of the Willow Unit staff. The assessment process includes an interview with the young person. Each young person in the unit has an individual care and management plan and a tailored regime including education, gym, healthcare, mental health and keyworker interventions. Most young people return to a standard wing once they have overcome their difficulty or crisis, but some stay there during their time at Hindley.

Her Majesty's Inspectorate of Prisons (HMIP)

35. The last inspection of HMP and YOI Hindley by HMIP was an unannounced short follow-up inspection in September 2011 of a previous inspection in October 2009. Inspectors' findings included:

“Young people still experienced lengthy waits in court cells before they arrived [at Hindley] and still sometimes travelled with adult prisoners...

“... young people expressed a lack of confidence in the anti-bullying procedures, comparatively worse than at the previous inspection ...

“... behaviour intervention plans [to address a range of behaviour, including perpetrators and victims of bullying] were not yet being implemented to a consistently high standard ...

“... Young people who were particularly vulnerable or challenging or who had specific needs continued to be managed effectively through the well attended multidisciplinary weekly safer regimes meeting. Some, but not all, vulnerable young people had behaviour intervention plans but the plans were not sufficiently comprehensive and needed further development in order to be used to effectively assess, plan and review the individual needs of young people with a variety of complex needs.

“Overall, healthcare provided an excellent service. The staff skill mix was good and staff were well trained and committed to the provision of a high standard of care for young people. The Willow Unit provided a high standard of specialist care ...”

Independent Monitoring Board

36. Each prison and YOI has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated humanely and fairly. The young person never asked to see a member of the IMB.

37. In its most recent annual report, for the year to April 2011, the IMB made the following comments

“The establishment continues to operate a violence helpline where relatives of the young people resident at Hindley can make contact with the staff to voice any concerns they may have regarding an individual ... Exit surveys continue to be offered to young people when leaving this establishment. 90% plus of young people completing the survey indicate that they felt safe at Hindley.

“... Hindley continues to be pro-active in seeking prosecutions of young people who commit any serious offence whilst in their care. 25 young people were successfully taken to court in 2011. 22 of which have been sentenced to a total of 6.5 years imprisonment. One young person is awaiting sentencing for arson... Hindley continues to be pro-active in building and maintaining the focus on violence reduction by holding a number of events aimed at engaging the young people on a regular basis.”

Previous deaths at Hindley

38. There has been one previous death at Hindley since the Ombudsman took on the role of investigating deaths in custody in April 2004. The previous death was a self-inflicted death in September 2005. The main similarity between that young person and this young person was that he too had reported being bullied.

KEY EVENTS

Court appearance 6 December 2011

39. The young person had had little contact with the youth justice system before December 2011. He had one conviction before that date for an offence of criminal damage in July 2009 for which the court imposed a six month referral order. (This means referral to a youth offender panel which reviews the offence and agrees a contract with the young person to address reparation and restoration to the victim or wider community together with a programme of interventions and activities to deal with the risk of re-offending.) He appears to have engaged well with the terms of his referral order contract.
40. In October 2011, the young person was charged with assaulting his girlfriend. He was convicted of this offence and listed to appear in court on 6 December for sentencing. Ahead of this a Youth Offending Service (YOS) worker completed a pre-sentence report. In her report, she said:
- “... His offending behaviour appears to be characterised by poor conflict resolution skills, poor decision making, and limited internal emotional controls. These deficiencies may be heightened due to him having a diagnosis of Conduct Disorder, ADHD, and dyslexia ...
- “... He ... disclosed that he has thoughts about killing himself but has no intention of carrying this out; he tells me that he feels worthless and depressed most of the time ...
- “He is aware that he could receive a custodial sentence and has stated that he is worried by this possibility. His diagnosis and his requirement for ongoing treatment and support from CAMHS means that he is a vulnerable young person and his vulnerability would be significantly increased if he were to go into a custodial environment.
- “... given the circumstances of this offence and its impact on the victim, I’m mindful that custody will be a serious consideration today. Whilst a custodial sentence would protect the public in the short term and send a clear message to him, it is unlikely to provide the one to one intervention in areas highlighted in the ... Asset assessment such as conflict resolution, decision making, and for him to continue his work with CAMHS [Child and Adolescent Mental Health Service] to enable him to develop his internal emotional controls ...”
41. The role of the court officer is to assist the court in providing information for sentencing, to take notes for the young person’s case manager, to complete a post court report and to help the young person and family understand what has happened in court. The court sentenced the young person to a four month Detention and Training Order (DTO). The YOS court officer on 6 December told the investigators that she spoke to him in the court cells after the court had made its decision. She said that he was worried about his girlfriend and was very emotional. In her report she wrote:

“[The young person] struggles to understand conversations and instructions, will need repeating and explaining - full statement of special educational needs ... He has ADHD, conduct disorder ... mum states [he] has ... cut arms recently, he confirmed this in the cells and showed me the scars to his forearms [self-harm disclosure is new information. He states no intention of self-harm or suicide but was very upset in cells and YOT are concerned now.]. Recommended Action: ACCT document, single cell, close observations and access to CAMHS ...”

42. The YOS court officer told the investigators that on reflection she should not have written “scars”, as the wounds were more in the way of scratches and were still healing at that stage. She said that she asked the young person if he intended to harm himself again and he said that he would not. She estimated that she spent around ten minutes with him and she then passed the documentation to the court custody staff. She did not complete a suicide and self-harm warning form to alert other staff.
43. An electronic “placement confirmation form” was produced at 3.35pm confirming the young person’s allocation to Hindley. Under a heading “self-harm / suicide risk”, an entry was made that he was a “potential self-harmer”. Other “risk factors” were noted to be: history of abuse or trauma; learning difficulties; victim of bullying; ADHD; on medication; aggressive behaviour – currently. A warrant is produced at court to confirm the legality of detention. Handwritten on his warrant was “see attached PSR [pre sentence report] – suffers from ADHD and depression, risk of self-harm identified”.
44. According to the Person Escort Record (PER), completed by escort staff, the young person left court at 5.05pm (the PER travels with the young person in custody and is used to highlight any concerns as the person is transferred between the different agencies looking after them). There is space to tick different categories to alert staff to potential difficulties. The PER was marked to say he had ADHD, conduct disorder, dyslexia and depression. A box to indicate potential risk of suicide or self-harm was marked to show that there was no risk.

Arrival at Hindley

45. The young person arrived at Hindley at 8.11pm. The post court report arrived with him, and the Asset (Young Offender Assessment Profile) document, including the pre-sentence report, risk management plan and vulnerability management plan had been emailed to Hindley in advance of his arrival.
46. A senior officer met the young person when he arrived and signed the documents that arrived with him. It has not been possible to identify the senior officer in charge from the signature, and none of the reception senior officers remembered him arriving. One of the Reception SOs explained the reception process. He said that the documentation arrives electronically before the young person. The SO checks risk factors on the Asset and then the PER when it arrives and the post court report if it comes with the young

person. They are spoken to individually in an office, where key information is checked about their identification and offence. Other staff then search the young person, issue them with clothing, remove their property and list it. The SO then sees the young person again and asks them questions about vulnerability, records next of kin details and explains expectations about behaviour. Then they see the nurse.

47. A nurse conducted the young person's first reception healthscreen. She said they had received a phone call, probably from his YOS worker, in advance to tell them he was on medication. She also said she had the Asset form with her when she assessed him. She recorded that he appeared calm and relaxed and engaged well in conversation. He told her that he had experienced depression "a few years ago" following the death of his stepfather and been prescribed medication at that time, but had stopped taking the medication about a year previously when he started to feel better.
48. When asked if he had a history of self-harm, the young person said he had cut his arms when he had felt depressed at the time of his stepfather's death but had no current thoughts of self-harm. He told the nurse he had ADHD and took Equasym 30mg twice a day and methylphenidate 5mgs, two tablets at night. He also said he had dyslexia and conduct disorder, and was under the care of CAMHS and reviewed every six months. He knew he was due for a review the next day but that would not now be possible. He said he smoked and his last cigarette had been at 2.00pm that day. Hindley is a non-smoking establishment and the nurse recorded that nicotine replacement therapy would be discussed with him the following day. He was referred to the doctor for his medication. It is recorded that he drank alcohol occasionally at weekends and did not use drugs. The following morning the nurse contacted his GP in the community and confirmed his prescription.
49. The young person was taken to the first night centre, where an officer completed a risk assessment form. This is timed at 9.43pm. The officer did not remember much about him and said he did not especially stand out. He said he had read his Asset before conducting the assessment.
50. The officer said that the young person was quiet and not forthcoming with answers, but he understood that the young person had ADHD, learning difficulties and conduct disorder. The officer noted the post court report had detailed that he was upset when in the court cells and the YOS was concerned. He recorded that the young person had previously self-harmed but had no current thoughts of self-harm and he said he had no immediate issues with being at Hindley.
51. Section 2 of the risk assessment form explores whether the young person is a potential victim. The officer wrote "[he] is a big lad for his age and shouldn't have any issues". The investigators asked the officer what he meant by this. He replied:

"There are some big and some small, but he was a fairly big lad. Now it's more factual that he's a big lad and really the way he seemed to me on the

interview he wouldn't have ... it wasn't to say well big lads can't get bullied ... It was basically to say it was something factual. If somebody looked at it they'd be able to see him as he ... was a fairly tall lad and from his attitude and everything I didn't think he would have a problem. That's all that I really meant."

52. The young person told the officer he was bullied when he was younger, at school, due to him being "thick" but this changed as he got older. He stated that he should not have any issues with other young people.
53. Section 4 of the risk assessment form is the risk management plan which asks what actions are to be taken to reduce anxiety/vulnerability or risk of suicide/self-harm, or the risk the young person poses to others. The officer wrote "hourly observations for first 48hrs, 7 day Induction programme, Personal Officer Scheme". He also noted that the young person felt contact with his family would help him. (It is standard practice at Hindley for young people to be checked hourly during their first 48 hours in custody.)
54. The officer went on to complete the "immediate needs initial assessment". He recorded that the risk assessment form was completed within two hours of arrival and he had been given a phone call and hot meal. He had also been issued with a reception pack, arranged his first visit, and signed various compacts.
55. At around 9.30am the following morning, the young person saw a doctor. He prescribed medication in line with his community GP; Equasym 30mg capsules two capsules in the morning; and methylphenidate 10mg tablets, one to be taken in the afternoon.
56. The young person was assigned a named mental health nurse. The medical record states the reason for working with him as "first time in custody, has had contact in the past from CAMHS Team. He's currently on medication. A mental health nurse will refer him to a Consultant Adolescent Forensic Psychiatrist for ADHD medication. Review 4th January".
57. A nurse also met the young person to discuss nicotine replacement therapy, but he said he thought he would be fine without it. She also contacted North Derbyshire Child Health, who informed her they had no vaccination history for him.
58. An officer went through another risk assessment with the young person at 10.00am to consider if further action was needed against some of the risk factors. The officer said that as usual he had read the young person's records before meeting him. He said that Asset records often contain a lot of information, much that is not especially relevant. The major aspects that he concentrates on are those relating to issues of self-harm. The officer noted that the young person had harmed himself in the past but had said that that had been some time ago and he had no current thoughts of doing so. The officer said that the young person was polite and friendly. He said that the

young person appeared to be feeling positive and just wanted to get on with his sentence.

59. The officer did not assess the young person as a potential victim and noted “First time in custody, however, he is big for his age and should be able to manage on normal location”. The officer said that making a note of the young person’s size as well as his positive comments helped him build a picture that he was a person who should be okay going to a standard wing.
60. A mental health nurse assessed the young person and noted that it was his first time in custody, he appeared settled in mood and engaged well. He said that he lived with his mother in Derbyshire and was at college doing hedge cutting. He said he had no worries about being in custody. He said he had had contact with CAMHS, due to having ADHD and conduct disorder diagnosed in 2007. He said he felt a “bit fed up” due to being in custody, but had no current symptoms of anxiety or depression. He said he did not have any feelings of hopelessness. He told her he had self-harmed in the last two years following the death of his stepfather, who he said he was close to as he had brought him up. The nurse offered him counselling but he said he felt okay. He said he was expecting to receive visits from his mum and sister. He denied any traumatic incidents or psychotic experiences, although he said that he sometimes heard people shouting his name when no-one was there. He could not provide any further details about this, such as the type of voice. He reported that this last happened a few weeks before. He said he had told his mum and she told him not to worry.
61. The nurse wrote in the young person’s clinical record “No concerns re current mental state, added to [the psychiatrist] waiting list re ADHD medication, added to Wednesday’s allocation list re ADHD, follow up in two weeks to see how settled, referral to [the psychiatrist] Child and Adolescent Psychiatrist”.
62. At interview, the nurse said that the young person was “not responding to external stimuli” during their consultation so she had not been unduly concerned about his report of hearing voices. She said she would have followed this up with him at a further consultation except he had been quickly allocated to a named nurse.
63. The YOI chaplain visited the first night centre at lunchtime to speak to newly arrived young people. He met the young person and recorded that it was his first time in the YOI and wrote: “he has made a phone call and expects visits. He has no current self-harm thoughts. States he had depression two years ago. He is aware of the Chaplaincy support available.” The chaplain also recorded the young person’s mother’s contact details.
64. The young person completed various elements of the induction programme, including visiting the gym, receiving a talk from the Barnardo’s team and IMB. He attended a group session about Hindley, including information about rights, how to arrange visits, contact with family, seeing healthcare, the YOI rules and regime, and other general information.

65. In the afternoon, the young person asked an SO if he could telephone his girlfriend. As she was the victim of his offence the SO contacted the girlfriend first to obtain her consent. She was happy for him to phone and, as she was over 18, the SO allowed the call.
66. Because the young person had been identified as having learning difficulties, a nurse from the learning disability team visited him on the wing that evening. The nurse knew from the records there were no immediate concerns following mental health assessment although he had been referred to the psychiatrist due to his ADHD. He told the nurse that he had been okay since his arrival but the nurse noted that he had since spoken to his mother and girlfriend and this appeared to have had a negative impact on his mood. The nurse wrote "although he has self-harmed in the past he states he does not feel like that at this moment however he became tearful when recalling this. I've decided to postpone [learning disability] screening until he is in a better frame of mind and I've contacted an RMN for him to see him".
67. A mental health nurse visited the young person about an hour later. He told the nurse that he felt low and was fed up with being in custody. He was concerned his family might be angry with his girlfriend because of his sentence. He was also concerned about his mother and her health and worried she might die. The nurse said he offered him support. The young person said he had no current thoughts of self-harm or suicide. He said if he was upset at home, he would generally withdraw or make things from wood. He said he would watch television and draw to keep himself occupied while in custody. He intended to phone his mother to say goodnight. He told the nurse he was due in court again on another charge and was expecting a further custodial sentence. The nurse explained the different support mechanisms available and how to access them. The nurse recorded that, when he left the unit, the young person was interacting well with other young people. He recorded that he spoke to the wing staff and they had no concerns. He concluded that the plan of action instigated by another mental health nurse should remain in place.
68. A further note was made the following day by the young person's named nurse to say that if concerns persisted, a referral for a full assessment should be made to the psychiatrist.
69. The young person moved from the first night centre to Fir wing on 8 December at 2.30pm. This was a standard allocation for those with sentences of less than 10 months.

Court appearance 9 December

70. On the morning of 9 December, the young person went to Crown Court, in connection with an offence of affray, separate to the offence for which he had been convicted on 6 December.
71. One of the young person's co-defendants was a close friend. His friend saw that he had cuts to his wrist. The young person said he was having trouble from some young people from Liverpool who wanted him to give them some of his canteen items (goods from the prison shop). He had refused and they had threatened to stab him. He told his friend that he had told an officer. He also said that he would not cut himself again.
72. The PER form completed by the escort service (GEOAmey), indicated that no matters of concern arose during the day. The young person arrived back at Hindley at 9.13pm.
73. An officer recorded in the Fir wing observation book that the young person had returned to the wing at 9.50pm. A nurse wrote in his medical record at 11.23pm that he said he did not want his medication as he just wanted to go on the wing and "get his head down". We presume from this that the nurse saw him in reception and made the entry later.
74. The following day the young person received a visit from his mother, sister, girlfriend and niece.
75. On 11 December, the young person attended a mental health group work session. He was asked to complete a form about his expectations of the group. He wrote that he joined the group to "pass the time". In response to asking what he would like to achieve from the group, he wrote "to get along with people". When asked on a scale of 1-10 how well he thought he could cope and manage his emotions (0 meaning can't cope at all and 10, very well) he circled 8. He also wrote that he knew ways of calming himself down and these were to think of his family and look after them. He was asked:
- "How much does the following statement apply to you? Please circle your answer:*
- "I feel that I have no control of events that might affect me and no control of my reactions or behaviour."*
76. The options provided were "Never, Sometimes, Often, Always". The word "Sometimes" was circled.
77. The final question asked *what do you understand about anxiety and stress?* The young person wrote "It makes you do stupid things what you will nev[er] do befor[e]".
78. That evening, a mental health nurse saw the young person as he had a painful tongue. She noted that he had ulcers around his tongue and his whole

tongue was coated, and painful. She referred him to see the doctor and the doctor assessed him the following morning. The doctor noted that the young person had had blisters on his tongue for two days but was able to eat and drink normally. She diagnosed mouth ulcers and prescribed a five day course of topical antifungal treatment miconazole, 20mg, and oromucosal gel. She noted that he should be reviewed after this course of treatment. A nurse later gave him the oromucosal gel to keep in his cell and he was also given some paracetamol.

