PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in November 2013 at HMP Belmarsh

Our Vision

‘*To be a leading, independent investigatory body, a model to others, that makes a significant contribution to safer, fairer custody and offender supervision’*

This is the investigation report into the death of a young man who was found hanged in his cell at HMP Belmarsh in November 2013. He had only recently turned 18 years of age. I offer my condolences to his family and friends.

A clinical review of the care the young man received Belmarsh was conducted. All agencies involved cooperated fully with the investigation.

In May 2013, when the young man was 17, he was charged with murder and remanded in custody. He spent a short time in a secure training centre and several weeks in a psychiatric hospital before he transferred to HMYOI Feltham in September. He was convicted in October and, on Friday 8 November, was sentenced at the Old Bailey to be detained at Her Majesty's pleasure for a minimum period of 18 years.

Feltham had intended that he should return there after he was sentenced, but this information was not passed on. The young man became 18 between the time of his conviction and sentencing and I am concerned that there was no effective transition planning for his future management as a young adult. This resulted in confusion about where he should go after he was sentenced. On the day of his conviction, there were significant communications failures among those responsible for him, including Feltham and the Youth Justice Board, which led to his inappropriate transfer to Belmarsh.

Local prisons in London had only recently started to take sentenced young adults aged 18 to 21. It does not appear that Belmarsh was well prepared for this responsibility and it failed to recognise the young man's vulnerabilities. These were stark: he had been convicted of a heinous offence, which had attracted a lot of publicity and a very long sentence; he was held in the daunting environment of an adult high security prison just days out of his childhood; he suffered from the effects of a brain injury and had previously self-harmed. While Belmarsh recognised that he was at risk from the general population, it did not identify him as at risk of suicide and self-harm, despite concerns conveyed by staff at the Old Bailey.

As a result, necessary safeguards were not put in place to protect the young man. Instead, because Belmarsh's vulnerable prisoner unit was full, he was held temporarily, effectively in isolation, first on the induction unit and then on another wing. He had a minimal regime and received little or no support. While I do not consider that he should have gone to Belmarsh in the first place, it was the prison's responsibility to protect him and ultimately it failed.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **September 2014**

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SUMMARY

1. In May 2013, when the young man was 17 years old, he was charged with the murder of an elderly woman. He was remanded in custody and initially spent time in a secure training centre (STC) and then a psychiatric hospital. On 17 September, the young man transferred to HMYOI Feltham. On 7 October, at the Central Criminal Court (Old Bailey) he was convicted of murder and returned to Feltham. On 11 October, he turned 18.

2. On 8 November, the young man left Feltham A (holding children aged 15-18) to be sentenced at the Old Bailey. He was sentenced to be detained at Her Majesty's pleasure, with a minimum period to serve of 18 years before he could be considered for release. After he was sentenced his community YOT worker and his legal team reported their concerns about his safety and his state of mind. Court staff completed a suicide and self-harm warning form to alert prison staff that the young man was low in mood and that he might be volatile. Because it had been recognised that the young man was particularly vulnerable, it had been intended that he would return to Feltham but there was confusion and miscommunication about the arrangements. Instead, he was taken from the Old Bailey to HMP Belmarsh which had only recently begun to take young adults between 18 and 21 years old.

3. When the young man arrived at Belmarsh the reception supervising officer and nurse noted the suicide and self-harm warning form completed at court, but they discounted the warning as they believed the form had been used inappropriately to record information about his volatility. They did not consider this relevant to the young man's state of mind and did not act on the other information that he seemed depressed and had had an adverse reaction to his sentence. A mental health nurse in the first night centre saw the warning form but took no action. No one else at Belmarsh saw the form. The reception staff did not regard the young man as at risk of suicide and self-harm.

4. None of the staff who interviewed the young man in the prison's first night centre considered him as at risk of suicide and self-harm. He spent his first four nights at the prison on Houseblock 3, the prison's induction unit. He had been recognised as at risk from other prisoners because of the nature of his offence and was classed as a vulnerable prisoner. As there was no room in the prison's designated vulnerable prisoner unit, on 12 November, the young man moved to a spur on Houseblock 4 (HB4), which was used to accommodate vulnerable prisoners temporarily.