79. In the afternoon of 13 December, the young person had a consultation with a psychiatrist. The psychiatrist explained that young people who are prescribed certain medications, such as antidepressants or stimulant medication for ADHD, are routinely referred to him. In part, this is for the psychiatrist to check that the person's medication regime is right for them and also to ensure they are suffering no side effects. The psychiatrist said that with the young person, his community prescription was for a fixed dose of a longer acting drug in the morning, which he supplemented with an additional dose in the evening if required.
80. The psychiatrist wrote in the medical notes that the young person had: "... reported having problems with other lads on the wing who appear to have been trying to intimidate him. He's trying hard not to retaliate as he does not want to get extra time". (This is the first mention of bullying in the young person's records.)
81. The psychiatrist also recorded the young person's medication and wrote: "He is a tall slim young person who was easily engaged in the meeting. Speech normal in rate and flow. Eye contact good. No abnormality of movement. Not restless. No tics". He told the psychiatrist that he lay awake or paced in his cell as he was worried about his mother and her health. He also worried about his girlfriend and her daughter, and was concerned that his dad was soon to emigrate to Australia and he wanted to see him before he left. He was concerned about getting a longer sentence at his next court appearance. He said he was eating but his appetite was reduced. He rated his mood as 0/10, although he did not appear that low to the psychiatrist.
82. The young person reported no recent acts of self-harm. He told the psychiatrist that he had thought about it but he would not self-harm as he wanted to see his mother and stepdaughter (his girlfriend's child). He said he had previously cut himself after the death of his stepfather and after relationship breakdowns. He said he worried about everything, including being assaulted. The psychiatrist observed no phobias, or features of obsessive compulsive disorders, but noted he could be prone to anger outbursts and had previously damaged his home. The psychiatrist recorded "no abnormality of thought or paranoid ideation, ideas of reference, delusion thinking, perception or beliefs. Has heard his name being called before – has happened frequently".
83. The psychiatrist's plan was recorded as "see in a week, get [community] mental health records, see a mental health nurse weekly, sessions with a

nurse from the mental health day centre, have low threshold for [opening] ACCT, if deteriorates consider [the Willow Unit]". Although this is recorded in the young person's medical records, it was not in any other records and does not appear to have been communicated to other staff.

84. Credit for telephone accounts (pin phones) is topped up weekly, every Friday. The young person had used up all his pin phone credit by the evening of Wednesday 14 December.
85. The young person saw the learning disability nurse on 15 December. The nurse wrote in his clinical record that he appeared to be interacting well with other young people on the induction unit (where he had been for an education assessment), and appeared relaxed. However, when asked how he was, he just shrugged. The nurse agreed to visit him the next day.
86. After completing his education assessments, the young person was allocated education in the mornings and workshops in the afternoons. On 16 December, the learning disability nurse saw him in the workshops. He noted that he seemed more settled and was happy to be doing woodwork. He told the nurse that everything was good on the wing. He asked some questions about his sentence, which the nurse could not answer and advised him to speak to his key worker. The nurse then contacted an officer from the key worker team, who agreed to visit him later that afternoon. The nurse planned to see him again on 19 December.
87. The young person's keyworker visited him that afternoon. A keyworker should meet the young people they are responsible for within a couple of days of arrival. The keyworker said he could not remember if he had met the young person before and not written it down, or if he had not met him until 16 December. In the case notes in the Asset, it says that on 16 December, he explained the keyworker role to the young person and how he could contact him if he wanted to speak with him. This would suggest this was the first time they had met.
88. The young person told his keyworker he wanted to appeal his sentence because his mother was unwell and he felt he should be at home caring for her. He said he had no concerns for himself. During interview, the keyworker described him as being unhappy at being in Hindley and anxious. He said that when he spoke about his mother he would get a bit tearful. He gave his keyworker his mother's phone number, and the keyworker contacted the young person's solicitor. The keyworker checked that the young person's mother had visited and another visiting order had been sent to her. The keyworker wrote in the Asset case notes that he had explained to him that he just needed to ask wing staff to contact him if he wanted to see him.
89. On 17 December, a nurse saw the young person who still had ulcers in his mouth and had run out of the gel. He said he was worried about his mother and the impact on her if he received a longer sentence. The nurse ensured the young person was on the list to be seen by the doctor and noted that he

was under the care of the mental health team. As he felt low, she contacted the mental health team that day for someone to come and see him.

90. A mental health nurse visited the young person on Fir wing a few hours later and recorded that he was “facially flat”. He again expressed concern about his mother’s health and said he was missing his girlfriend and her daughter. He said he had been due to have a visit from his father that morning but his father had not arrived. He was concerned he might not see him before he emigrated. He told the nurse that some other young people had made comments about his family that had angered him. The nurse recorded that he had encouraged the young person to speak to wing staff about this and to tell them who was making the comments. He said he would not “grass”. He also said he had been teased and threatened while at the mental health unit. The nurse said this was unacceptable and asked him who had threatened him, but he would not say.
91. The young person told the nurse he did not have any thoughts of self-harm. The nurse said he would return over the weekend to offer him extra support. The nurse also recorded in the medical records that he had told wing staff that the young person was low in mood. Wing staff had no concerns. The nurse recorded that the plan was to review the young person again on Sunday 18 December and to feedback to his named nurse. At interview, the nurse said he had told wing staff that the young person had reported having difficulties with other young people. However, he could not recall who he had spoken to. The nurse acknowledged that an option would have been for him to make a record in the wing observation book or to submit a security information report, but he thought telling wing staff was a more immediate way of dealing with the matter.
92. The nurse returned to Fir wing the following day, 18 December, to see the young person. He recorded that the young person appeared more settled and relaxed and said he had been watching the film “The Never Ending Story”, which was something he did every Christmas. He said he was still feeling down but watching Christmas films was helping. The nurse said he would return to see him again the following day (the young person’s named nurse was not due into work until Tuesday 20 December). The nurse recorded that he told wing staff he would come back the next day, although there is no record of him returning then or of him being seen by any other member of healthcare staff on 19 December.
93. On the evening of 19 December, an SO submitted a Security Information Report (SIR). The SO did not usually work on Fir wing but was covering the wing that evening. At around 7.00pm, one of the nurses told her that the young person needed to be escorted to Elm wing to receive his medication. (The ADHD medication which he took is classed as a controlled drug and there are strict requirements as to how it is stored and dispensed. It has to be kept in a locked cabinet and two nurses have to be present to dispense it.) In the SIR, the SO pointed out that Fir wing was left temporarily short staffed while an officer escorted the young person to and from Elm wing to get his medication. The SO told investigators the arrangements were explained to

her the following day, but she was concerned that this marked the young person out as different from others on the wing.

94. The nurse who dispensed the young person's controlled medication said that he had not mentioned any concerns about having difficulties with other young people because he was coming to Elm wing for his medication. However, the potential victimisation of young people having to go off their wing for medication was a matter which nurses had raised with management previously.
95. The young person was due to have a consultation with the psychiatrist on 20 December, but a planning meeting for his DTO had been scheduled for the same day so his appointment was rearranged for the following week. (The psychiatrist attends Hindley once a week).
96. The young person's YOS officer attended the DTO meeting, along with his mother, the young person himself and his keyworker. The keyworker made a note of the meeting in both the Asset and P-NOMIS records (electronic case notes) and noted that the young person's behaviour had been good and he attended education. Healthcare staff reported that he had received treatment for mouth ulcers and was listed for review by the doctor the next day. It also noted that a review of his medication was to be done by a psychiatrist. His mother told the lead investigator that she had been concerned that her son was not receiving the correct dose or timing of his medication and agreed to ask his community doctor to fax healthcare staff a medication brief. The keyworker noted that the young person was due in Crown Court on 13 January for sentencing for an offence of affray. They planned the next meeting for 20 January, which could either be his final DTO meeting or a review, depending on the outcome of his sentence.
97. Following the DTO meeting, the keyworker phoned healthcare to pass on the young person's mother's concerns about his ADHD medication times and spoke to a nurse. The nurse recorded in his clinical record that the young person had also raised this issue with her. He had said he would prefer his second dose of ADHD medication at 4.30pm rather than at 7.00pm, because it affected his sleep. His mother confirmed this was the time he usually took medication when at home. The nurse checked with the young person's named nurse, who agreed it would be acceptable. The nurse recorded that she had made the wing senior officers aware of the time change.
98. A doctor examined the young person on 21 December, and recorded that the ulcers had eased with the gel but were still there. The young person said his eating and drinking were not affected. The doctor diagnosed oral candidiasis (fungal infection) and prescribed fluconazole, miconazole and more of the gel, and planned a review for 3 January 2012.
99. Later on 21 December, the young person received a visit from his mother, father and step-mother. The learning disability nurse also recorded that he had received a copy of his statement of special educational needs and noted

in his clinical record that the statement highlighted difficulties that staff working with him should be aware of. He wrote:

“He was assessed and found to have low cognitive ability. He also has a long history of [difficulty] acquiring basic skills. He has difficulties in; literacy, numeracy, attention, concentration and self-esteem. In addition, he has [ADHD] which impacts on his: ability to accept direction and correction; compliance; disaffection; social interaction.”

100. The young person's named nurse saw him on 22 December. He said he did not always want his medication at the times it was dispensed but thought he would be punished if he refused it. The nurse advised him that he was entitled to decide not to take it and would not get into trouble.
101. The young person then had a meeting with his solicitor using a video-link. The learning disability nurse saw him when he was in the mental health centre later that afternoon and recorded that he seemed in good spirits. He told the nurse he had good news from his solicitor and had a “50/50 chance of being released”. The nurse recorded that he stressed the importance of not building his hopes and being realistic about both possible outcomes. Although the young person seemed to accept this, the nurse recorded “his elevated mood leaves cause for concern as to his interpretation”. The nurse noted that the young person's court date was 13 January and agreed to review him again after his return from a period of annual leave.
102. An entry was made in P-NOMIS by the young person's teacher on 22 December. She recorded that he had had another excellent week in education displaying good behaviour and attitude.
103. The young person made a number of telephone calls to his family and girlfriend over the next two days. On 24 December, Christmas Eve, two and a half weeks after his arrival at Hindley, an officer noted in the P-NOMIS records that he introduced himself to the young person as his personal officer. The officer said that he had only just found out he was to be the young person's personal officer. He recorded that the young person said he was fine and had no problems.
104. Nothing is recorded about the young person over the Christmas period. The next entries relate to an incident on the morning of 29 December. The young person was in the waiting room of the healthcare centre waiting for a routine dental appointment. A Healthcare Assistant (HCA) heard another young person from Fir wing giving “a lot of verbal abuse”. The HCA said that the young person just sat there and ignored the other person. He thought that the young person was very mature and commended his attitude. The HCA said many lads start retaliating or getting into fights, but the young person seemed to ignore it. During interview with the investigators, the HCA could not remember the specific things that were said, but said it was general name calling and abusive. He said he asked the young person if he was alright and he said “oh they are just nosey boss, leave it”. The HCA was not very concerned about the young person because of his mature attitude but made a

note of this in P-NOMIS. The HCA did not raise a safeguard referral or security information report, and told the investigators that with hindsight, he thought he should have done.

105. The investigators interviewed the other person involved on 29 December. He described the young person as “weird”. He told investigators that the young person did not engage with other young people and hardly came out of his cell and always ate in his cell by himself. He said if he did come out during association he would sit on the floor outside his cell. Also, he collected his medication from another wing. This witness said that the young person was not being bullied and denied abusing him. This person was one of the only young people interviewed who said the young person was not being bullied.
106. The young person’s YOS worker visited him on the afternoon of 29 December, to prepare a pre-sentence report for the court. In her report, she noted that the young person displayed low self-esteem and self-confidence. It also said “the aggression he has displayed towards others seems to emanate from poor conflict resolution [skills] and the lack of emotional controls which may be heightened by his diagnosis of ADHD and Conduct Disorder ... He also disclosed that he feels worthless and depressed most of the time and has thoughts about killing himself although he says he has no intention of carrying this out”.
107. The YOS worker wrote in the pre-sentence report:

“... He has verbalised his motivation to change his behaviour and demonstrated some awareness of the consequences of re-offending. He is aware that he could receive another custodial sentence and has stated that he is worried by this possibility ... his diagnosis and his requirement for ongoing treatment and support from CAMHS means that he is a vulnerable young person. Whilst he is trying, engaging and following the regime, he reports that he is struggling to manage in this environment. I have great concern in regards of his vulnerability with him disclosing that he is being bullied and appearing unable to follow the processes to report his feelings which have been highlighted through DTO meetings and legal visits. As a result of these concerns I assess him as a medium risk of harm to himself whilst in custody.”
108. The investigators did not receive a copy of this report until after they had met the YOS worker. She told the investigators that her meeting with the young person had lasted around 90 minutes. She described him that day as agitated, aggressive and erratic. He was anxious about his approaching court appearance as he did not want another custodial sentence, but she found it difficult to obtain from him the information she needed in order to complete her report. He disclosed that he was being bullied and he gave her a name of the young person involved. She asked him about his mood and whether he would harm himself, but he said he would not do that. She told the investigators that his main concern during the meeting was who was looking after his mother.

109. The YOS worker said she filled out a safeguarding form detailing her concerns about the young person's disclosure of bullying, including the name of the other person he had mentioned. She said she gave the form to one of the visits staff, although she could not recall who that had been. At first Hindley said this form could not be found but after a further request and additional searches it was discovered and provided on 11 September. The form asked if there were any immediate concerns regarding the young person, and the YOS worker had ticked 'yes'. She wrote:

"He informs me that he is getting grief off a YP. He feels he may react if it goes any further. He feels he may harm himself and feels he would be better off dead and the officers take the piss out of him".

110. There is space on the form for visits staff to document the actions they have taken. Options include: Wing SO informed, ACCT opened, Orderly officer informed, Safeguards referral, SIR, NOMIS updated". The only box ticked was "Wing SO informed". An officer wrote below "wing SO informed and spoke to the young person, who said he didn't mean what he said and was just upset with the visit from his YOS".
111. The SO on duty on Fir wing that day said that visits staff telephoned her and said the young person had made some comments following his visit saying "he had nothing to live for". Visits staff asked the SO to speak to the young person. The SO did not remember being told by visits staff about any allegations of bullying. She was not usually based on the wing, so she had not met him before. However, she had previously been the safer custody officer and understood safer custody policies and assessments. She spoke to the young person who, she said, told her he was okay. He said the YOS worker had "pissed him off" as she kept talking about his past and suggested he finish the relationship with his girlfriend. The SO asked him about self-harm. He said he had harmed himself in the past but had too much to look forward to and was hoping to be out in a month.
112. The SO also asked the young person about the incident in the healthcare waiting room, and if he had problems with another young person. He said he was getting comments from the other person mainly about his medication and saying he was on methadone, but the young person said he could just ignore him. He said he did not want to move cells and did not want staff to do anything. The SO made an entry in the Fir wing observation book to notify staff about both matters and made an entry in P-NOMIS. She did not see the form completed by the YOS worker and the only reference to bullying she knew of, was the one from an HCA on P-NOMIS about the incident on 29 December.
113. Over the next few days the young person made a number of short phone calls. His pin-phone credit ran out on Sunday 1 January and was not replenished until Friday 6 January.
114. On 3 January, the young person had a review with the psychiatrist when he reported that his mouth infection was making eating and swallowing difficult

and he was experiencing problems with others on the wing. The young person said staff had told him that other young people were making threats against him and he also told the psychiatrist that he had received a “minor report” for improper use of his cell bell (there is no confirmation of this in any other records). The young person was very worried about his mother and said he had a fast or irregular heartbeat at rest even when he was not feeling anxious. (This is known as tachycardia.) The psychiatrist referred him for an ECG (electro-cardiogram). The young person said that officers had discussed the possibility of him moving to Willow Unit but he was concerned that this would make him look like a victim. The psychiatrist tried to reassure him that Willow might be helpful for him.

115. In the afternoon, the young person saw the learning disability nurse on the wing and said he was supposed to have seen a doctor that morning to check his mouth ulcers. The nurse checked the appointments list and told him that his appointment was for two days later.
116. In the evening, the nurse went back to see the young person. He was in his cell while other young people were out on association and the nurse spoke to him in the senior officers’ office. The nurse noted that he was “difficult to engage, presenting in a low mood”, and also noted that the young person had some history of self-harm but not while in custody. He was mainly concerned about his upcoming court appearance. The nurse recorded that he would return to see the young person the next day when it was quieter as “I feel he finds the evenings on the wing intimidating during association”. The nurse also e-mailed the young person’s named nurse to suggest he might need further support.
117. At interview, the learning disability nurse explained that the comment in his note about the young person finding the evenings intimidating, was his own assessment rather than based on any comment from the young person. The nurse said that there were situations where the young person interacted with other young people, such as in the workshops, but he did not generally look comfortable in a social group setting. The nurse also found that the young person’s mood fluctuated.
118. There is a record in the wing observation book from an SO (not timed) saying that the young person appeared upset in his cell that evening. The SO said at interview that, although she knew the young person from seeing him around the wing, she had not previously had any significant dealings with him. Her recollection was that, towards the end of evening association, an officer asked her to speak to him as he appeared to be upset. The SO said she sat with him in his cell. At first he would not speak and she explained to him that she needed to know if he was safe and needed to know if there was anything the staff could do to help him. Eventually, he began to talk and he spoke about his forthcoming court case, his worry that he might receive an additional custodial sentence and his worry that his girlfriend would leave him if that happened. She said that she tried to reassure him telling him that he should not pre-empt what might happen at court, while trying to reassure him that if his girlfriend loved him she would not end the relationship because of an

additional sentence. She asked him if he had any thoughts of self-harm. After speaking to him, she noted in the wing observation book that he had no thoughts of suicide or self-harm and “feels he can speak to staff if his feelings change”.

119. The following morning, 4 January, the young person’s named nurse made a note in his clinical record that she had discussed him with the psychiatrist and the learning disability nurse about increasing support. The young person was due to start weekly structured one to one sessions with a mental health nurse and support worker the next week. In addition, his named nurse arranged to see him the next day.
120. The young person refused to go to education that day for the first time since his arrival at Hindley. He was issued a minor report (minor disciplinary matters are dealt with by the wing SOs through the minor report system). His personal officer made an entry in P-NOMIS to say that he had spoken to him at length over the previous few days about a letter he had written to the judge for his court appearance and which he had posted to his mother.
121. The learning disability nurse returned to see the young person that morning. He said he had refused to attend education as he felt unwell and had a temperature. He said he had seen the nurse but removed the thermometer because “he couldn’t be bothered waiting”. The nurse recorded that the young person seemed to find this amusing and, when he challenged him on this, he became confrontational and refused to engage. The nurse left and noted he had discussed this with his named nurse.
122. Another SO also saw the young person that morning to discuss the minor report. He was charged with breaking YOI rule 55 paragraph 25, disobeying any lawful order, by refusing to go to education. He told the SO that “he couldn’t be bothered going”. The SO gave a punishment of one day’s loss of association and eating out of his cell. (Tables are set up on the wing at meal times so young people can eat their meals together in the communal area.) At interview, the SO was unable to recall this incident. He said many minor reports were issued and it was not unusual for a young person to say that they could not be bothered about going to education. His clinical record indicates that he refused to take his ADHD medication that afternoon.
123. On 5 January, the young person saw a doctor for a review of his mouth infection. The infection had improved with treatment, so the doctor prescribed a further course of the same medications that another doctor had prescribed a fortnight before. The doctor also ordered blood tests to explore possible reasons for the cause of his mouth infection and his symptoms of tachycardia.
124. The young person’s named nurse saw him when he went to the mental health unit. She recorded that he presented in a “euthymic” (stable) mood, made good eye contact and had relaxed posture. He said that he had been told he might move to the Willow Unit but did not want to go. He said he was sleeping okay but did not have much appetite and his mouth ulcers were causing him problems with eating. He said he had encountered a few

problems in education. The named nurse told investigators that the young person would not give further detail about the problems he had had when he attended education but said he could ignore it. She said that when a young person reported bullying she would speak to the wing SO and submit a safeguard report and a security information report, but had not thought there were grounds for doing so in his case. The way the young person presented himself did not make her feel he was being bullied. She completed her entry in his healthcare records by noting that he was eager to start attending twice weekly group activity sessions which were due to start the following week and that she would continue to monitor him.

125. An SO from the Willow Unit told investigators that when a young person is referred to the Willow Unit, a member of the unit staff will speak to him to explain how the unit operates as full engagement is necessary. She accepted that there was a stigma attached to Willow which made some young people reluctant to come to the unit. She said that she was not aware that this young person was ever discussed as a candidate for referral to Willow.
126. The young person's tutor said that he had been quite quiet when he first started education classes, but in time he became more relaxed and more comfortable with the other learners. She did not notice that he made any particular friends, but spoke to everyone. She said there were only around four or five learners in his class and she was surprised to learn about the note made by his named nurse as she had not witnessed or heard of him having problems with others. She said that she had been on leave for the first two weeks in January, but on her return the young person was more confident than he had been since she had last seen him. The locum tutor did not pass on any concerns about him having difficulties with other learners.
127. On 6 January, the young person went to hospital for an ECG to investigate possible causes of his tachycardia. The results were normal.
128. The young person's pin-phone was credited on Friday 6 January and he made a number of phone calls. He received a visit from his mother and his girlfriend on Saturday 7 January. He continued making phone calls over the weekend.
129. On Monday 9 January, it is recorded in the young person's medical notes that he was due to start group activity sessions, supervised by mental health nurse and was due for a mental health review on 1 February.
130. The psychiatrist assessed the young person again on 10 January. He recorded that he had had an ECG which was normal. He noted that the young person was "physically better this week, but still on the mend. Solid food difficult. Sleep not great". He also recorded that he was concerned that if the young person received a further sentence after his court appearance on Friday 13 January that "his mood will crash". In his plan, the psychiatrist said he would see him the next week and staff would need to keep a close eye on him after Friday. The next day, he attended the mental health group and no concerns were raised.

131. On 11 January, the young person attended a support group session in the healthcare unit. A mental health nurse explained that young people referred to the support group are usually those who are finding life difficult on the wings because of the number of other young people and he understood that that was the reason for this young person's referral. The support group is composed of a small number of four to six young people, who engage in activities such as art, cookery and relaxation. It meets twice a week and runs for six weeks. The nurse said that the first session includes explaining the aims of the course and the standards of behaviour expected. His colleague recorded that the young person had: "... interacted well with staff and peers, though minimally participated within the group discussion".

Court appearance Friday 13 January

132. On the morning of 13 January, the young person was taken to Crown Court for sentencing following his conviction for affray the previous month. His YOS worker said she saw him before and after his court appearance. She noted in his records that he was concerned at the prospect of receiving an additional sentence, but accepted this might happen. She said that she prepares young people for that eventuality.
133. The young person's meeting with his YOS worker ended at around 10.30am. Around 40 minutes later one of the court custody officers, a YOI Custody Officer (PCO) went to the cell to collect him to take him to see his solicitor and saw that he was crying. The PCO told the investigator that she asked the young person if he was all right, but he ignored her. She suggested that he wash his face before she took him to see his solicitor. She then told her line manager, a Senior Custody Officer (SCO), and made an entry in his escort record.
134. The SCO wrote in a statement to the investigators that, after being advised about the young person crying, she spoke to his legal team who told her that while he was anxious about being in court, he did not have a history of self-harm or suicide attempts. She wrote that she checked the escort record to see if Hindley had highlighted any potential suicide or self-harm risks and there were no such warnings. She made a note about this in the escort record.
135. When the young person appeared in court he was given a six month DTO which meant his mid-point release date would now be 24 March 2012. His YOS worker went back to see him but she found it difficult to get his attention because he just wanted to speak with his friend, who was his co-accused and who had been sentenced at the same time. She said that the young person was happier now that he was with his friend but she still considered a placement at a secure training centre (STC) or in the Keppel Unit at HMYOI Wetherby would be preferable. She telephoned the placements team at the Youth Justice Board to inform them about the additional sentence and her recommendation for the best placement for him. She recalled being told by the placements team that he would not be going to an STC or the Keppel Unit

that day but would instead be returning to Hindley. She could not recall what explanation she was given for this. She added that she intended to make a referral to the Keppel Unit during the following days, but did not see this as a great priority as other than the concerns she had passed on in December, there were no indications from Hindley about him being vulnerable¹.

136. An officer from the Youth Justice Board's placement team, to whom the YOS worker spoke on the afternoon of 13 January, wrote a statement about the conversation:

"[On] Friday 13 January 2012 I received a telephone call from a YOT worker to book the young person in.

"She said he was not happy and said he was being bullied at Hindley ...

"From memory, she what she had to do to get him into an STC. I said that the procedure ... is normally done by way of transfer.

"We had a discussion about the Keppel Unit. I explained the benefits of Keppel and that the approach to Keppel is normally done by ... referral ... I believe I referred her to our website and offered to fax [a referral form] to her ...

"I believe she said she would speak to [a manager or colleague] and submit [a] form to the YJB once decided. My feeling is she was not sure which was more suitable and did not wish to make a decision there and then. I am sure I asked if she was sure he would be okay tonight, to which [she] replied yes.

"I have dealt with telephone conversations like this on numerous occasions. Where possible, we have been told that all transfers must be dealt with by means of a transfer request form, but where we have a YOT worker adamant that a [young person] should not return to a particular establishment, this is immediately investigated by contacting the establishment and ... the decision to move the [young person] could be granted without a transfer request form in significant cases.

"This was not the case in this instance. After I answered the question of how a transfer could be made, she did not even continue to talk about how he was feeling ... [she] did not stress ... urgency in this transfer ... or suggest that he would not cope another night in Hindley and to my knowledge [did not submit] a transfer form or Keppel request. Another thing which makes me certain that the urgency of this transfer was not mentioned or ... made apparent, is that even if a transfer is not granted on the day of placement, when a YOT worker raises concern about a [young

¹ At the time the investigators met the YOS worker they had not received all documentation from the Youth Offending Service. When these documents were later provided, they did not include a post court report for 13 January on which the young person's vulnerabilities and any risk of self-harm would be noted. Following further enquiries, the investigators were told by the Youth Offending Service that it seemed likely that no post court report had been completed.

person] returning to a particular establishment, I would send [an e-mail] ... asking ... the establishment to open an ACCT/keep an eye on the [young person] ...”

137. The officer later left her employment with the Youth Justice Board. The investigation team wrote to her twice at her last known address to arrange an interview but received no response.
138. One of the two escorting staff who took the young person from court back to Hindley that evening told the investigator that before collecting him from his court cell he first checked the paperwork. He saw from the escort form that the young person had been anxious and upset earlier on in the day but people had spoken with him and he had calmed down. The escort form indicated that there were no past or present concerns about self-harm or suicide. The PCO said that when he collected the young person from his cell, he was smiling and seemed in good spirits. They arrived at Hindley at around 9.00pm and the PCO and his colleague took him into reception.
139. The young person was checked by a nurse in reception. She made an entry in his records:

“... seen in reception after [return] from court. Sentenced to a 6 month DTO, he will serve 3 months. States was upset at first but is ok now, will ask mental health to see him tomorrow.”
140. The young person’s friend and co defendant said that he did not seem particularly upset at court that day and was cheerful on the journey back to Hindley. While waiting to be seen in reception, they watched television and he remained in a good mood. (From reception, the young person went back to Fir wing while his friend went to Juniper wing – the first night centre.)
141. An officer made an entry in the wing observation book at 9.45pm to say that the young person had returned to his cell on Fir wing and had been given a hot meal.

14-16 January

142. On 14 January, A mental health nurse visited the young person on Fir wing to see how he felt after his court appearance. He appeared settled. He explained he had to serve a further three months but it would soon pass. He said he had no problems with his appetite or sleeping. He said he was in contact with his mother and girlfriend and that they might be visiting that day.
143. Over the weekend (14 and 15 January) the young person made a large number of mostly short phone calls to his girlfriend, his father, and his mother. He informed all three that he was being threatened by other young people. He told his girlfriend he was going to be moved to Wetherby (another young offenders’ establishment) “because everyone’s threatened to stab me”. However, he added “I’ve said I’m not moving; I’m not scared”. In his next call to his father, he said “I’m supposed to be getting stabbed in a bit ... [I’ve told

staff and] that's why they're supposed to be moving me". He told his stepmother that "... at the end of the day they won't, they wouldn't dare stab me". In another call to his father a few hours later he said "They're just being knob-heads dad, I've been asking to see the [Senior Officer] for about an hour and a half ... the [Senior Officer's] not even busy, he's not even come to see me". In a call to his mother shortly after he said "They're all ...calling me a scrubber, saying I fucking smell ... I tell a member of staff and they don't ... do nowt ... I asked to see ... a Senior Officer about two hours ago and he still ain't come to see me". (While telephone calls are recorded, only a small percentage of calls are routinely listened to, so it is unlikely his comments were heard by staff at the time.)

144. There are no entries in the young person's records covering the morning of 16 January, and it appears it went to education as normal. He refused to attend Elm wing to collect his medication in the afternoon. An hour later, an officer made an entry in P-NOMIS to say that he had been placed on minor report for jamming a mirror in his door frame and blocking entry to his room. The officer said that staff had spoken to the young person for about ten minutes trying to persuade him to remove the blockage. Eventually, staff had to open the door from the opposite side (cell doors are designed to allow them to be opened from the side opposite to which they ordinarily open). The young person was abusive, but he did not appear to be upset. The officer could not recall him giving any explanation for his actions.
145. There is a note in the young person's clinical record saying that he did not attend a hospital appointment due to staff shortages and this was to be rebooked. There is no record of what this appointment was for.
146. The learning disability nurse saw the young person on the evening of 16 January and made an entry in the clinical record the following morning. Officers had told the nurse that the young person had been settled lately but that he had had a negative afternoon. The nurse noted that it began when the young person had been kept behind on the wing from workshops that afternoon as he was due to attend hospital, although he did not think he had an appointment. He placed his mirror into the lock of his door to prevent staff from entering his cell and covered his observation panel. The nurse described the young person as very subdued. He said he was receiving "constant abuse" from other young people and his mood was low although he said he would not harm himself. The nurse noted that the young person seemed to be finding it hard to come to terms with his sentence and that his behaviour, such as isolating himself, was attracting negative attention from other young people. The nurse contacted the keyworker to share his concerns.

Tuesday 17 January

147. On the morning of 17 January, the young person's keyworker visited him on Fir wing and recorded in the Asset that he was very quiet. The young person said that "the other lads keep taking the piss and are always at my door during association". The keyworker told him to involve himself more and not

talk about himself too much. The keyworker did not pass this information on or write it in the PNomis records.

148. In the early afternoon, the young person telephoned his girlfriend. He told her that he had received some good news. This was that his release date was 24 March, which was earlier than he had anticipated.
149. Not long after speaking to his girlfriend, the young person saw the psychiatrist. He said that he had received a further DTO but would be released on 24 March in time for his girlfriend's daughter's birthday, although not in time to see his father before he moved to Australia. The psychiatrist noted that the young person appeared physically much better and described himself as "chilled". The psychiatrist planned to see the young person the following week.
150. The young person also saw an SO in response to receiving the minor report for jamming his door. He admitted the offence, and received punishment of one day loss of association, eating out and gym.
151. At about 9.40pm, the young person pressed his cell bell and the officer responsible for Fir wing that night went to see him. He had smashed his television and told the officer he wanted to see the nurse. He would not tell the officer why he had smashed his television. The officer rang the orderly officer: the SO in charge of the establishment that night. As officers do not carry keys during the night (except a cell key in a sealed pouch to be used only in emergencies), the orderly officer had to be called to open cells in non emergency situations.
152. The orderly officer arrived on Fir wing at about 9.50pm with a nurse. When the orderly officer opened the door he saw that the young person had made cuts to his left wrist and cut his left forearm, using the plastic from the television. The orderly officer told the investigators that he was struck by the young person crying. He said very little at first other than he wanted to be with his mum. The orderly officer convinced him to come out of his cell and to speak in the wing office. This was partly so that other young people would not hear and partly so officers could clear his cell of any debris. In the office, the nurse cleaned the young person's wounds and treated them with steri-strips. He said he had smashed his television and self-harmed because of the abuse he was receiving from other young people, but would not say who they were. He talked about other young people shouting out the windows. The orderly officer opened an ACCT and explained what it was for. He told the investigators that he got the impression the young person found it difficult to ask for help. He spoke freely about his family and appeared to calm down. The orderly officer made a mistake with the young person's first name when he completed the front of the ACCT. The observation level was set at five times an hour. The orderly officer asked the young person if he would be more comfortable being moved, but he wanted to go back to his cell. The orderly officer telephoned the duty governor, who agreed that this would be acceptable.

153. After the orderly officer's discussion with the young person, he completed the ACCT immediate action plan. He wrote that he should remain in the same cell but because of the allegations of bullying, a move should be considered after a full review by a multidisciplinary team. He set the level of observations at five times per hour at irregular intervals. He also recorded that the young person should be given a phone call to his mother following a review the next day.
154. The nurse also made an entry in the clinical record. She said that when she arrived at the cell the young person would not make eye contact, he was crying and refusing to talk. He said he just wanted to go home. He then agreed to talk to the orderly officer and told him he was being harassed by other young people on the wing and they were shouting out the windows at him. The nurse wrote that the young person understood he would be seen again in the morning and might move to another wing. She made a referral to the mental health crisis team.
155. An officer made entries to this effect in the Fir wing observation book and in P-NOMIS. He made a safeguards referral and submitted a security information report. The orderly officer also submitted a Bullying Vulnerability Referral (BVR). On this, he wrote that when the young person self-harmed he disclosed that this was because other young people on Fir wing had been constantly abusing him over a prolonged period of time. He suggested a unit move. The BVR would be considered at a weekly meeting. The next one was scheduled for the following day, 18 January.

Wednesday 18 January

156. On the morning of 18 January, an officer went to speak to the young person. She wrote in his ACCT that they spoke about the events of the previous night and he said he had been "pissed off". She asked him if he wanted to move rooms to the Douglas side of the wing but he declined and "basically demanded a wing move". She explained she thought this would be unlikely but he could move to the other side. He said that he would be going to Willow soon but she said she did not know anything about that. He initially refused to go for his medication, but then changed his mind and went to collect it.
157. A trained ACCT assessor carried out the young person's ACCT assessment on 18 January. The ACCT assessor told investigators he had not properly met the young person before that morning. He had supervised breakfast that morning and stood near the young person's cell, so looked in on him regularly. The ACCT assessor he could not always see the young person so he opened the door to check he was okay. He was polite but just said he was trying to get some sleep. When the ACCT assessor left the cell, he did not lock the door so the young person could come out, but he got up and locked it from inside.
158. During the assessment, which lasted about an hour, the young person told the ACCT assessor that his frustration had built up and he was receiving "a lot of hassle" from others on the wing. He said other young people were calling him

“meth head” and other names. The ACCT assessor told investigators that the young person seemed most concerned about missing his girlfriend and being worried he would not see his father before he emigrated. He said he just did not think and smashed his television, and cut his wrist as a way to cope. He said he regretted it soon after, and felt guilty that his family would worry. The ACCT assessor told investigators that he had asked him if he acted without thinking a lot, and he responded that he was sometimes just spontaneous. He said he had not been sleeping properly. He said he did not come out for his tea and staff offered to take it to him. He said he did not want to interact with other young people, but he felt okay. He said that he had a young stepdaughter (his girlfriend’s daughter) and a caring family. He felt this would stop him from further self-harm. He said he had no current thoughts of self-harm or suicide. He said he would like to continue to see mental health staff and would like to stay on Fir wing but he understood he might be moved.