5. During the four days that the young man was at Belmarsh he rarely left his cell, except to collect his meals. There is little evidence that staff had any meaningful interactions with him and he appears to have gone largely unnoticed by staff. On the evening of 12 November, the young man told another prisoner he was scared. An officer found him hanged in his cell. It was evident that he had been dead for some time. At 9.45am, the

young man was pronounced dead.

6. The investigation found that there was no structured plan to manage the young man's transition on sentence from the juvenile to the young adult estate after he became 18. This, and poor communication of a plan for him to return to Feltham, resulted in him being sent to Belmarsh. At Belmarsh, his evident risks of suicide and self-harm appear to have been missed and a suicide and self-harm warning form from the court was discounted. The young man was regarded as at risk from other prisoners at Belmarsh and spent most of his time locked in his cell. We consider that he had a number of known risk factors and should have been managed under Prison Service suicide and self-harm prevention procedures to support him in the early days in custody which are recognised as a particularly vulnerable time. Instead, the young man was left almost entirely alone by staff at Belmarsh, with an impoverished regime and little to distract him from thoughts of suicide.

7. We make a number of recommendations about the transition planning to the young adult estate, communication of transfer arrangements, identification of risk, support for vulnerable young adults at Belmarsh and emergency procedures.

THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners at Belmarsh informing them of the investigation and inviting anyone with information to contact him. No one responded.

9. The investigator obtained all relevant documents from the young man's time in prison. During the course of the investigation, he interviewed a number of staff at Belmarsh and two prisoners. He also interviewed staff at Feltham, the Central Criminal Court (Old Bailey), the Youth Justice Board (YJB) placements team and the National Offender Management Service (NOMS). He gave feedback to the Governor of Belmarsh and other interested parties, about the emerging findings of the investigation.

10. NHS England (London Region) appointed a clinical reviewer to review the clinical care the young man received at Feltham and Belmarsh.

11. We informed HM Coroner for the Inner South London district of the investigation and we have sent the Coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted the young man's family to inform them of the investigation and to invite them to identify any relevant issues they wanted the investigation to consider. His family had a number of questions about the background to the decision to send him to Belmarsh, the transfer to Belmarsh, his induction arrangements at the prison and about what documents were transferred with him. They wanted to know more about his time at Belmarsh, the assessment of his risk and whether he had been assaulted at the prison. We have endeavoured to cover these issues in the investigation report.

HMP BELMARSH

13. HMP Belmarsh is a high security and local prison serving the courts of South East London and South West Essex. It opened in 1991 and holds over 900 adult male prisoners. The prison is made up of four houseblocks, with three spurs leading from a central hub. Each spur contains 42 single and double cells.

14. The first night centre and induction unit at Belmarsh is located on Houseblock 3 (HB3), Spur 2. At the time of the young man's death, all new prisoners, including young adults and vulnerable prisoners, spent their first few days at Belmarsh on the induction unit. While most prisoners received their induction on the unit, in groups over several days, vulnerable prisoners received their induction individually, often in their cell.

15. The vulnerable prisoners' unit, Spur 1 on Houseblock 4 (HB4) has accommodation for approximately 75 prisoners. When no spaces are available on the vulnerable prisoners unit, prisoners are located in "overspill" cells on the top landing of Spur 2. Vulnerable prisoners held there are unable to associate with other prisoners on the spur and remain there until a space becomes available on Spur 1.

16. Care UK, provides healthcare services at the prison.

17. In June 2013, the Ministry of Justice agreed that young adults on remand, (aged between 18 and 21) would be dispersed from HMYOI Feltham (which had previously held all young adults on remand in London) to London adult local prisons. From 20 December 2013, Feltham B was scheduled to hold only convicted young adult prisoners. As a result, Belmarsh began to take young adults from 2 September 2013.

Her Majesty's Inspectorate of Prisons

18. HM Inspectorate of Prisons' (HMIP) most recent inspection of Belmarsh was an unannounced inspection in September 2013. Inspectors noted that the prison:

> "… had recently been identified to receive up to 66 young adult prisoners. Before their arrival, staff had visited other prisons that held young adult prisoners and a formal strategy was developed to ensure their safety and fair treatment."

19. Inspectors found the prison's reception to be an unwelcoming environment and that staff engagement was minimal and distant. Many prisoners felt unsafe on their first night. Although first night staff displayed a caring approach, inspectors were not assured that night staff were focused on the vulnerability of new arrivals or that arrivals were offered a shower or a telephone call. Vulnerable prisoners on the first night centre were identified by their cell cards, which indicated who they were to other prisoners and increased their anxiety. Induction for vulnerable prisoners

was described as haphazard.

20. Although inspectors saw some positive staff behaviour, they noted that many were reluctant to engage with prisoners and appeared disinterested. The quality of written entries about prisoners was mixed and inspectors noted that far too many residential wing staff were distant and seemed unprepared or unable to engage positively with prisoners. Many prisoners did not know who their personal officer was and personal officers had little knowledge of the prisoners for whom they were responsible.

21. Inspectors found there was too little time out of cell for many prisoners and too much regime curtailment, with 54% of prisoners locked in their cells during the day. Opportunities for daily exercise were limited to 30 minutes, but could be shorter for many prisoners.

Independent Monitoring Board

22. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its 2012/13 annual report, the IMB noted that vulnerable prisoners unable to be located on the vulnerable prisoner spur were held on a separate spur and had little time out of their cells as they could not mix with the other prisoners living on the same spur.

Previous deaths

23. The young man's death is the fourth self-inflicted death at Belmarsh that the Prisons and Probation Ombudsman has investigated since July 2010. In May 2011, we recommended that the Governor should ensure that staff use the appropriate local emergency code. In 2013, on two occasions we asked that the Governor ensure that an ambulance is called immediately when an appropriate emergency code is called. Similar issues about emergency procedures arose in this investigation and it is a concern that the prison does not appear to have implemented recommendations accepted in previous investigations aimed at promoting safety.

HM Young Offender Institution Feltham

24. HMYOI Feltham is divided into two parts. Feltham A holds children and young people, between 15 and 18. Feltham A is made up of eight units. Feltham B holds young adult men aged between 18 and 21. It is made up of 10 units with each having a mixture of double and single cells.

25. In January 2013, Feltham issued Governor's Notice to Staff GN005/2013, outlining a protocol for young people from Feltham A moving to Feltham B when they become young adults. The YJB say this notice was not shared with them and their placements service was unaware of it. The notice stipulated that planning would begin three to four months before they reached their 18th birthday. The notice stated that:

> "young people who turn 18 during their trial will remain in the young people's estate until their case has been concluded to ensure stability during what can be a difficult time for them."

The notice went on to say:

> "young people due to remain in the young people's estate following their 18th birthday will, when attending court, have noted on their PER – TO RETURN TO YOUNG PEOPLE'S ESTATE (FELTHAM A).

26. In June 2013, the Ministry of Justice agreed that Feltham B would change its function and hold convicted young adults only. Remanded young adults would be dispersed, over time, to London local prisons, including HMP Belmarsh. The aim was for the change to be completed by 20 December 2013. It was agreed that the allocation of vulnerable young adults, between 18 and 21, would be dealt with on an individual basis with the option of a prisoner returning to or being sent to Feltham B if it was considered that their vulnerability required this. (Vulnerable 18 year old prisoners could still return to Feltham A as part of transition arrangements.)

27. An existing NOMS protocol of September 2012, which gave guidance on the transition process would remain in place. The assumption was that any 18 year old prisoner due to transfer into the adult estate from Feltham A would return from court to Feltham B for assessment and a risk based allocation at a later date before onward transfer to a suitable establishment. The protocol appears to contradict the Governor's Notice to Staff that was issued in January 2013 which said that such prisoners would return to Feltham A.