159. The ACCT assessor told investigators that, in the context of completing ACCT assessments regularly, he was not too concerned about the young person. He said he had been very talkative and relaxed.
160. Soon after the assessment, the young person attended an initial case review chaired by an SO in company with the ACCT assessor and a mental health nurse. It was the first time the SO had met the young person as he was just covering Fir wing which did not have a regular wing SO on duty that day. The nurse later recorded in the medical record that the young person engaged well and was chatty. She recorded that he identified the reasons for his self-harm as being in custody and away from his family and bullying. He said he had been isolating himself, not attending to his personal hygiene needs or collecting his meals. She noted that he did not identify those bullying him by name but gave some limited description so staff were trying to identify the alleged perpetrators. He said he was determined not to let bullies get to him, and wanted to engage more and not hide away. The SO told investigators that he had not wanted to mix with others as he said they were “not the kind of boys” he wanted to be friends with.
161. The nurse noted that the young person did not want to move wings though he said another SO had said he could go to Willow Unit. He said that he “100% wouldn’t try to kill” himself as he had too much to lose. He had worked out that he only had around 89 days left before release, and was confident that he would not return to custody. He said that he only had limited contact with his family as he spent all his phone credit on the day he got it, but he would try to budget it.
162. The SO wrote in the summary of the case review that the young person maintained good eye contact and openly discussed the previous evening. He said he would try to associate with other young people and asked to stay in the same cell on Fir wing. He said he had too much to lose if he hurt himself. The SO also spoke to the young person’s mother after the review, who told him that her son had written to her saying he was having trouble the previous week and had thought of ending it. The SO wrote that he asked her to phone Hindley if her son told her anything else of concern.

163. The review assessed the young person's risk as "raised" (rather than low or high). The ACCT assessor said this was because his self-harm had been a spontaneous act after a build up of frustration. It was noted he had been referred to the mental health team and the next ACCT review was scheduled for 21 January, three days later.
164. The SO then discussed the Caremap, which sets out the issues the young person is facing and actions to resolve them. The identified issues and actions were:
- Not going out on association – him to associate with others and staff to encourage him.
 - Improve hygiene – him to shower and shave regularly
 - Not taking medication – him to take medication and staff to encourage him.
 - Withdrawal symptoms – him to talk to staff if low, and talk when bored, and ask for equipment to use in cell. (The SO explained this was about isolation rather than withdrawal from medication.)
165. The young person's observations were reduced to two each hour. The ACCT assessor checked on him soon after the review. He had eaten a sandwich, drunk a cup of tea, and was at his desk colouring in a book. Because of his attendance at the ACCT review, he missed the support group run by a nurse and a tutor. He had also missed the previous support group session on 13 January because of his court appearance that day.
166. The young person was discussed at the weekly BVR meeting that morning which was held at the same time as his ACCT review. The minutes record that the meeting was chaired by the manager of Elm wing, who usually chaired the meeting when her line manager, the Head of Residence, was absent (although he was also recorded as present.) The minutes stated that the young person smashed his television and cut his arm, which he said was because other young people were constantly abusing him and that he was being supported and monitored through the ACCT process. The planned action was for ACCT support and monitoring to continue and for his keyworker to speak to him and then to feedback to the manager of Elm wing. The manager told one of the investigators that the SO who chaired the ACCT review had telephoned her after the ACCT review, and after the BVR meeting, to tell her that there appeared no reason to be too concerned because the bullying issues had been addressed and he was quite content. She added that she had a recollection of somebody else telling her that his keyworker had seen him and he also felt that most of the issues were resolved.
167. Later, the young person attended the woodwork workshop and was reported as having a good afternoon. An instructor in Hindley's practical crafts (woodwork) workshop told one of the investigators that a maximum of eight young people attend each workshop. He said when the young person first attended he was very quiet. He seemed to really enjoy coming to the workshop but he kept himself to himself, preferring to speak with the tutors

rather than the other young people. He said that after Christmas, he seemed a totally different person. After Christmas the group had reduced in size and some of the strong personalities who had been there previously had left. He said the young person started interacting more with the other young people and would exchange some banter.

168. After teatime, the young person's keyworker went to see him on Fir wing. He was using his colouring book and told him he had received two letters. He commented that he had missed his niece's christening.
169. The keyworker was supervising evening association on Fir wing with another officer on 18 January. He told investigators that because he was aware the young person had said he was experiencing problems with other young people, he decided to unlock his cell before the others on the wing so he could make a telephone call. The young person used the phone and then went to have a shower. The keyworker said that when the other young people were unlocked, two of them went straight to the young person's cell and he told them to stay away. There are some comfortable chairs at different points around the wing, one of which was next to the young person's cell. The keyworker decided to sit there during association so he could keep other young people away from the young person's door. He said that the young person finished his shower, collected his medication and then went back to his cell. The keyworker thought he seemed quite happy spending time on his own.
170. At the end of the association period, the young people are locked in their cells and the officers go to each cell offering hot water to make a cup of tea in their cell. At this point, staff let out young people who have missed association as a punishment to allow them to use the phone. The keyworker told the investigators that one young person was let out of his cell to use the phone but:
- "he ran straight to the [the young person's] door and started shouting something, I don't know what it was. Then I turned round, I still had the jug in my hand and everything, I told him to get back behind his door and then he went back and he was locked up again."
171. These incidents were not recorded. An officer noted in the ACCT that the young person chose not to associate with other young people that evening, but had a shower and saw the nurse. He told the officer he wanted to go to sleep. The officer went to see him soon after 8.00pm to offer him hot water for a cup of tea. He asked for paper so he could write a letter, which was given to him. No problems were recorded overnight.

Thursday 19 January

172. On the morning of 19 January, the young person was charged with a disciplinary offence for breaking his television. He had a shower, collected his breakfast and returned to his room to eat it. There is a further entry in the

ACCT on-going record at 10.55am from an officer which reads “He stood at his door, talking to the cleaners out on the wing”.

173. An operational manager went to Fir wing to conduct the young person’s adjudication (disciplinary hearing) for damaging his television. She told the investigators that she spends some time trying to build rapport with a young person before going through the adjudication process. She had not met the young person before, but as soon as he came in the room she was concerned about him. She described him as angry, frustrated and moving about in his chair. When she asked why he had smashed his television, he started listing reasons. She told investigators:

“He was clearly annoyed, unhappy, upset. He was ... saying that he hates it in here, that was one of the major things that he kept saying and he was swearing a lot. He said that he was getting a hard time on the unit off other young people and that the staff didn’t care about that ... Told me basically he wants to go home, he kept saying ‘I hate it here, I want to go home, I want to go home’ ... when he was in his room people were shouting out of their windows telling him to rape his step-daughter.”

174. The operational manager told investigators she explained to the young person how she could help him and encouraged him to tell her everything. When she asked who was saying these things, the young person said it was “loads of people”. She said that she was very concerned about his demeanour and the seriousness of what he was saying. She said that he was jumping from subject to subject. Firstly he talked about young people shouting through the windows, he then said a young person urinated under his door, then he said he had been asking staff for new shoes. She said she kept trying to get more detail of the incidents and timings so that she would be able to view CCTV to trace the perpetrators. He said he would not give names as he would be a “grass”. She said that the way he was flicking from story to story made her concerned about his mental health. She said that her view was that either these things were taking place or that he was really distressed and it was in his mind.
175. The operational manager asked the young person if he was seeing mental health services and if he was on medication. He said he was and he took ADHD medication every day. She decided to stop the adjudication and take advice from mental health staff as to whether he was fit to proceed. She told investigators she also wanted to get to the bottom of what was happening on the wing.
176. She then telephoned a nurse in the mental health team and asked for the young person to be reviewed before she continued with the adjudication. The nurse told her that they were short of staff that day so it would be difficult to see him. However, she advised that the psychiatrist had seen him two days earlier on Tuesday 17 January, and she (the nurse) had seen him the day before and there were no new concerns at either of these reviews. The nurse agreed to assess the young person again the following day.

177. The operational manager said she told one of the wing SOs that she was very concerned about the young person. She told the SO about the young person's allegations including urinating under his door and that she needed some names. She asked for someone to report back to her later that afternoon. She said the SO told her he was aware of the problem and someone was looking into it. The SO told one of the investigators that as his shift was coming to its end he left a note for the next shift to make the young person move to the other side of the wing that afternoon. There was no note about this in the SO handover book.
178. Two officers spoke to the young person about moving cells and told him he was being kept back from activities that afternoon so that he could move. He was adamant he would not move and said he would "deal with the problem myself". He refused to identify the young people who were abusing him. One officer said he tried to persuade the young person by saying he might receive a minor report for refusing to move cells. He said he did not intend to issue a report but used the threat of one to try to persuade the young person to move.
179. The operational manager returned to the wing soon after 2.00pm to speak to the young person about moving cells. She recorded that he was still very annoyed and kept saying he would not move and asked "why should I move to keep staff happy?" He also threatened to bite a young person's ear off. This person lived in the cell above and was a wing cleaner. After she left the young person's cell, he kicked the door for several minutes. She contacted the mental health team to check whether he had been taking his ADHD medication, which he had.
180. An SO said that the operational manager spoke to her about her conversation with the young person. The operational manager said that the young person was being bullied by the wing cleaners and she named one of them. The SO told her that as she did not usually work on Fir wing she did not know the cleaners. She asked her what the plan was and the operational manager said that she was going to arrange a mental health assessment and, depending on the outcome, might consider a transfer to the Willow Unit or perhaps elsewhere.
181. An officer wrote in the Fir wing observation book that the young person had threatened to bite a young person's ear off as he was verbally abusing him through his door when cleaning. The officer made a safeguards referral saying that the young person had also named another young person who was verbally abusing him. She submitted an SIR and updated the ACCT.
182. Later in the afternoon the young person's keyworker visited him. He made notes in the Asset saying he had spoken at length with him the previous day as well as 19 January. The keyworker wrote that the young person was receiving hassle from other young people, which led him to smashing his television, self-harming and threatening other young people. The keyworker tried to advise him of the benefits of moving but he did not want to and said he had things under control. At interview, the keyworker told investigators that the young person said other young people were shouting out the windows at

him and calling his mum names. He said staff were not helping him, but the keyworker told the investigators that he was on duty during association the previous evening and had spoken to the young person several times during the two and a half hours, during which he remained in his cell.

183. The keyworker wrote that he would refer the young person to the “safer regimes” meeting, and had completed referrals for the TEAM programme (the emotional awareness and management programme) and anger management. He wrote that the young person was quite demanding of staff and did not seem to want to help himself. He said he was fine one minute and would agree to move cells but then would change his mind. The keyworker noted that the young person was struggling with custody. A DTO meeting had been scheduled for the following day with the YOS officer and the young person’s mother, so he planned to see what the YOS officer advised.
184. There is an entry in the ACCT to say that the young person had been given a phone call and had been over to collect his medication. It does not seem he made a call as the number he dialled from the pin-phone was simply “9”, and was therefore invalid.
185. A young person told investigators that he worked as a cleaner on Fir wing. He said that young people in Hindley shout insults to one another about their families. He accepted that he shouted insults at the young person subject to this investigation, but said that this young person had shouted similar insults back at him. They also threatened one another. The young person had threatened to bite off his ears and nose, while he had told the young person that he would punch his head off. He did not think he had given the young person a harder time than the young person had given him. He denied trying to take some of the young person’s canteen and denied being part of a group who were targeting the young person together. He also said that the young person stood out because he did not speak to other young people.

Friday 20 January

186. An officer woke the young person at 7.20am on the morning of 20 January to ask if he wanted to get up and have breakfast. The young person said he wanted to remain in his cell as he was not hungry and wanted to go back to sleep. The officer returned half an hour later and the young person was dressed and ready to go to education. He requested another pair of tracksuit bottoms as his others had a rip in them. The officer collected another pair for him.
187. The young person went to healthcare that morning to attend a support group session. This was his second session following his first attendance on 11 January (for reasons previously explained, he had missed sessions on 13 and 18 January). A nurse noted that he raised no concerns, that all his interactions had been appropriate and that he contributed well in the group. At interview, the nurse said that the young person was chatty and appeared confident among other young people in the group. The investigators watched

CCTV footage from the mental health unit that day which suggests that the young person was engaging with the other young people on the unit.

188. In the late morning the young person was given some sandwiches and hot water for a cup of tea. He asked an officer for some paper and a pen. She gave him the paper but said she did not have a pen at that time. His personal officer gave him a pen about an hour later.
189. The young person was assessed by mental health nurse in response to the concerns raised the previous few days. He said he had been feeling increasingly stressed and his “head went” when he smashed his television. He said he had eight weeks of custody left and generally got on okay. He said he had made some friends but, as he was from Chesterfield, he did not know many of the young people in Hindley. He said he was a little upset that he would not see his father for a long time. He also reported sometimes feeling guilty that he had not been able to save his stepfather from dying. (His stepfather had a heart attack in front of him.) The nurse recorded that he did not display symptoms of post traumatic stress disorder but did require support. He said he had no further thoughts of self-harm. The nurse made corresponding entries in both his ACCT and on P-NOMIS.
190. The young person’s YOS officer had been due to visit him that day, together with his mother, but had had to cancel due to illness. An entry was later made in his Asset by another key worker at Hindley:

“Discussion with his Keyworker ... The keyworker had contact with him on Friday but did not have chance to make a case note. The keyworker tells me that the young person was due to have a DTO Meeting on Friday PM but his YOT worker telephoned and cancelled due to being off sick, he gave her an update on him and re-arranged the meeting to Tuesday 24th. The keyworker then saw him and informed him of this. He tells me that he presented as ok, they discussed his meeting being re-arranged and the fact that his mother, sister, partner and niece all had a visit booked to see him the following day. The keyworker did not have any additional concerns at this time. He expressed that he was looking forward to his visit. He walked him to his woodwork class.”
191. The investigators asked the YOS worker whether a duty worker could have gone to the meeting with the young person in her place. She said that when she telephoned her office to report that she was unwell she had discussed what to do about the meeting with him with her manager. They agreed that it would be better for the meeting to be rescheduled rather than to send a duty worker who did not know the young person and his various issues, including his ADHD. She rearranged the meeting for the following week and telephoned the young person’s mother to explain.
192. The keyworker told the investigators that, when he told the young person about the cancellation of the meeting, he was fine about it. He told the young person that his mother, girlfriend and other family members were visiting the next day and that the DTO meeting would now be early the following week.

This meant he could go to his woodwork class and he walked over with him. The young person completed all the work assigned to him in the workshop and the tutor described him as being very buoyant that afternoon. As he was leaving he said “good bye, see you next week”.

193. Another person attending woodwork described the young person as generally quiet but when he talked it was usually about getting out and back to his family. He spoke about his stepdaughter and having to look after his mum when he was released. On 19 January, they had been at woodwork together and had been messing around with a ball. He described the young person as being his usual self.

194. The officer supervising the woodwork workshop that day told investigators that the young person had said he had received a letter from his girlfriend. He said she had given him a:

“bit of a rollicking ... because of what he'd done on the Tuesday night when he'd smashed his telly. And that's when the ACCT document was opened. I said 'well you probably need something like that to buck your ideas' and he said 'yes, you're right, I do'. And then later on in the day I had to stop him trying to play football in the workshop, but there was nothing untoward in his behaviour...”

195. An officer noted in the ACCT at 5.05pm that the young person had collected his tea and ate in his room. She said he had “a bit of attitude ... but no major concern”. When interviewed, she explained that the young person was normally fine when he was collecting his meal. That evening he seemed to think he would be having to have fish for dinner and did not want to. When she checked, he had selected kebab anyway. When she told him this he calmed down and collected his kebab and took it back to his cell.

196. The young person was checked in his cell at 5.44pm. He had covered his observation panel but removed the obstruction when asked. However, he did not answer when asked if he was okay. He was described as “just sat on his bed writing”. (The signature of the member of staff making this entry is impossible to decipher and Hindley were unable to confirm the writer's identity.)

Evening association, 20 January

197. At around 6.00pm on 20 January, staff began unlocking cells for evening association. Officer A explained that he unlocked the cells one side of the wing and Officer B the other. He said that some young people needed their PE kits to go to gym so it took a bit longer while they collected their kit. Officer A then walked back to the main association area near the table football, which was close to the young person's cell. He realised the young person was still in his cell and asked Officer B if he was coming out. Officer B had started opening cells on the other end of the landing and had missed him by accident. So Officer A went to unlock his door.