Youth Offender Team

28. Youth offending teams (YOT) are multi-agency teams coordinated by local authorities, but overseen by the Youth Justice Board (YJB). YOT workers are designated probation officers who work with young offenders, under the age of 18, and are supported by other agencies. The aim of the YOT is to support young offenders with the intention of reducing the risk that they might re-offend, provide advice and to assist in rehabilitation. They engage in a wide variety of work with young offenders in order to achieve their aims. YOT workers supervise young people who have been ordered by the courts to serve sentences in the community and in secure accommodation, including secure children's homes, secure training centres (STC) and Young Offender Institutions. They are able to make recommendations to the Youth Justice Board about the best place to hold a young person in the secure estate.

Serco

29. Serco's Prisoner Escort and Custody Services (PECS) provide secure transport of prisoners between police stations, courts and prisons. Serco PECS also operate court custody suites, including those at the Central Criminal Court, also known as the Old Bailey. Since September 2012 Serco PECS have also provided transport services to the Youth Justice Board (YJB) to escort children.

Youth Justice Board Placements Team

30. The Youth Justice Board (YJB) works with young offenders and aims to reduce re-offending, protect the public and promote the welfare of children and young people in the criminal justice system. The YJB placements team places young people, aged 17 and under at the point of remand or sentencing. The YJB placements team, working with other agencies, including YOT workers, place young people under the age of 18 in secure environments such as STCs and YOIs.

Assessment, Care in Custody and Teamwork (ACCT)

31. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should not be carried out at predictable intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the caremap have been completed.

KEY EVENTS

32. On 24 May 2013, the young man was arrested for the murder of an elderly woman. It was a heinous crime that received significant press coverage. At the time of his arrest, a number of other charges against him were pending, including taking a vehicle without consent and the possession of a blade. The young man had one previous conviction, in 2011, for theft and criminal damage for which he had received a nine-month referral order. He had never served a previous custodial sentence. Throughout his short life, the young man had had significant contact with local authority children's services.

33. In April 2012, a police car hit the young man and he sustained a serious brain injury. He became more unpredictable and agitated after the accident. A neurological assessment established that his intellectual functioning was that of a child, between six and eleven years old with learning difficulties. This was attributed to the damage caused in the accident, which also resulted in disinhibited behaviours such as violence, anger and other personality changes

The young man's arrest

34. The young man was arrested on 24 May and appeared at Magistrates Court on 27 May. His YOT worker completed an assessment to determine where he would be best placed in custody. The young man told his YOT worker that, if he were remanded in custody for a long period, he would try to take his own life. The young man said that his parents had stopped him from hanging himself within the last six weeks. The YOT worker noted that the young man did not say he was afraid of being held in custody: he said that there was nothing to fear as he would kill himself. The YOT worker noted that the young man expressed a number of morbid thoughts and asked that she should tell his parents not to worry about him as he would meet them again in the next life. The young man's father was also concerned that his son might harm himself or someone else.

35. Because of concerns about the young man's demeanour in court and his level of vulnerability, his YOT worker recommended to the YJB placements team that he should be remanded in a Secure Training Centre (STC). The YJB placements team agreed and he was remanded to Medway STC. When the young man arrived, he was initially managed under the STCs suicide prevention procedures.

36. The YOT worker kept in regular telephone contact with the young man at the STC. In one telephone call, he said that there was another side to him which was taking over his body and was going to do something bad. The YOT worker said she became concerned as his behaviour changed and he became more volatile and aggressive. A psychiatrist from the Bluebird Unit at an adolescent psychiatric unit in Southampton examined him and

concluded that he should have a full psychiatric assessment.

37. On 31 July 2013, the young man was admitted to the Bluebird Unit. On 9 September, his case was discussed at a multi-agency meeting at the unit. It was noted that he had experienced some personality changes due to his brain injuries, but that there was no evidence of psychotic illness and that he would not benefit from long-term hospital treatment. The psychiatrist reported that the hospital could not provide any effective treatment for the young man's mental disorder. As the young man had no significant history of self-harm, he was assessed as being a low risk to himself, but a high risk to those around him due to his volatile mental state, impulsivity and aggressive outbursts. The meeting agreed, with input from the young man's YOT worker and a worker from the YJB placements team, that he would transfer from the Bluebird Unit to Feltham A, in preparation for an eventual transition to Feltham B after he became 18.

HMYOI Feltham

38. On 17 September, the young man transferred to Feltham A and he had a full induction. An officer interviewed the young man to identify any risks to himself or others and to identify any immediate needs. The officer noted that the young man had previously self-harmed and had made threats to hang himself while at court. (It had previously been reported that the young man had attempted to hang himself six months earlier.) The officer recorded that the young man did not appear to be disturbed at the fact that he was facing a serious charge of murder and a possible life sentence. The officer said the young man was calm, chatty and engaged will throughout the interview and assured him that he had no thoughts of self-harm. However, the officer was wary of what he said and assessed the young man as a medium risk of self-harm. The officer referred the young man to the prison's mental health team

39. On 22 September, a nurse assessed the young man's mental health. The young man said he had no history of self-harm or suicidal behaviour. The nurse noted that he was coping well, his mental state was not impaired and that previous fluctuations in his mood had not occurred. The young man said that this was because the staff were fair with him. At a mental health team meeting on 25 September, he was discharged from the mental health team's care.

40. During September, officers noted in the young man's record that he was coping and had not expressed any thoughts of self-harm. He said that he sometimes suffered panic attacks when he was angry and confined in a small space. The young man's personal officer noted that since he had arrived on the unit he was very polite and followed instructions. The young man attended education and other activities, had no outbursts of aggression, remained quiet, polite and courteous to staff, kept his cell clean, got on with other young people and had raised no concerns.

41. On 1 October, a transition meeting was scheduled to take place. This was organised by his Offender Supervisor. No one invited attended. Although not documented, a decision was taken that he could remain in Feltham A, until sentencing and not because of any vulnerability issues.

42. On 7 October, the young man appeared at court. He changed his plea to guilty and was convicted of murder. After attending court, the young man returned to Feltham A.

43. On 9 October, the young man told an officer that he felt down after his court appearance and realised that he was likely to receive a long custodial sentence. The young man told the officer he wanted to move to Feltham B as soon as possible after he became 18, in two days time.

44. On the young man's eighteenth birthday, an officer noted that he had spent time out of his cell and raised no concerns.

45. The YOT worker visited the young man at this time and said that he appeared very calm. He told her that he liked the structure, boundaries and the environment of the prison and felt safe there. The young man told the YOT worker that Feltham A was the best place that he had been so far as he had felt unsettled at Medway STC and referred to the Bluebird Unit as a "madhouse". The YOT worker said she did not consider he appeared at risk of self-harm at the time and just wanted to be sentenced and serve his time.

46. On 16 October, an officer spoke to the young man and noted that he appeared to be in better spirits than when they had last spoken. The young man told the officer he was putting his trust in his religious faith and would accept his fate. He said he was keen to move to Feltham B. On 23 October, the officer noted that the young man continued to maintain good standards of behaviour and was polite and respectful to staff.

47. On 7 November, an operational support grade prepared the young man's Person Escort Record (PER) form in preparation for his journey to court for sentencing the next morning. She noted on the form that the young man was going from Feltham A to court, but did not include a note on the front of the form that the young man was to return to Feltham A after his court appearance.

Friday 8 November 2013

48. On Friday 8 November, the young man arrived at court for sentencing. The YOT worker, his solicitor and barrister met him in the court cells before the hearing. The YOT worker said he appeared calm and a little jokey. He did not seem anxious or agitated and talked about how many years he might get. She said that she got the impression that he just wanted the hearing to be over. The judge sentenced the young man to detention at Her Majesty's pleasure with a minimum term of 18 years before the Parole Board would be able to consider his suitability for

release. (Detention at Her Majesty's pleasure is the equivalent, for those under 18 convicted of murder, of a mandatory life sentence for an adult.)

49. At 3.40pm, a Serco prisoner custody officer (PCO) spoke to an officer from the Serco control room to check that the young man would be returning to Feltham. The Serco control room confirmed that this was the case, but they would need a placement order from the YJB placements team. The Serco control room told the PCO that the young man would move to Feltham B the next day.