198. Officer A said that the young person was irate and swore at him. He was angry as he had wanted to use the telephone before others were unlocked. The officer told investigators that he explained to the young person that it had been a mistake that he had not been unlocked. He said they were not aware he wanted to use the phone before the others were unlocked. It was a Friday, so the pin phone credit had been issued, which meant a lot of young people wanted to use the phone and a queue was forming. The young person said he did not want to come out then and the officer said he told him he could come out at the end of association if he wanted. He said he was going to carry on writing his letter.
199. At around 7.00pm, the young person started kicking and banging his cell door repeatedly. Officer B opened his cell flap and asked him what the matter was. He said he wanted to make a phone call. The officer said that he could come out to make a call at the end of association if he did not want to come out during the association period. The officer said that the young person became abusive and so he said that if he carried on being abusive he would not be allowed out to use the phone at all.
200. The investigation team observed the CCTV footage for that evening. The recording shows other young people going to the young person's cell door at various points from 7.13pm onwards. The recording is silent so we do not know what they said but some young people can be seen looking into his cell making gestures, appearing to point to their wrists.
201. At about 7.25pm, an SO and Officer A went to see the young person as he was still banging and kicking his door. An entry in the young person's ACCT form stated that he was abusive and uncooperative. He had covered his observation panel with paper and, when the SO removed it, he again was abusive to staff. As he was on an ACCT it was important staff could see into the cell and therefore the paper needed to be removed.
202. The CCTV footage shows young people returning to the young person's cell at 7.43pm and they are near to or around his cell for the next ten minutes or so. During this time they can be seen to be opening the observation panel flap to look into the cell and at times appear to be laughing. On a number of occasions, they appear to strike the door with a table tennis bat. One young person runs and jumps at the door and kicks it at around chest height.
203. For part of the association period Officer B played table football with some of the young people. A large number of people were gathered around the table, which was outside the young person's cell. Officer B gestured for young people to come away from the young person's cell door a couple of times, but there is little evidence of the officers actively supervising and challenging the young people who were apparently harassing the young person.
204. Association finished just before 8.00pm. The SO returned to the young person's cell and found that he had again blocked his observation panel with paper. Officer A said that he had also put paper around the cracks in his door. The SO discussed this with him and removed excess paper from the

cell. Both officers started offering hot water to young people so they could make a hot drink. They did not offer any to the young person as they thought it could be dangerous given his level of aggression.

205. Officer C arrived on the wing at about 8.00pm and started to check the rooms on the landings. He arrived at the young person's room at about 8.20pm. He could see that he had smashed some furniture in his cell and told the SO. The SO went to the cell at 8.25pm with Officer C to remove the debris and speak to him. Officer C recalled the SO asked the young person why he had smashed his furniture and he said it was because he had not been allowed a phone call. When investigators visited the cell, the fitted desk had been damaged and had exposed a number of screws and nails in the wall. The SO said he spoke to the young person and was not concerned about him. There was no review of whether the level of observations needed to be raised or whether the young person should be moved to another cell, in the light of the damage and whether this might be a risk.
206. Soon after, the day staff on Fir wing went off duty. Officer C turned out the main lights on Fir wing and went to the staff room and completed paperwork including reporting that the young person had smashed his cell.

From 8.30pm

207. The orderly officer came on duty at about 8.30pm and he was told that the young person had smashed his cell, the debris had been cleared out and he was okay. The orderly officer dealt with some paperwork in the centre. He said there was still an extra nurse on duty in reception and an SO in reception as some young people were late arriving from court.
208. Officer C told investigators that three young people were on ACCTs on Douglas unit. He went to check on them at about 8.40pm and arrived at the young person's cell at about 8.43pm. The young person was sat at his desk writing, his cell light was on and he looked up when the officer looked in. There is no indication that the officer spoke to him when he saw him.
209. Officer C then came back to the wing at around 9.10pm. He checked another young person on an ACCT and then went to the young person's cell. As the landing lights had been turned off, he could see that the young person had turned his cell light off and his room was in darkness. Officer C used his torch to look into the room and saw him hanging from a noose made out the bed-sheets attached to the window bars. His lower body was on the floor. The officer radioed for assistance and ran to the centre to turn the lights on. He broke the seal on his key pouch and went straight into the cell. The CCTV records this as 9.13pm. Officer C cut the sheet with his cut down tool while supporting the young person's head with his other arm. He then laid him on his back on the floor and removed the sheet and started CPR at the ratio of two emergency breaths followed by 30 chest compressions. He noticed that he had wet himself. He also made another radio call saying "code blue urgent assistance".

210. The orderly officer said that at approximately 9.13pm he heard Officer C on the radio saying "Urgent assistance F1-24, young person hanging". He said he started running and could hear from his voice that Officer C was shaken. He said that, while he was running, he used his radio to instruct officers from reception and from the gate to come to the emergency. When he arrived, Officer C was conducting CPR.
211. The orderly officer radioed the control room to request an ambulance urgently (this is recorded on the incident log as 9.20pm). An officer arrived from reception and he and the orderly officer took over CPR.
212. Nurse A arrived to begin a night shift at 8.45pm. She said she heard over the radio that assistance was required on Fir wing and that the emergency nurse was needed. The call was not announced as a code blue emergency (which signifies breathing difficulties), but she said it was clear from the voice of the caller that it was an emergency. She had a restricted set of keys (in keeping with night state requirements), but another nurse (Nurse B), who was about to go off duty, still had her set of keys so she took her to Fir wing. Nurse A had brought the emergency bag and she went to the cell. She thought it took around two minutes to get there from the time of receiving the call. CCTV shows that she arrived at 9.17pm.
213. Nurse A said that when she arrived, officers were attempting CPR with mouth to mouth breathing and chest compressions. She asked the reception officer if he wanted the face mask and oxygen cylinder but he said he was more confident using mouth to mouth. She saw that the young person's chest was rising when rescue breaths were given which confirmed that air was being delivered properly. She took over chest compressions and the reception officer continued with giving rescue breaths delivered at cycles of 15 chest compressions to two rescue breaths. She checked regularly for a pulse, but there was none.
214. After taking Nurse A to Fir wing, Nurse B had begun to leave the establishment but then realised that her help might be needed so she returned to Fir wing. When she arrived at the cell, she took over chest compressions while Nurse A gave rescue breaths. On checking him again for a pulse, Nurse A found one and she could also see that his heart was beating. She began to give him oxygen and at that point, ambulance paramedics arrived and took over. The control room incident log recorded the paramedics as arriving at 9.26pm and the ambulance one minute later. The gate is some distance from F wing and CCTV indicates that paramedics arrived at the cell at 9.31pm.
215. Nurse B was asked at interview why she had not used a defibrillator. She said that to use a defibrillator there needs to be a shockable heart rhythm, but in the young person's case there was no pulse so a defibrillator would have been of no use.

216. The orderly officer instigated the contingency plans for such an event and phoned the duty governor. Various staff arrived at the YOI, including the Governor.
217. CCTV shows that, after everyone left the cell and the young person had gone to hospital, two people went back into his cell. One of the officers said that during the emergency he thought he had lost the cell key he had released from his sealed pouch. This has serious security implications, so he and one of the operational managers went into the cell to look on the floor for it. The officer said they did not touch anything and when they could not see it on the floor they came back out of the cell. He then realised that he had the cell key on his person after all.
218. Observations of other young people subject to ACCT were increased during the night and ACCTs were reviewed the next day. The young person's friend received additional support, including from one of Hindley's chaplains.
219. Debriefs were held with YOI staff involved to consider whether there was any immediate learning and support staff. Officers said that they felt well supported. Some nurses said that they would have wanted more support but the Head of Healthcare explained to the investigators what management had done and this appeared reasonable.
220. When the young person's cell was searched, a letter was found addressed to his mother in which he wrote (using his own words and spelling):
- "...mum thay kepet giving me shit I told the staff and thay did not do nothink a bout the problem. So mum if you are reading this I not alive cos I can not cope in prison people giving me shit evan staff ..."
221. The young person's mother later provided copies of letters posted by her son during his time in Hindley. Most of the letters were from him to his mother, two were to his girlfriend and one to his father. None of the letters were dated. Some of the letters were optimistic in tone, but in most he said how difficult he was finding his time at Hindley. He wrote about being bullied by other young people and that staff were aware of this but were not helping.
222. The Governor told the investigator that he was at a friend's home on the evening of 20 January when he received a telephone call from the deputy governor informing him that there had been an incident of serious self-harm. He drove to Hindley and was updated along the way. He was told that a young person had not been breathing when he was found, but had started breathing again and had gone to hospital. He received a fuller briefing when he arrived at Hindley. He said that he needed to decide how best to inform the young person's family. It would have taken around two hours for staff from Hindley to reach the mother's home in Chesterfield, and just as long for his family to get back to Wigan and to the hospital. He therefore decided that the best option was to ask Chesterfield police to contact the family. He gave the police Hindley's telephone number as well as his own mobile number.

223. The Governor then went to Fir wing to speak to staff and also visited other parts of Hindley. He then received a call from the young person's sister, who was in a car with her mother travelling to the hospital. She thought they would reach the hospital around midnight. He arrived at the hospital soon after the family. They were in a family waiting room and the Governor joined them and gave them as much information as he could.
224. One of the hospital doctors came to the room and the young person's mother asked the Governor to stay as any information would be relevant to him. After the briefing from the doctor, his family were able to visit the young person. The Governor joined them before returning to the family room. The family later joined him and he spent some time talking with them and left the hospital at around 1.45am.
225. The Governor telephoned Hindley at about 8.00am the following morning. He was told that the young person had been transferred to a hospital in Manchester and was in intensive care. He went to the hospital and again spent time with the young person's parents. The family had received an update from a hospital doctor which indicated that there was little chance that he would recover.
226. The Governor said that hospital staff had questioned the presence of escorting officers in the intensive care room where the young person was being treated. They were concerned that the officer would be in the way in the case of an emergency and suggested they used the hospital staff restroom, around 100 metres from his room. He agreed and informed the parents.
227. The Governor remained in the hospital until the late morning. During that time, one of Hindley's chaplains came to the hospital to see the young person and his family. The Governor returned to the hospital that evening, by which time several other family members had started to attend and were asking many questions. The young person's mother was concerned that the escorting officer was asking for the names of visitors. The Governor explained that the officer was following standard instructions, but he would inform him that he did not need to do this any longer.
228. The Governor was not able to visit the young person the following day, Sunday 22 January, but other senior staff from Hindley, including a governor, visited. The family told the governor that they considered the bed-watch officer was being too intrusive. The officer had been checking the young person every hour and making entries in the ACCT form. The governor advised the officer to remain in the staff restroom and just periodically check with nurses for updates on his condition. The Governor told the investigators that he had considered whether to release him on temporary licence (ROTL). He decided not to, as he wanted a member of staff at the hospital in case the family needed anything and so they could keep him up to date with any changes in the young person's condition.

229. On the morning of Monday 23 January, the Governor went to the hospital again and spent some time with the family answering their questions
230. The Governor was driving to Hindley the following day when he received a telephone call to say the young person had deteriorated significantly the previous evening. He diverted to the hospital, and arrived at around 8.30am. When he arrived, he was told by one of the nurses that the young person had died with his family around him. Hindley then formally appointed a family liaison officer. Arrangements were made for the family to visit Hindley. He had previously spoken to the family about them having the opportunity to visit and he asked them if they wanted the cell to be restored to the condition it would have been in when their son first moved into the cell. He understood that the family wanted to see the cell as it had been while he was living in it, so he instructed staff to clear away any debris from the floor and to re-make the bed with fresh bedding. It was in that condition when the family subsequently visited. They also spent some time in the chapel, where they prayed and lit candles. Hindley offered to meet the funeral costs.
231. Over the course of the following days a total of seven young people reported to various members of staff that the young person had been bullied during his time at Hindley.
232. The family's solicitors identified another young person whom they believed had relevant information. One of the investigators spoke to this person who said that until mid January he had occupied a cell near the young person's. They did not speak but he saw him around the wing. He said that other young people gave the young person a hard time and called him a rapist, looked into his cell and banged his observation panel. They also pressed down the telephone receiver when the young person was trying to make calls. The witness did not wish to name the bullies but said that officers were aware of what was happening, and seemed to think it was funny and encouraged this misbehaviour by nodding their heads to the bullies when the young person came out of his room. The officers also said that the young person was on methadone and, when they did ask the bullies to stop, they would say "leave the victim alone". The witness named two officers as being involved but said most of the male officers behaved that way. He said that another officer, whose name he did not know, made a number of offensive remarks about the young person after his death.

ISSUES

Allocation to Hindley

6 December 2011

233. The young person's mother told investigators she had understood that if her son went to a YOI after he was sentenced it would be to Wetherby, as it was closer to the family's home than Hindley and easier for visits. In the placement alert form completed by his YOS worker, Hindley was noted as the preferred location.
234. The YOS worker explained that the allocation was made because Hindley is the YOI identified for the catchment area which includes Chesterfield. As Wetherby is closer to Chesterfield than Hindley and a much more convenient journey for families we were surprised at this. Nevertheless, the YJB confirmed that Hindley was the standard allocation for young people going to a YOI from the Chesterfield area. The YOS worker had identified the young person's vulnerability in her pre-sentence report for the court which she said would be exacerbated significantly in custody. Concern about his vulnerability was also identified at court but an allocation to a secure training centre was not considered as an option and there was no specific recommendation for an STC. It is unusual for 17 year olds to be allocated to STCs, but it is a possibility when someone is considered particularly vulnerable. We accept it is unlikely at that stage that his vulnerabilities would have led to an alternative allocation, but it is not clear whether any consideration was given to anywhere other than Hindley.

13 January 2012

235. In the pre-sentence report prepared for the young person's court appearance on 13 January, the YOS worker referred to his anxieties about another custodial sentence. She again outlined his vulnerabilities including his diagnoses of conduct disorder and ADHD and his ongoing treatment from CAMHS. She referred to his disclosures about being bullied at Hindley and what she considered was his inability to follow the process to report how he was feeling. She assessed him as a medium risk of harm to himself in custody.
236. The YOS worker completed a placement alert form which was sent to the YJB which is responsible for deciding where young people sentenced to custody should go in the young people's estate. She recommended that he should be allocated to an STC rather than a YOI. She noted his vulnerabilities on the placement alert form including that he was low in mood, showed signs of significant poor coping, had had thoughts of suicide and had recently disclosed bullying. The form requires the author to enter the name of the preferred unit. She wrote, the "Keppel Unit, HMYOI Wetherby". She told investigators that this was not a mistake, but meant to act as a failsafe. She wanted him to go either to an STC or the Keppel Unit at Wetherby. Although his vulnerabilities, including ADHD, conduct disorder and learning difficulties

were little changed since 6 December when she had recommended Hindley as a placement, she explained to investigators that her main additional concern was that he was not coping at Hindley because he was being bullied. She was concerned that he did not understand the process to deal with this. (This may have been an erroneous assumption on her part as the issue seemed to be more one of Hindley failing to deal appropriately with his allegations.)

237. The YOS worker said that she telephoned the YJB placements team after the young person was sentenced as she still considered that he should go to an STC or the Keppel Unit, and made this clear to the placements officer. Her recommendation was turned down but she was unaware of the reasons why it was decided that he should not go to an STC. She understood that she needed to complete a separate referral form for the Keppel Unit. She explained that she had not completed an earlier referral for the Keppel Unit as, despite her concerns about him at Hindley, the YOI had not raised any issues about his safety with her. She said she was in the process of completing a referral to Keppel when he fatally self-harmed.
238. The placements officer at the YJB agreed that the YOS worker had told her that the young person was being bullied at Hindley, but she considered that she was asking for advice about how to make a referral to an STC and the Keppel Unit. She said her understanding was that the YOS worker was going to discuss the options with her line manager and then make a transfer request.
239. Despite the lack of clarity about the telephone call between the YOS worker and the placements officer, it was apparent from the placement alert form that a recommendation for an STC or the Keppel Unit at Wetherby was being made. While it is possible that the YJB made an appropriate decision, we would expect the allocation decision for a vulnerable child to be fully considered and recorded, taking account of all the available information. Without a clear documented consideration and rationale for the decision there is no explanation why it was decided that the young person should return to Hindley.

The Youth Justice Board should give clear documented reasons for a decision to allocate a young person to a young offender institution when a placement to a secure training centre has been proposed.

Bullying

Hindley's policy

240. Hindley's violence reduction strategy states its aims as: raising awareness, developing skills and effective management. It defines bullying as "any incident, in which a person is abused, threatened or assaulted; this includes explicit or implicit challenge to their safety, well being and health". The policy goes on to outline potential effects of bullying as "fear and tension, difficulty in

settling/making use of facilities, depression, suicide/self-harm ... isolation, illness/reporting sick ... neglect of hygiene”.

241. The policy encourages early intervention at the first signs of unacceptable behaviour. It highlights possible triggers for intervention including “reports or observations of verbal insults, minor conflicts, exclusion ... or other signs that someone is feeling bullied”. During interviews with YOI staff, different staff described what might alert them to bullying. Their comments ranged from social isolation, sitting near officers when out on association, young people going to other young people’s doors, shouting out of windows, as well as physical conflicts.
242. The policy states that action should include an informal meeting to “mark the behaviour, engage the participant/s, reach agreement on how to restore positive interactions, note the proceedings on the history sheet (P-NOMIS)”. It goes on to say that if the behaviour continues further intervention might be necessary. The violence reduction coordinator said both bullies and victims could go on Behaviour Intervention Plans to monitor them.
243. It is explicit in the policy that:
- “a **safeguards referral report** and a **SIR** must be raised immediately following the discovery of a bullying incident or where bullying is suspected...
- ... the bully or those suspected of bullying must be confronted with the allegation but in such a way to avoid any risk to the victim. **At no time is the victim to be identified to the alleged bully.** [bold in original]
244. The young person told his mother, father, stepmother and girlfriend in telephone calls and in a note he wrote before his fatal act of self-harm that he was being bullied and staff knew, but did nothing about it. We accept that he presented differently to various staff at different times. Sometimes he suggested that the problems he was facing from other young people were not a major issue and at other times he was explicit about difficulties he was facing. However, there is little doubt that he was being bullied and there is evidence of this throughout his time in Hindley. It is a concern that there were a number of missed opportunities to act on information and investigate matters further. Ultimately, it is hard to escape the conclusion that the bullying he experienced was a major factor which led to his death and that Hindley did little to protect him. He was well behaved until the days before his serious self-harm. According to him, he had a build up of frustration which led to two separate outbursts of violence against property, and then to himself. The second incident led to his death.
245. Broadly, our concerns fall into three areas; how information was shared, how seriously allegations of bullying were treated and the level of protection the young person was given, particularly on the evening of 20 January.