50. An officer from the YJB placements team told the investigator that she had received a call from a prisoner custody officer at court asking for authorisation to send the young man back to Feltham A. The YJB officer said the PCO had told her that the Serco control room had arranged with Feltham that the young man would be taken to Feltham A, as there was a problem with Feltham B, but it was intended that he would move to Feltham B the next day. The YJB officer said she had checked with colleagues and the YJB case management system to see if any arrangements had been made for the young man to return to Feltham A, but none had. They YJB officer told the PCO that as the young man was now 18, it was for the National Offender Management Service's (NOMS) population management unit to place the young man, not the YJB.

51. The PCO spoke to the officer in the Serco control room at 4.23pm and said that the young man had received an 18-year sentence and had asked if he would be going to Feltham B. The officer in the Serco control room told the PCO that the young man would be going back to Feltham A, once she had a placement order from the YJB. The PCO explained that the YJB had told him that because the young man was 18 he must go to Feltham B. The Serco control room officer, said that she had spoken to a member of staff at Feltham A earlier who had told her that the young man had to return there, and that he would be transferred to Feltham B the next day. The PCO said this was contrary to what the YJB had told him.

52. The YOT worker and the young man's legal team saw him in a cell at the Old Bailey at 4.25pm. The YOT worker said that while the lawyers were discussing a possible appeal, she had left the cell and asked an unidentified PCO if the young man would be going back to Feltham. The YOT worker said she had acknowledged to the PCO that, because of the young man's age, she now had no influence over his placement and it was no longer a matter for the YJB placements team. Nevertheless, the YOT worker asked that he should go back to Feltham because of his particular needs and vulnerabilities.

53. The YOT worker said that she was concerned about the possibility of the young man going to Belmarsh as he had not been prepared for a totally different environment and that none of the staff there knew him. She said the PCO told her that he would be going back to Feltham and that she thanked him for this. The YOT worker went back to the cell and told the young man that arrangements had been made for him to return to Feltham

as the staff there knew about him and would look after him over the weekend if things got difficult.

54. After the legal team's visit, another PCO wrote in the young man's PER, "Visit over his barrister has raised concerns that he may kick off or turn it on himself".

55. The YOT worker stayed with the young man to check how he was feeling. She said she did this as she knew from her previous contact with him that he would sometimes "absent himself". She explained that sometimes his eyes would switch off like a light. The YOT worker told the investigator that she thought that this was happening when the young man was speaking to his legal team and so she became concerned about his wellbeing. The YOT Worker said he expressed no intent to self-harm and they talked about the future.

56. The YOT worker told the investigator that she could spot the signs of the young man absenting himself because she had known him some time, but others would be unlikely to notice it. She had thought it would be helpful to get him to think ahead. She said that she had asked the young man if she could visit him in a week or so and she asked him to telephone his father when he got back to Feltham, which he said he would do. When the YOT worker left the court cells she asked the staff to check on the young man.

57. At 4.38pm, the officer from the YJB placements team spoke to the officer in the Serco control room. She asked the Serco control room officer who she had spoken to at Feltham. The Serco control room officer said that she had just spoken to someone in reception at Feltham A about the process for returning him. She had been told to bring him back to Feltham A and they would move him to the B side the next day. The officer from the YJB placements team told the Serco control room officer that as the young man was now 18, he would not be able to return to Feltham A. The Serco control room officer then asked her supervisor to speak to the officer from the YJB placements team. The officer from the YJB placements team explained to the supervisor that the young man had left Feltham A as a remand prisoner and, as he had now been sentenced and was over 18, he would need to go back to Feltham B or wherever else the NOMS population management unit allocated him.

58. The supervisor explained that Feltham B had no places available that day and that young adults were being directed to HMP Bedford or HMP Highdown, unless he could go to Belmarsh. The officer from the YJB placements team reiterated that as the young man was 18, he could not go back to Feltham A and his allocation was a matter for the NOMS population management unit. The supervisor repeated his understanding that Feltham A was expecting the young man to return to them before transferring to Feltham B the next day. The officer from the YJB placements team said that, other than the calls they had received from court, the YJB placements team had no knowledge of this and that

Feltham A did not have the authority to accept an 18 year old. The supervisor told the YJB placements officer that Serco would therefore place the young man through the population management unit who he thought would send the young man to Belmarsh as this was a standard placement from court. The call concluded at 4.49pm.

59. At 5.00pm the officer from the YJB placement team sent an e-mail to her colleagues in the YJB placements team telling them that arrangements made by Serco and Feltham for the young man to return to Feltham A and then onward to Feltham B had not been approved by the YJB. The investigator established with the officer from the YJB placements team that she had not made any direct enquiries with staff at Feltham about the proposed arrangements. The officer from the YJB placements team had considered this unnecessary, as she had checked the position with her senior managers.

60. An officer from NOMS population management unit told the investigator that he remembered that he had had a telephone conversation with someone in the Serco control room who had asked where the young man should be sent. The officer from NOMS population management said that the person from Serco had not told him that the young man had come from Feltham A, but he recalled that Feltham B had had no spaces at the time.

61. A court PCO noticed that, in contrast to his previous demeanour, the young man began to act strangely after he was sentenced. She said that the young man's eye contact was poor and that she "…just got a bad vibe" about him and became concerned about his risk of self-harm. The PCO described the young man as looking lost and as if he was having dark thoughts. She said that because of his presentation, the fact that he had just received an 18 years sentence and that he was going to Belmarsh she decided to complete a suicide and self-harm warning form, which she did at 5.00pm. She noted the young man seemed depressed and that he had had an "adverse reaction" to being sentenced to 18 years in prison. She also recorded that his mood was low, that he was very quiet and that his legal team had been concerned that he might become volatile. (She did not note that his team had also said he might turn this in on himself.) The PCO noted inside the PER that a suicide and self-harm warning form had been completed, but did not note this on the front of the document as is expected.

62. The young man was then taken to Belmarsh. Because a suicide and self-harm warning form had been completed, the escorting PCO placed the young man in the first cell of the escort van, from where he could be observed easily throughout the journey. The young man arrived at Belmarsh at 6.40pm.

HMP Belmarsh

Friday Evening 8 November 2013

63. The young man began to be booked in at Belmarsh's reception at 7.00pm. The Serco staff handed over all accompanying documentation, including the PER and suicide and self-harm warning form, to a supervising officer (SO). The SO said he had earlier received a call from staff at the Old Bailey letting him know that there were concerns about the young man and that he might "kick off". The SO said he noted the young man was a young adult from Feltham who had just been sentenced to life imprisonment, but that there was not a great deal on the PER to cause him concern.

64. The SO acknowledged that he had seen the suicide and self-harm warning form. He told the investigator that, because of the young man's age and reaction to his sentence, it was appropriate that the warning form had been completed. However, he said the entry noting that his legal team were "... concerned he may kick off, maybe volatile" was not a proper use of the form. On the bottom of the warning form, the words "very inappropriate" had been written. He said he did not write this and it seems most likely it was the nurse who was also on duty in reception that evening. (She has since retired and moved to Northern Ireland. Attempts by the investigator to contact her were unsuccessful.)

65. The SO asked the young man how he felt about his sentence and suggested to him that it was not likely to have sunk in yet. He said that he was very quiet and subdued and he could not recall him making any comment. The SO said that the nurse had also observed him. Despite the warning form and his sentence, neither the SO nor the nurse considered that the young man was at risk of suicide and self-harm and they did not open an ACCT (Prison Service suicide and self-harm prevention procedures). The SO said that he had thought about it, but decided to leave the final decision to the nurse because of her medical experience. The SO believed that the nurse would have opened an ACCT if she had had any concerns. The SO said that, through an oversight on his part, he did not sign to say he had received the warning form before he passed it to the nurse.

66. The nurse wrote in the young man's medical record that his minimum term of 18 years "had not yet sunk in" and that he had an underlying mental health problem. The nurse noted that a self-harm warning form had been completed, but that it said nothing about his thoughts of self-harm, but that he might "kick off". The nurse noted that escort staff had used the warning form inappropriately. (In fact, the form did include concerns about his risk of self-harm.)