Information sharing

246. Hindley has some well developed systems to deal with bullying. Staff can submit security information reports, behaviour vulnerability referrals and safeguards referrals. There are regular multi-disciplinary meetings to discuss individuals, build a picture and make decisions about what to do. Options include greater observation and recording this formally in a behaviour intervention plan (BIP), investigation of allegations of bullying, moving young people to keep others safe and/or referrals to the Willow Unit. The meetings are well attended by senior managers. However, the young person was not referred into any of these pathways until 17 January and no action had been taken by the time that he fatally self-harmed. Action should have been taken to protect him much sooner. Ultimately this was a failure of child protection, defined by the Department of Education as the 'activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm'.
247. P-NOMIS is the electronic case note system on which YOI and prison staff record their interactions. Clinical interventions are recorded on SystemOne by healthcare staff. Between 13 December and 17 January, there were no fewer than 10 recorded incidents where the young person told staff about incidents of bullying. The only time this resulted in a safeguards referral or security information report, was when he self-harmed on 17 January. The only person to prompt a note on P-NOMIS was the HCA, when he witnessed him receiving verbal abuse on 29 December.
248. The young person's clinical records contain a number of references to him reporting bullying to various members of healthcare staff. On 13 December, he told the psychiatrist that young people on the wing were trying to intimidate him. On 17 December, he told a nurse that he had been threatened and other young people had been making inappropriate comments about his family. On 29 December, the HCA made an entry on P-NOMIS that was followed up by a wing SO. The same day, the YOS worker completed a form to alert staff that he was being bullied. This included the name of one of the young people allegedly responsible. She passed this information to an officer in Visits who, in turn, reported it to an SO
249. On 3 January, the young person told the psychiatrist that an officer had told him that other young people were making threats towards him. Also on 3 January, the learning disability nurse recorded that the young person found evening association intimidating. On 5 January, he told his named nurse he had some trouble at education. The YOS worker also knew he was being bullied at his court appearance on 13 January and had discussed it with the YJB placements team. On 16 January, he told the learning disability nurse he had received "constant abuse". On 17 January, he told his keyworker that he was receiving abuse from other young people who were constantly at his cell door during association periods.
250. Both the psychiatrist and a nurse noted that they do not have access to P-NOMIS. For reasons of medical confidentiality officers are unable to access SystemOne, the medical record system. The psychiatrist said that he

understood from what the young person told him that he had also told officers on his wing about the difficulty he was having with other young people. The nurse acknowledged that he could have made a manuscript entry in the wing observation book but thought a better option was to speak directly with the wing staff which he said that he did, although he could not recall which officer he had told. The learning disability nurse said that he spoke to the keyworker following the report from the young person on 17 January. The keyworker made a note that day about the young person's difficulties with other young people, although he made no reference to any conversation with the nurse. We know that he told his keyworker of some difficulties he was experiencing from other young people on 17 January.

251. As the psychiatrist suggests and from what the young person told his family, it is likely that the young person had reported his difficulties to other officers on the wing but there is no written record of officers on the wings noting his concerns at that time. What we do know is that none of the staff above followed Hindley's violence reduction policy when he reported his concerns. None of them made a safeguards referral, completed an SIR or made a behaviour vulnerability referral. This was a serious omission which meant that concerns about him being bullied were not directed to the appropriate people until too late and opportunities to protect him were missed.

The Governor and Head of Healthcare should ensure that all staff working with young people in the YOI are trained in the operation of the violence reduction strategy and understand the importance of making referrals in accordance with the strategy whenever there is concern that a young person might be being bullied, intimidated or threatened.

Challenging bullying behaviour

252. The young person gave many signs to wing staff which should have caused them concern that he might be being bullied. He chose not to interact with other young people on the wing and he began to need encouragement to come out of his cell to shower. There is little indication that the reasons for this were properly investigated. When he came out of his cell during association, several staff commented that he would normally sit near and talk to them rather than other young people.
253. During interviews, officers reported a good understanding of the expectation to challenge young people who were shouting out of windows or talking at cell doors, both common aspects of bullying and harassment. However, there is no evidence of this in wing observation books. The investigators spent some time on Fir wing during association periods. Their observations were that young people were often told to come away from cell doors, but without sanction or threat of sanction. We recognise that making a note every time a young person is spoken to would be unrealistic. However, there was very little information about observed bullying behaviour in the wing observation book. Without information being recorded and shared it is difficult to get a picture of what is happening on the wing. An example of the failure to record important information is the incident on 18 January, when the keyworker said

a young person went straight to the young person's cell door when he was unlocked for a phone call and started shouting at him. This was not recorded despite the concerns about him at that time.

The Governor should ensure that officers actively challenge all examples of potential bullying and make appropriate entries in P-NOMIS case notes and wing observation books which are regularly monitored by managers to establish any patterns of behaviour or individual concerns.

Dealing with allegations and protecting the young person

254. When the young person was away from Fir wing, he seemed to interact better with other young people and was also quite open with staff. It is possible that his good engagement with some staff lessened any concerns they might have had about him. From what he said it did not appear that he was scared of other young people but he found their constant abuse intolerable. It frustrated him and made him angry and upset.
255. When the young person self-harmed on 17 January, he told the orderly officer that this was because he was being bullied. Appropriate referrals were made under the orderly officer's direction. The orderly officer asked him who the bullies were but he would not say. Another SO asked the young person about this in his ACCT review the following day. Although he did not name the bullies, there is no evidence that staff followed up the allegations of bullying by monitoring him and others around him more closely.
256. The operational manager instructed wing staff to investigate the young person's allegations of bullying further when she was concerned about his evident distress at an adjudication hearing on 19 January. He had told staff that a young person had bullied him and it was previously known that another young person had verbally abused him. This information had also been passed on by the YOS worker at the end of December. By 19 January, he was not prepared to disclose who he was being bullied by. The CCTV footage of the evening he fatally self-harmed showed a group of young people involved. We consider it was unlikely to have been restricted to that evening as he had reported constant abuse. It should have been easy for officers to identify who was responsible.
257. Some of the young people who appeared to be involved in bullying the young person were cleaners. The wing staff explained that young people who were disruptive in education or at work were sometimes excluded and wing staff had to find them activity, resulting in some of the more difficult young people becoming cleaners. Even after it was known he had accused cleaners of bullying, there was an entry in his ACCT on 18 January that some cleaners were talking to his at his door, with little apparent awareness that this could have been bullying behaviour.
258. After the young person's death, investigators were given the names of several young people who were alleged to have bullied him. The investigators

examined the files of three young people, all of whom had been alleged as bullies. Two of these were clearly seen on CCTV at the young person's cell door on 20 January. They hit his door with table tennis bats, and made gestures towards his cell earlier when his cell flap was open. There was no reference in YOI records to these young people potentially bullying the young person, other than to note they could become targets after his death as other young people believed them to have been responsible for bullying him. None of them were subject to extra monitoring or spoken to about their behaviour. Although one had been referred to twice on 29 December as allegedly bullying the young person, there was no record of this in his security file. Even without names of alleged bullies, YOI staff should have increased their monitoring of the young person and the activity around his cell. The allegations of bullying were not properly investigated and appropriate action was not taken to protect the young person. He made it clear to his family and in the note that he left behind, that he had told staff he was being bullied but no one had done anything about it.

259. At times the young person appeared open to the possibility of moving cells or moving to another unit. However, at lunchtime on 19 January, he rejected moving. He said that a move was only to keep officers happy. He was mostly ambivalent about moving cells but ultimately he was a child and YOI staff had a duty to protect him. If moving cells was the only way this could be achieved they should have required him to move.

The Governor should ensure that when there are allegations that a young person is being bullied, effective monitoring and supervision arrangements are put in place to protect him from further harm.

Supervision of association

260. Investigators interviewed 10 young people and spoke to others informally on the wing. Most said that the young person got shouted at and some said he retaliated by shouting back. They generally agreed that he stood out from others, mostly because he was regarded as a "pad rat" who did not come out of his cell much and because he had to collect his medication from another wing. The fact that he came from a different part of the country than most of the other young people also marked him out.
261. The CCTV of the 20 January shows young people at the young person's cell door throughout the association period opening and closing the observation panel, speaking through the side of the door, kicking the door and hitting the door with bats. He was constantly putting paper over his observation hatch and round his door, an indication that he was trying to prevent others looking in at him. Occasionally officers asked young people to come away from his door. For some part of the evening he was also kicking his cell door which annoyed other young people.
262. At this stage, wing staff knew of the allegations that the young person was being bullied, they knew he had recently self harmed and was subject to ACCT procedures. One of the officers on duty, Officer A, was his personal

officer. Apart from a short time when Officer B played table football with some of the young people, both officers sat on chairs on one side of the wing for most of the association period. Their view of his cell was mostly blocked by young people. They did not walk around the landing or alter their position. When the investigators visited Fir wing during association, the staff on duty at that time were sitting in the same chairs in the same position, which suggested that this was the usual practice.

263. According to Hindley's violence reduction coordinator, key areas for bullying are around the telephones and showers. The young person's cell was near both, and these are key areas for supervision. We are not satisfied that the officers on duty on the evening of 20 January were sufficiently vigilant or made enough effort to protect the young person from harassment, yet only three nights previously, he had self-harmed after receiving abuse from other young people. The officers should have taken further steps to protect the young person, such as positioning themselves near his cell when it was clear that other young people were bothering him. They could have moved the table football away from the young person's cell so it would be more obvious when other young people went to his cell.
264. We consider that Officers A and B did not supervise association sufficiently well on the evening of 20 January to ensure that the young person was appropriately protected from bullying behaviour from others. As his vulnerabilities were well documented by that stage, this was a serious failure.

The Governor should carry out a disciplinary investigation into the apparent failure of Officers A and B to supervise the association period adequately in order to protect the young person from harassment on the evening of 20 January 2012.

The Governor should ensure that all officers assigned to oversee association periods actively patrol and supervise young people to enable a safe environment, and take into account the particular need to protect young people with identified vulnerabilities.

Assessment of risk

Transfer of information from YOS staff to Hindley

265. While in court on 6 December, the court YOS officer said that the young person was worried about his girlfriend and was very emotional. She completed a post court report, which noted his special educational needs and explained he would need instructions repeated. She also noted that he had shown her scars from recent self harm by cutting and recommended an ACCT was opened with close observation.
266. The electronic placement confirmation form noted that the young person was a potential self-harmer. The court warrant also had a hand written note that a risk of self-harm had been identified. However, escort staff did not indicate that he was at risk of self-harm on the PER and the YOS officer did not

complete a suicide self-harm warning form. At his third court appearance on 13 January, the YOS worker increased her assessment of his risk of self-harm to medium, reflected this on the placement alert form and wrote that he was not coping well. Again, a suicide self-harm warning form was not completed. The YOS officer told investigators that the only document YOS court officers complete after sentencing is the post court report.

267. A suicide self-harm warning form is a national form used between police, escort staff and prisons to identify current risks of suicide or self-harm, to alert agencies to the risk and need for assessment. When one is completed the YOI or prison is required to sign to confirm receipt of the suicide self-harm warning form and the staff involved in initial assessments must consider whether opening an ACCT is necessary.
268. The Asset, placement confirmation and post court report had been sent electronically before the young person's first arrived at Hindley, and the warrant and PER travelled with him. His vulnerabilities were therefore mostly well documented and passed to Hindley. However, the suicide self-harm warning form is an important tool that should be used when a risk is identified to ensure escort staff are aware, and to ensure there is a clear record that the warning is passed on to the YOI or prison. It is a concern that the YOS officer appeared not be aware of suicide and self-harm warning forms.

The Youth Justice Board should ensure that court officers understand the importance of suicide self-harm warning forms and how and when to complete them.

269. Hindley had no copy of the pre-sentence report prepared for 13 January and no post court report from the court appearance. There is no explanation why Hindley did not have the pre-sentence report as it should have been on the Asset paperwork. The investigators checked this at Hindley and it was not in their files. However, the YOS staff were clear that they had a copy on their Asset paperwork.
270. The YOS Worker said she had completed a post court report, but one was never received at Hindley. Further investigation has indicated that there was a contemporaneous note of a post court interview completed by her on the YOS electronic record. This had not been sent to the YJB and it does not appear that a formal post court report for 13 January was ever completed.

The Youth Justice Board should ensure that pre-sentence and post court reports are completed as required and provided to establishments holding the young person to help with their assessment of risk.

Assessment on arrival, and early days in custody

271. When the young person arrived at Hindley on 6 December, he was assessed by a number of staff. All relevant documentation arrived with him, or had been sent in advance. He moved quickly to the first night centre where an officer completed assessments on him. The officer said he had read the post

court report. Although this contained information about recent self-harm and other vulnerabilities, the officer said he could not remember reading about self-harm. He thought that the young person had disclosed previous self-harm, but was confident that there was no current risk.

272. A nurse said she had seen the Asset when she conducted the initial health screen with the young person. She said that she was aware that he had self-harmed in the past but that was at the time of his stepfather's death and he had not done so since.
273. The officer and nurse both appeared to consider that the young person had no current risk but the evidence of his recent self-harm was documented in the post court report. Concerns about his vulnerability were clearly documented on a range of forms, including the pre-sentence report which recorded concerns about his ability to cope should he receive a custodial sentence. The post court report explicitly recommended an ACCT be opened.
274. The young person had a number of identified risk factors which increased his risk of suicide and self-harm when he first arrived at Hindley which we are not satisfied were fully considered. He had been highlighted in the accompanying documents as at risk of self-harm, and had had a recent episode of self-harm. He had mental health problems and learning difficulties and it was his first time in prison. In addition, his offence had been against his girlfriend. Hindley's own suicide prevention policy notes the increased risk of young people charged with violence against a family member or partner and requires that additional risk assessments and care must take place to keep such young people safe. It also requires a record to be kept of what action was taken. There is no evidence that any account was taken of his offence when assessing his risk.
275. Many children who end up in custody have a range of vulnerabilities and are very troubled, making it difficult to identify those who are most vulnerable and at risk of suicide and self-harm. However, when the young person arrived at Hindley, there appears to have been too much reliance on how he presented at the time, rather than an objective assessment of all the known and documented risk factors. Good quality information recorded in his Asset and other documents does not appear to have been taken into account. It is surprising that there does not appear to have been any serious consideration about opening an ACCT when this was an explicit recommendation of the YOS court officer. Monitoring him under ACCT procedures might not have prevented his future actions, but it would have meant he was referred to the safeguards team at Hindley at an early stage and it would have allowed a better assessment of his vulnerabilities.

The Governor should ensure that all information about a young person's risk of self-harm or suicide is fully considered and assessed on arrival taking into account known risk factors. Decisions about suicide and self-harm monitoring should be clearly documented to explain why a recommendation for monitoring is not followed.

276. Proper assessment on arrival is important and can help establish an appropriate pattern of management. When the young person arrived, appropriate referrals were made to the mental health team and the learning disability team. There was also a great deal of information in the Asset about his ADHD and conduct disorder and how this affected him and his interactions. It is unrealistic to expect wing officers to read the Asset information of all the young people on each wing, although we would expect the key worker and others with specialist roles to do so.
277. When the young person transferred to Fir wing on 8 December, wing staff had little awareness of his vulnerabilities and especially how his ADHD and learning difficulties needed to be taken into account in his management. At the very least it would have been helpful for the officers on his wing to have been briefed about his difficulties so that they were aware that he struggled to follow and remember some instructions and they might need to repeat instructions and information to ensure he understood.

The Governor should ensure that wing staff are given key information about a young person's special needs to help effective communication and management on the wings.

278. A key worker is expected to meet the young person they are responsible for shortly after arrival. The young person's keyworker did not meet him until 16 December, 10 days after his arrival. Personal officers are also supposed to introduce themselves quickly. His personal officer did not introduce himself until 24 December. He said he had been on a period of leave and had not realised the young person had been allocated to him.
279. Key workers and personal officers are an important source of support for young people to help them understand the routines of the YOI and how to access services and support. It is particularly concerning that a young person who had just arrived in the YOI, who had no previous experience of custody and had a number of special needs, should have had to wait so long to speak to officers whose role was specifically designed to provide support.

The Governor should ensure there are no delays in the appointment of key workers and personal officers, and that the officers introduce themselves to young people shortly after they arrive.

Information from medical records

280. The clinical reviewer considered in detail the gathering and sharing of information from healthcare sources. The young person was under the care of the Derbyshire Child and Adolescent Mental Health Service (CAMHS), yet no steps appear to have been taken to obtain these records. He suggested that if this was typical then it indicated that not enough emphasis was placed on the importance that historical records can contribute to the assessment process. In the absence of such historical information and the lack of information sought from his mother, mental health assessments relied too

much on the young person's presentation and self-reporting during consultations.

281. The clinical reviewer considered that had a fuller medical history been obtained not just from CAMHS, but also through speaking to the young person's mother, this might have helped understand better the confusing picture that he could present. One example was his ability to interact in a very mature manner with adults whom he trusted, while also having a tendency towards rapid mood change and a limited ability to deal appropriately with conflict and stressful situations.
282. There was also only limited sharing of information about the young person's statement of special educational needs. This highlighted that his condition of ADHD impacted upon his ability to accept direction and correction, as well as impacting on his compliance and social interaction. The learning disability nurse made a note of this in the young person's medical records, but this was only available to healthcare staff and not officers. The nurse said that he told the young person's personal officer and the senior officer on the wing at the time but he made no entry in his P-NOMIS record system to which YOI staff have access.

The Head of Healthcare should ensure that a young person's full medical history, including information from their families, should be obtained and taken into account when making assessments. Relevant information should be shared with other staff as appropriate.

ACCT

Decisions about whether to open an ACCT

283. Before an ACCT was opened on 17 January, we consider there were three other occasions when the possibility of monitoring under suicide and self-harm monitoring procedures should have been considered. As already discussed, there was sufficient information about the young person's risk when he first arrived to suggest an ACCT should have been opened on 6 December.
284. On 13 December, the psychiatrist noted that there should be a low threshold for opening an ACCT for the young person, but this was not communicated to wing staff. On 29 December, the YOS worker wrote on a referral form that the young person felt that he might harm himself and he had told her that he believed he would be better off dead. Although she said that he then said he would not do so, these were clear indications of risk of self-harm. An officer in Visits received the form from the YOS worker and telephoned the wing SO. He could not remember if he read out the form verbatim or gave the general theme. The SO said she was told the young person had made a comment about having little left to live for and then had a discussion with him. During this conversation she believed that the young person was upbeat and engaged well. She had no concerns and phoned the officer to relay this. The officer recorded this on the visits form. He did not make a safeguard referral

and the possibility of opening an ACCT was not explored more thoroughly, despite the YOS worker's clearly conveyed concerns.

285. The YOS worker is a trained social worker who had previously conducted in depth assessments on the young person and more weight should have been given to the information she had provided, rather than the views of a senior officer who did not know him and relied on his personal presentation in a brief conversation. We consider that the information that she provided on 13 December was mishandled and should have resulted in a safeguards referral and an ACCT being opened, even without the information from the psychiatrist that his risk suggested there should be a low threshold for opening an ACCT.
286. Finally, when the young person was sentenced on 13 January, although there was no post court report, it was recorded in the PER that he had been upset at court. The nurse in reception asked him about this, who said he was upset but had calmed down. Arrangements were made for him to be seen by the mental health team the following day but there was no documented consideration of whether an ACCT should be opened. The new sentence would mean that he would be away from his family for longer than expected, which was a possible trigger for self-harm. The nurse in reception would have had access to his medical record in which the psychiatrist had flagged the need for a low threshold to be used when considering open an ACCT for him.

The Governor should ensure that full consideration is given to opening an ACCT whenever concerns are raised indicating that a young person is at risk of suicide or self-harm. Decisions not to open an ACCT should be fully explained and documented.

The Governor should ensure that concerns passed to visits staff about the safety of a young person are always passed to the head of safeguarding to consider and take appropriate action.

Opening the ACCT

287. An ACCT was opened appropriately on 17 January after the young person became so distressed he smashed his television and made cuts to his wrists. Although the orderly officer did not know him, and mistakenly entered another name on the ACCT document, he appears to have interacted well with the young person and listened to him talk about his family. Appropriate steps were taken to ensure his safety during the course of the night including setting a high level of observations of five an hour. Relevant referrals were also made about his allegations of bullying and to the mental health team.
288. The ACCT assessor conducted a thorough assessment and the first case review included a mental health nurse as well as an SO and an officer from the wing. The young person seems to have engaged well throughout the process. It is possible that his calmness lulled staff into thinking that he was coping better than he actually was. Although staff at the review seemed reassured that he was able to cope with the bullying he was experiencing

from other prisoners, his actions of the previous night did not suggest this was the case. The care plan was focussed on encouraging him to associate more with other young people rather than on tackling bullying. It included appropriate referrals to mental health services. The level of observation was reduced, but he was still considered as a raised risk. The ACCT assessor explained this was because his self-harm had been unpredictable after a build up of frustration.

289. The “risks and triggers” section of the ACCT document was not completed. It is the role of the assessor to complete this section. The ACCT assessor seemed unclear that this was his responsibility. When investigators asked him what he would have seen the young person’s risks and triggers to be, he thought that his concerns were largely about his family. The ACCT assessor also went on to say that if the young person smashed items in his cell again after losing his temper, he would see that as a significant event. The failure to complete the risk and triggers of the ACCT document meant that the ACCT review did not consider all the issues affecting him. After the ACCT review, a nurse noted that the young person had said his contact with his family was limited as he spent all of his phone credit on the day he got it. There does not appear to have been any consideration at the ACCT review about what could be done to help a vulnerable child keep in contact with his family, yet it was recognised that being apart from his family was one of the major triggers of his self-harm. Family contact was not part of his care plan.
290. The SO who chaired the ACCT review spoke to the young person’s mother after the review. ACCT guidance indicates that it is good practice to involve families in the case review yet the SO did not speak to his mother until after it was over. His mother told the SO that her son had written to her the previous week and said he had thought of ending it. This was important information about his risk and indicated that he was having active thoughts of suicide, yet it was not available at the ACCT review. There is no indication that the SO considered whether this increased the risk of self-harm and whether the decision of the ACCT review to reduce observations to two each hour needed to be reconsidered. We consider it should have been.

The Governor should ensure that the risks and triggers section of ACCT assessments are completed and discussed at ACCT reviews to help set effective care plan targets covering identified issues which help protect the young person at risk.

The Governor should ensure that important new information about the risk of suicide and self-harm of a young person being monitored under ACCT procedures should lead to an immediate review of the level of risk and frequency of observations, if possible by a multi-disciplinary team.

The Governor should ensure that families are invited to be involved in ACCT case reviews in appropriate cases.

The young person's withdrawal

291. Fir wing staff were aware that the young person isolated himself, by eating his food in his cell and not coming out to mix with other young people during social periods (known as association). Most YOI staff said they were not concerned as they had discussed this with the young person and believed this was how he preferred to spend his time.
292. Hindley's suicide prevention policy makes specific mention of young people who remain in their cells during association. It says: "A key indicator that a young person is vulnerable or at risk can often be his reluctance to associate with others at evenings and weekends". It goes on to explain that sometimes this will be for acceptable reasons, but to avoid missing "this potential vulnerability indicator" a protocol is in place which instructs officers to ask the reason a young person is staying in their cell. If the reason is regarded as acceptable the officer must make a note in the wing observation book. If the response is unacceptable, the officer must speak with the senior officer to decide whether it should be dealt with using the behaviour intervention plan or ACCT procedures.
293. The policy goes on to say that as the wing observation book is examined by managers everyday, behavioural patterns will soon come to light. It says "these actions are designed to ensure that vulnerable young people do not slip through the net unnoticed". The investigators examined the Fir wing observation book for the time the young person was there. There is no mention that the young person routinely stayed in his cell during association or any other reference to him isolating himself and what this meant. This meant another opportunity to identify his vulnerability was missed.

The Governor should ensure that wing staff abide by Hindley's suicide prevention policy and record in wing observation books when a young person stays in his cell at association times, unless this is being dealt with through an ACCT or behaviour intervention plan.

Escalation in risk

294. On 20 January, upset and frustrated that he had been unable to make a telephone call to his family, and after being harassed by other young people during the association period, the young person smashed part of his desk. This was removed from his cell but it left nails and screws exposed. The SO was aware the young person was on an ACCT and had previously self-harmed through cutting/scratching. The SO made a judgement at the time that the young person had calmed down and he was not concerned about further self-harm. The investigators asked the SO if he had considered the implications of leaving him in the cell with exposed screws. The SO said:

"My concern was to take the stuff away so he doesn't try to break anything more. Usually a lot of lads think 'I've done it now, I'll chill out now for the night' ... But with the nails, yes in hindsight, again maybe it would be good to take them out, but a couple of factors (1) I don't have any tools to take

them out with and (2) if he wanted a nail he'd just take another top off and there'd be nails protruding from the wall then. So it's a bit like where do we stop, do we take everything. But again there were no signs that he would do anything; he never threatened to do anything. When I asked him would he it was 'oh no, I wouldn't do anything like that', so I can only go off what the kid's saying at the time."

295. An ACCT case review should be held where there is evidence of raised risk. The SO did not think a further case review was required. The SO had not met the young person before 20 January. Officer A (his personal officer) and Officer B both knew him better, and neither thought a case review was necessary, or were concerned that he might self-harm.
296. We are concerned that self-harm and acts of violence such as the young person smashing his cell furniture were seen in isolation rather than as part of a more complex pattern of behaviour which should have caused concern about his level of risk. He had a number of issues and vulnerabilities: he was missing his family, it was his first time in custody, he had recently received a longer sentence, he was being bullied, and his ADHD and learning difficulties meant his coping ability was reduced. That evening he had behaved in an aggressive and unpredictable way.
297. A case review would have given staff the opportunity to discuss whether it was safe for the young person to remain in his cell or move to another cell, including a safer cell (with reduced ligature points), or whether his observations should be increased. It would have enabled him to explain the bullying and harassment he had received from other young people and his frustration at not being allowed a telephone call. No one appeared to consider whether he should have been given a telephone call to his family to help him settle down. We accept that YOI staff must make judgements based on the situations they are presented with. However, it is a concern that there was no apparent consideration that his escalation in anger and violence was risky behaviour which linked to his risk of self-harm.
298. A major part of the part of the problem with managing the young person's increasingly risky behaviour was that there was little high level sharing of information about him and what should be done to help him. No one had done anything effective to deal with the bullying which he undoubtedly experienced. There was no senior management involvement in the ACCT process and the ACCT review was led by a senior officer who had never met the young person before and attended by one wing officer and a mental health nurse (who had had no previous contact with the young person). There was little involvement of qualified people with professional experience of managing troubled adolescents.
299. Each YOI for young people under 18 has a qualified social worker with relevant experience of working with children yet there was no social work involvement in the ACCT process. In the young person's case there were multiple issues to be considered: his ADHD, his conduct disorder, his learning disability, his being bullied by other young people, his guilt about his girlfriend

and his mother who he believed to be ill, his feelings about the death of his stepfather, and the impending loss of his father when he emigrated. There was little coordinated professional management of all these complex dimensions of his risk and vulnerabilities. There seemed to be a lack of understanding that children and young people in emotional distress and with mental health problems might exhibit difficult and challenging behaviour as a sign of their distress. While it could be argued that had all the procedures been followed correctly then he would have been protected, we do not believe that the ACCT process – essentially designed for adult prisoners – is necessarily a suitable vehicle to deal with the complexities and special vulnerabilities of children. Imprisoned children are among the most vulnerable children in the country and those judged as at risk of suicide and self-harm are much more vulnerable. It is unsatisfactory that their case management is identical to that for adult prisoners and that there is little recognition of their special status as children. While we have made recommendations in this report based on the current ACCT process we do not think it is fit for purpose in juvenile establishments. We consider a more high level and holistic approach is needed to caring for young people under 18 who are assessed at risk of suicide and self harm.

The National Offender Management Service and Youth Justice Board should devise a more child-centred approach to managing risk of suicide and self-harm, which takes an appropriate holistic view of all aspects of a young person's risk and vulnerabilities, with cases actively considered at senior management level and involving a range of qualified professionals to meet the identified needs of each young person at risk.

Access to telephones for children at risk

300. On 18 January, after the young person's ACCT review, the SO spoke to his mother, who said that her son had written and said he 'had thought of ending it'. The SO asked her to phone Hindley if her son told her anything else of concern. This would have been easier to do if he had had ready access to a telephone or his mother was able to telephone him directly.
301. On 20 January, the evening that the young person fatally self-harmed, he became upset as he had not been unlocked to use the phone before association began, as he had expected. When he banged and kicked his door Officer B said he would let him out at the end of association, but not if he carried on being abusive. We do not consider this was a sensitive or appropriate way to manage a child who had been identified as the victim of ongoing bullying and was regarded as a risk of suicide and self-harm. His main support was his contact with his family by telephone. No further consideration seems to have been given to allowing him a telephone call that evening, during which he experienced further unchecked bullying from other young people. He was not let out at the end of the association period to make a call. When he later broke some furniture in his cell, he explained to the senior officer that this was because he had been upset at not being able to telephone his family. There was still no consideration of whether he should

be allowed a telephone call to help him calm down. Instead it seems it was treated solely as a discipline issue.

302. Access to telephones is an example of an area where the experience for children in custody exactly replicates that of adult prisoners. Calls can only be made from pin phones on wings. The cost of telephone calls is very expensive compared to usual telephony rates. The young person relied on the telephone to speak to his mother and girlfriend for support and often used up his weekly telephone credit in one day. The times when a child is alone and vulnerable in their cells in the evening and at night are when they most need to speak to their families for support. Young prisoners are able to use Samaritan phones but often, as with most children, it is a family member, someone they know and trust, who they need to speak to. The imprisonment of a child is an extreme state sanction and we do not consider it needs to, or should replicate the experience for adult prisoners, or that all the same security concerns necessarily apply. Security issues need to be balanced against what is in the best interests of a child. Particularly when a child is regarded as at risk of suicide and self-harm and, as in his case, the importance of family support has been recognised. We consider that the Prison Service needs to allow a much enhanced opportunity for young people to speak to their parents or other appropriate people outside the prison. It is noteworthy that in secure training centres such telephone access is much easier, particularly if there are concerns about a child. This includes the ability to receive incoming calls and access to telephones in a child's own room.

The National Offender Management Service and the Youth Justice Board should ensure that, where this would help protect them, children in Prison Service custody who are at risk of suicide and self-harm are able to telephone their parents or other appropriate family members at all times.

Medication: timings and collection from another wing

303. In the community, the young person was prescribed methylphenidate for ADHD. He took the main dose of medication in the morning with an additional dose later in the day if needed. It appears that he understood well how and when he needed to take a further dose. Methylphenidate is a controlled medication and the young person was not allowed to keep supplies himself and had to receive his medication on Elm wing and take it in front of the dispensing nurses. At first, he was given his medication in the morning, and in the evening, at 7.00pm. He found the timing of the evening dose was too late and disrupted his sleep. His keyworker discussed this with his mother and with healthcare and arrangements were made for him to receive his second dose at 4.30pm. This was an appropriate response and reflected good liaison between officers, healthcare staff and the young person's family.
304. As controlled substances were not dispensed on Fir wing, the young person and a small number of others had to be escorted to Elm wing where they were issued their medication. This singles out these young people as different from

others and it seems they are subject to being shouted at by other young people.

305. The Head of Healthcare explained that at the time the young person was at Hindley, just six young people were on controlled medication. Issuing controlled medication is resource intensive; the pharmacy technician has to check the places the controlled medications are dispensed, two nurses are required, and there is only a short window of time when young people are able to collect medication. We agree it does not appear practical to have dispensing points for controlled medication on each wing. However, this reinforces the need for staff to be vigilant that young people prescribed controlled medication are not victimised as a result.

The Governor should ensure that appropriate arrangements are in place to safeguard young people being prescribed controlled medication and that staff are vigilant about the need to protect them from harassment.

Role of the learning disability service

306. The clinical reviewer considered that the learning disability nurse demonstrated a good deal of enthusiasm and willingness to engage with the young person, as evidenced by a number of unplanned sessions with him. However, he found there was a lack of clarity about the role of the learning disability service in his case. He has identified a number of areas where the service could have provided him with useful and practical help such as helping him to learn to ration his use of telephone credit and to help him improve his social interaction skills to enable him to engage more easily with other young people. There was little evidence of the work of the learning disability service being integrated into the work carried out by other health care professionals.
307. The clinical reviewer considered that there is a need to review the role and purpose of the learning disability service which has much to offer young people and could also help YOI staff understand and manage more effectively young people with learning disabilities.

The Head of Healthcare should ensure that the learning disabilities team is effectively structured and managed to meet the needs of young people.

Possible move to the Willow Unit

308. The Willow Unit is a small self-contained unit that takes young people who, for a variety of reasons, experience difficulty on other wings at Hindley. This would include those such as he who might benefit from an environment with fewer young people. Some young people transfer to Willow for a period of additional support before returning to a standard wing. Alternatively, some remain on Willow for the remainder of their time at Hindley. Transfers to Willow are always with the agreement of the young person.

309. The possibility that the young person might be referred to Willow Unit was mentioned a number of times. The psychiatrist suggested it should be considered when he saw the young person on 13 December, if his mental health deteriorated. At first he appeared resistant to the prospect of a move because he did not want to be seen as a victim, but later he seemed more amenable to the possibility of a transfer. On 18 January, he told the Head of Residence that he would be going to Willow soon and at his ACCT review it was noted that he said an SO had said he could go to Willow. However, there was no record of any formal referral to Willow. At the earlier stage when he indicated his reluctance to go to the Willow Unit it would have been difficult and possibly self-defeating to force him to move. Nevertheless, if it was decided Willow was a more appropriate location for him in his own best interests then he should have been moved. Unfortunately at that stage it is not at all clear who was responsible for coordinating his care. As the possibility of Willow was suggested to him in early January it would have been helpful for someone to have asked the SO in charge of Willow Unit to speak to him and explain the potential benefits of the unit and show him round.

The Governor should ensure that a representative from Willow Unit explains the role of the unit to a young person who might benefit from a placement there and shows them around the unit to encourage them to transfer.

Treatment of the young person's mouth ulcers

310. The young person first reported problems with mouth ulcers at a nurse-led triage assessment on 12 December. He was seen by one of Hindley's doctors the following day. The doctor diagnosed Aphthous ulcers (a common type of mouth ulcer). The doctor prescribed antifungal medication and a gel to relieve his discomfort. He was asked regularly about his symptoms when he saw clinicians for other reasons and he often reported having difficulty with eating and swallowing. The condition was reviewed by doctors on 21 December and 5 January and these reviews showed the condition slowly responding to treatment. On 14 January, he reported to a nurse that he had "no problems with his appetite", but no specific reference was made to his mouth ulcers. We are satisfied that he received appropriate care for this condition.

The emergency response

311. When Officer C checked on the young person at around 8.43pm on 20 January, all seemed well. His cell light was on and he was sitting at his desk writing a letter. When the officer returned to make his next check, just after 9.10pm, he could see that he had switched off his cell light. The officer saw him hanging from a sheet tied to the window bars and ran to the centre to switch on the landing lights and radioed for assistance. He entered the cell using his emergency key, cut the sheet and started CPR. He also made a further radio call to clarify that it was a code blue emergency.

312. The orderly officer arrived within two minutes and a nurse arrived about three minutes later. They were then joined by another officer. CPR continued until eventually the young person regained a pulse. The nurse was giving him oxygen when ambulance paramedics arrived and took over. He was then transferred to hospital. Sadly, he died a few days later.
313. Having sought a view from a consultant in emergency medicine, the clinical reviewer concluded that the YOI staff response had been praiseworthy and effective. Even so, there are still lessons to be learned. One was that Nurse A had delivered CPR at a ratio of two rescue breaths to 15 chest compressions. This was the previously recommended ratio for delivery of CPR, but the current recommended ratio is two rescue breaths to 30 chest compressions. The nurse recognised this at interview with the investigators.
314. Another learning point relates to the use of a defibrillator. Nurse A said at interview that she had not asked for a defibrillator to be brought to the cell as the young person had no heartbeat, and without a heartbeat a defibrillator will not deliver a shock. While it is true that a stopped heart will not be restarted with a defibrillator, the Resuscitation Council UK advise that all healthcare professionals should consider the use of a defibrillator to be an integral component of basic life support. The defibrillator will give advice on management of the patient and there might be a point during the resuscitation process when a shock might be advised. This was fed back to Hindley. The Governor has since bought additional defibrillators so there is now one per wing.
315. The young person's family questioned how he could have survived so long without a heartbeat. The explanation is that effective CPR, as delivered by the staff who attended to him, artificially delivers oxygen to the body's organs to allow the possibility of resuscitation.

The Governor and Head of Healthcare should ensure that first responders to an emergency are up to date with current guidance on emergency and resuscitation techniques and include a defibrillator as standard equipment for a code blue emergency.

316. Officer C entered the cell at 9.13pm and according to the incident log made an emergency radio call at the same time to say a young person had been found hanging. After the orderly officer arrived, he said that he radioed the control room to request an ambulance urgently. The incident log records this call as being made at 9.20pm, seven minutes after the young person was found. From the accounts of the actions we have been given it is difficult to understand why this took so long but seven minutes is too much of a delay in such a situation.

The Governor should ensure that an emergency ambulance is called immediately whenever there are grave concerns about a young person's health.

Support for staff and young people

317. Following the young person's fatal self-harm, other young people who were subject to ACCT procedures were reviewed. His friend was offered additional support. The friend told investigators he had been well cared for, and had been able to speak to his mother and to the young person's mother in the weeks that followed.
318. The young person was in a coma for several days before his death, so the full contingency plans for a death in custody were not activated. Investigators spoke to a number of young people. Many of them said they heard what had happened to him from other young people. One said he had been told by staff on the mental health unit.
319. The SO on duty on Fir wing on 21 January said that staff had been briefed but were not aware what information to give the young people. Some young people asked if the young person had died and she told them individually he had not. At lunchtime, she telephoned the duty governor and he came to the wing with the Head of Safeguarding and explained the situation to the other young people. Staff and young people said the chaplaincy had offered support.
320. Most of the staff involved spoke positively of the support they received from senior managers and the care team. Some healthcare staff were less positive, and this was fed back to the Head of Healthcare.

Escort officers at hospital.

321. The young person's family were concerned that one of the officers on escort duty at the hospital acted in an insensitive manner and was intrusive in checking the identity of all visitors. One of the investigators spoke to the officer and the Governor. The officer said that when he arrived at the hospital on the morning of Sunday 22 January, he introduced himself to the young person's mother. He was working a 12 hour shift and he based himself in the nurses' rest room which was about 50 metres from where the young person was being treated. As he was still on an open ACCT, the officer thought it appropriate to check him around once an hour. On one occasion when he checked on him, there were a lot more visitors present, including two young women who he had not seen before and he asked them who they were, which he said he needed to know for security reasons. The officer said that when the Head of Residence visited later that day he told the officer that the family had complained about him being too intrusive. He told the officer to reduce the frequency of his checks on the young person. The officer told the investigator that it made him feel uncomfortable that the family had complained, but he had a job to do.
322. The officer told the investigator that he had carried out a number of previous hospital escorts but usually for routine treatment when there had been no family present. These would have been undemanding escorts, while in the young person's case, he found himself in the most difficult and sensitive of circumstances for which his previous experience would not have prepared

him. It does not appear that senior managers had fully thought through the situation and briefed the escort staff appropriately about what was expected of them. It is hard to see what purpose it served to continue to monitor him on an ACCT and this seems insensitive in the circumstances. There were no security concerns and when a young person is taken to hospital in such circumstances we consider it would be more appropriate to release on temporary licence.

The Governor should ensure that in appropriate cases young people who are taken to hospital are released on temporary licence.

CONCLUSION

323. The young person arrived at Hindley with a range of well documented vulnerabilities which the YOI either failed to recognise or act on. He was subject to bullying and harassment from other young people which he told staff about. There was poor information sharing and no effective action was taken to protect him. None of the systems designed to safeguard young people at Hindley were implemented until a very late stage, after he drew attention to himself by smashing his TV and using it to self-harm. There was then a continuing failure to deal with his problems and take action to safeguard him.
324. On the evening he fatally self-harmed there was a fundamental failure in supervision. The young person relied heavily on his family for support, yet little thought was given about how to allow him to access that support, such as through enhanced telephone contact. His vulnerabilities were not assessed in the round and there was no senior manager involved in coordinating his care to ensure he was effectively protected and all his needs as a vulnerable child met.

RECOMMENDATIONS

To the Youth Justice Board and National Offender Management Service

1. The National Offender Management Service and Youth Justice Board should devise a more child-centred approach to managing risk of suicide and self-harm, which takes an appropriate holistic view of all aspects of a young person's risk and vulnerabilities, with cases actively considered at senior management level and involving a range of qualified professionals to meet the identified needs of each young person at risk.

NOMS and YJB commented as follows:

"This recommendation raises significant issues which NOMS and the YJB need to carefully consider before substantively responding. To ensure this is done comprehensively and appropriately for the risks involved, a working group of the Safer Custody and Learning Board has been created."

2. The National Offender Management Service and the Youth Justice Board should ensure that, where this would help protect them, children in Prison Service custody who are at risk of suicide and self-harm are able to telephone their parents or other appropriate family members at all times.

NOMS responded as follows:

"The working group identified in recommendation 1 will consider the operational and policy issues which would be involved to meet this recommendation. A substantive response to the recommendation will be provided as soon as possible."

The YJB added:

"We accept the principle of the recommendation and hope to be able to implement it but need to further explore the practicalities, for both short-term and long-term solutions which are complex."

To the Youth Justice Board

3. The Youth Justice Board should give clear documented reasons for a decision to allocate a young person to a young offender institution when a placement to a secure training centre has been proposed

The YJB accepted the recommendation and said:

"We are undertaking further work to assure ourselves that our management checks are effective and that our guidance and communications are more transparent in explaining how professionals and families/carers can request transfers when they are concerned about a placement."

4. The Youth Justice Board should ensure that court officers understand the importance of suicide self-harm warning forms and how and when to complete them.

The YJB commented:

“We accept the spirit of the recommendation but our understanding of the current use of suicide and self harm warning forms would suggest that it would be more appropriate for work to focus on improving the efficacy and use of the PER”

5. The Youth Justice Board should ensure that pre-sentence and post court reports are completed as required and provided to establishments holding the young person to help with their assessment of risk.

The YJB commented:

“We accept that it is our responsibility to ensure that post court reports are provided to custodial establishments (though there may be occasions where it is not possible to provide them at the point of placement) and a project is already underway to improve performance here. However, and though we will think further on this issue, we do not currently require that pre-sentence reports are sent to us during the placement process, and are not clear that this would be the best way to ensure that establishments have what they need to assess risk, and so are unable to accept this recommendation in its entirety.”

To the Governor

6. The Governor should ensure that officers actively challenge all examples of potential bullying and make appropriate entries in P-NOMIS case notes and wing observation books which are regularly monitored by managers to establish any patterns of behaviour or individual concerns.

NOMS accepted this recommendation and said:

“Staff Information Notice has been issued to remind staff of their responsibilities in respect of safeguarding young people who remain in their room during activity or association periods.

Expectations Documents which include expectations around staff supervision, engagement, challenge and support of young people have been developed for both Senior Officers and Officers. These have been issued and are included as part of the discussion in staff appraisal meetings (SPDR Reviews).

The establishment has introduced a daily Safeguards “tasking” meeting which provides an opportunity for a multi-disciplinary team to discuss recently submitted Safeguards Reports and agree appropriate actions. All concerns are now entered onto P-NOMIS and Unit Observation Books are updated.”

7. The Governor should ensure that when there are allegations that a young person is being bullied, effective monitoring and supervision arrangements are put in place to protect him from further harm.

NOMS accepted this recommendation and said:

“A local Management of Vulnerability Policy has been developed and issued via a Notice to Staff.

The Safeguards referral process has been reviewed and revised. The new reporting arrangements have been issued, along with guidance, as a Notice to Staff.

The establishment has introduced a daily Safeguards “tasking” meeting which provides an opportunity for a multi-disciplinary team to discuss recently submitted Safeguards Reports and agree appropriate actions.

Support Intervention Plans (SIP) have been developed and these are used to monitor arrangements and evidence the supervision of those young people who have been identified as being vulnerable.

These plans are reviewed at the weekly multi-disciplinary Safer Regimes meeting.”

8. The Governor should carry out a disciplinary investigation into the apparent failure of Officers A and B to supervise the association period adequately in order to protect the young person from harassment on the evening of 20 January 2012.

NOMS accepted this recommendation and said:

“A Disciplinary Investigation has been commissioned by the Governor. This currently underway is being conducted by the Acting Governor of Styal Prison (who is also the Area Safer Custody Lead).”

9. The Governor should ensure that all officers assigned to oversee association periods actively patrol and supervise young people to enable a safe environment, and take into account the particular need to protect young people with identified vulnerabilities.

NOMS accepted this recommendation and said:

“A Staff Information Notice issued to remind staff of their responsibilities in respect of safeguarding young people who remain in their room during activity or association periods.

Expectations Documents which include expectations around staff supervision, engagement, challenge and support of young people have been developed for both Senior Officers and Officers. These have been issued and are included as part of the discussion in staff appraisal meetings (SPDR Reviews).”

10. The Governor should ensure that all information about a young person’s risk of self-harm or suicide is fully considered and assessed on arrival taking into account known risk factors. Decisions about suicide and self-harm monitoring should be clearly documented to explain why a recommendation for monitoring is not followed.

NOMS accepted this recommendation and said:

“All staff who work in Reception and First Night Centre have been advised of the local requirement to clearly evidence the factors they considered in their decision

making around the appropriateness of initiating ACCT procedures, and noting the reasons why these procedures have not been initiated when this judgement is made.

The RAM assessment is now completed for all young people newly received into custody as part of the establishment's first night procedures. This is a comprehensive assessment of risk and vulnerability.

Any decisions not to initiate ACCT procedures where outside agencies have identified risk of self-harm or suicide will be documented in P-NOMIS case notes."

11. The Governor should ensure that wing staff are given key information about a young person's special needs to help effective communication and management on the wings.

NOMS accepted this recommendation and said:

"The Governor has re-iterated to Healthcare management the need to adhere to the locally agreed information sharing protocol.

Where a young person is identified as having specific needs which may increase his vulnerability then e-ASSET and C-NOMIS will be updated accordingly."

12. The Governor should ensure there are no delays in the appointment of key workers and personal officers, and that the officers introduce themselves to young people shortly after they arrive.

NOMS accepted this recommendation and said:

"The Governor has reiterated to Head of Residential and Head of Keywork the need to adhere to the locally agreed timescales for the appointment of staff to these roles. A Quality Assurance system will be introduced to monitor compliance with this objective"

13. The Governor should ensure that full consideration is given to opening an ACCT whenever concerns are raised indicating that a young person is at risk of suicide or self-harm. Decisions not to open an ACCT should be fully explained and documented.

NOMS accepted this recommendation and said:

"The "Introduction to Safer Custody" Training which is delivered locally includes the requirement for full consideration to be given to opening an ACCT whenever concerns are raised. Decisions taken not to open an ACCT when information is received will be documented."

14. The Governor should ensure that concerns passed to visits staff about the safety of a young person are always passed to the head of safeguarding to consider and take appropriate action.

NOMS accepted this recommendation and said:

“The procedures for sharing concerns raised by professional or family visitors have been amended. Visits staff now submit a Safeguards Report (with the information sheet completed by visitors attached) directly to the Safeguards department. As with other Safeguards Reports, these are reviewed on a daily basis.”

15. The Governor should ensure that the risks and triggers section of ACCT assessments are completed and discussed at ACCT reviews to help set effective care plan targets covering identified issues which help protect the young person at risk.

NOMS accepted this recommendation and said:

“Locally delivered Safer Custody ACCT Case Manager Training includes this requirement. The establishment Suicide Prevention Co-ordinator checks compliance as part of their weekly quality assurance checks.”

16. The Governor should ensure that important new information about the risk of suicide and self-harm of a young person being monitored under ACCT procedures should lead to an immediate review of the level of risk and frequency of observations, if possible by a multi-disciplinary team.

NOMS accepted this recommendation and said:

“Locally delivered Safer Custody ACCT Case Manager Training includes this requirement.”

17. The Governor should ensure that families are invited to be involved in ACCT case reviews in appropriate cases.

NOMS accepted this recommendation and said:

“Locally delivered Safer Custody ACCT Case Manager Training includes this requirement. The establishment Suicide Prevention Co-ordinator will monitor the frequency of engagement with/by families as part of their weekly quality assurance checks.”

18. The Governor should ensure that wing staff abide by Hindley’s suicide prevention policy and record in wing observation books when a young person stays in his cell at association times, unless this is being dealt with through an ACCT or behaviour intervention plan.

NOMS accepted this recommendation and said:

“The Head of Residential has introduced a system of daily checks to ensure that young people who stay in their room at association times are spoken to by staff and this is recorded in the wing diary.”

19. The Governor should ensure that appropriate arrangements are in place to safeguard young people being prescribed controlled medication and that staff are vigilant about the need to protect them from harassment.

NOMS accepted this recommendation and said:

“Expectations Documents which include expectations around staff supervision, engagement, challenge and support of young people have been developed for both Senior Officers and Officers. These have been issued and are included as part of the discussion in staff appraisal meetings (SPDR Reviews).”

20. The Governor should ensure that a representative from Willow Unit explains the role of the unit to a young person who might benefit from a placement there and shows them around the unit to encourage them to transfer.

NOMS accepted this recommendation and said:

“A Senior Officer from Willow Unit undertakes this task at the request of the manager of the First Night Centre (upon a young person’s arrival) or as directed by the Safer Regimes meeting”

21. The Governor and Head of Healthcare should ensure that first responders to an emergency are up to date with current guidance on emergency and resuscitation techniques and include a defibrillator as standard equipment for a code blue emergency.

NOMS accepted this recommendation and said:

“To ensure that essential equipment is available, and to avoid any potential delays to treatment, a total of 9 defibrillators have been purchased. One is used for training purposes with the remainder being distributed to residential units and the gymnasium. All areas now have immediate access to this equipment.

All PCT front-line staff have been trained in the use of the new equipment. Prison staff who undertake Emergency First Aid training now also receive training in Basic Life Support including the use of defibrillators.”

22. The Governor should ensure that an emergency ambulance is called immediately whenever there are grave concerns about a young person’s health.

NOMS accepted this recommendation and said:

“A Notice to Staff has been issued to clarify circumstances when an ambulance should be called and how messages must be conveyed to the Control Room.”

23. The Governor should ensure that in appropriate cases young people who are taken to hospital are released on temporary licence.

NOMS accepted this recommendation and said:

“In line with National guidelines the Governor will consider Release on Temporary Licence for any young person taken to hospital on a case by case basis”

To the Governor and Head of Healthcare

24. The Governor and Head of Healthcare should ensure that all staff working with young people in the YOI are trained in the operation of the violence reduction strategy and understand the importance of making referrals in accordance with the strategy whenever there is concern that a young person might be being bullied, intimidated or threatened.

NOMS accepted this recommendation and said:

“All existing healthcare staff have been provided with a briefing on the new Safeguards report, the management of vulnerability and medical emergency response and in line with all other prison staff and will sign to state that this information has been read and understood.

A member of the healthcare team attends the daily Safeguarding meeting in order to share and obtain all relevant safeguarding information.

Training will be given to all new staff as part of the prison induction programme. Healthcare services have introduced a template on SystemOne for all safeguards referrals. This will allow Healthcare and the Safeguards team to monitor safeguards referrals and ensure that information is shared between all relevant staff.”

To the Head of Healthcare

25. The Head of Healthcare should ensure that a young person’s full medical history, including information from their families, should be obtained and taken into account when making assessments. Relevant information should be shared with other staff as appropriate.

NOMS accepted this recommendation and said:

“A new system has been introduced for the follow up and requesting of previous health information from other healthcare providers. This is tasked and recorded within SystemOne. Where requests are not acknowledged for information, there is an escalation process to ensure that all avenues have been explored to obtain the history.”

26. The Head of Healthcare should ensure that the learning disabilities team is effectively structured and managed to meet the needs of young people.

NOMS accepted this recommendation and said:

“The learning disability, speech and language and mental health services have been reviewed and an integrated care pathway has been established.”