67. An officer saw the young man in reception and knew that he had come from Feltham. In response to his questions, the young man told him that he had no immediate needs or problems and had no thoughts of harming

himself. Although the SO and the nurse had found him subdued, the officer said that he had seemed in high spirits for someone his age who had just been sentenced. The officer said that he had seen the PER, but not the suicide and self-harm warning form which would have been given to the nurse when he arrived, Because he considered he was in "quite high spirits" he did not think it necessary to open an ACCT.

68. A mental health nurse based on the first night centre carried out a first night reception health screen. He told the investigator that he knew the young man had been sentenced for murder and had seen the suicide and self-harm warning form, which said the young man was low in mood and quiet. He had noted the comments apparently from the first nurse, that use of the warning form was inappropriate. He said the warning form had suggested that the young man might be aggressive, not that he was at risk of suicide or self-harm. (Although the form clearly indicated concerns about his risk.) He told the investigator that when he saw the young man he was smiling, chatting, sociable and polite and denied any thoughts of self-harm. The mental health nurse said he could see nothing wrong with him.

69. The mental health nurse assessed the young man's mental health, based on his presentation at the time. The nurse noted that the young man had no history of, or current thoughts of, self-harm and had never been managed under suicide and self-harm prevention procedures. Although he had just received an indeterminate sentence with a minimum period to serve of 18 years, the mental health nurse noted that he had not experienced any recent change in his circumstances, such as a long prison sentence. He did note that the young man had previously been a patient in the Bluebird Unit. The mental health nurse had no concerns about the young man's mental health and did not refer him to the prison's mental health team or open an ACCT. However, he referred the young man to be seen that evening by the prison GP. The nurse said that he referred the young man to the GP because of his young age and offence and considered that the GP would admit the young man to the prison's inpatient facility if he had any concerns.

70. An officer in the prison's first night centre interviewed the young man for what he said was about ten minutes. The officer noted that it was the young man's first time in prison, that he had been given a meal and pack of tobacco and that he had explained to him how to access the Listeners and Samaritans. (Listeners are prisoners trained by Samaritans to support other prisoners in distress.) The young man turned down the offer of making a telephone call and told the officer he had no immediate needs. He said that he had never attempted suicide or harmed himself, but that he had previously been subject to suicide prevention procedures. The young man said that although he felt down because of his sentence, he had no current thoughts of harming himself. The officer said the young man communicated well, kept good eye contact and talked about future plans and the possibility of an appeal. The officer said that he assessed the young man's risk and concluded there was no need to open an ACCT.

He had seen the PER, but had not seen the suicide and self-harm warning form.

71. The officer noted in the young man's case history notes that, because he had been sentenced to 18 years for a high profile murder which had been extensively covered by the media, he had requested vulnerable prisoner status, as he feared he would be recognised. (This meant he would be formally kept apart form the general prison population for his own protection.) The duty governor had to authorise this and interviewed him first. The duty governor said the young man did not really want to speak, but she explained what it meant to be a vulnerable prisoner. The duty governor told the investigator that it was a difficult conversation and that that young man appeared arrogant and did not want to speak to her. She described him as angry and dismissive. She approved the young man's application for vulnerable prisoner status. The duty governor said that she was not aware that he had arrived at the prison with a suicide and self-harm warning form. She did not make any assessment of whether she considered he was at risk of suicide or self-harm.

72. The officer in the first night centre completed a cell sharing risk assessment, which is to decide whether a prisoner is a risk of violence towards other prisoners he might share a cell with. The young man told the officer that he did not want to share a cell and had previously had fights with other boys in secure units. The officer assessed him as high risk for sharing a cell and, with the approval of the duty governor, the young man was put in a single cell.

73. At 9.00pm, the prison GP saw the young man. He noted in the medical record that the young man had transferred from Feltham to Belmarsh and that he said he felt okay. The doctor is no longer employed at Belmarsh and the investigator's attempts to contact him for further information about his contact with the young man were unsuccessful.

74. The young man spent his first night in Belmarsh in the prison's induction wing, HB3, Spur two and remained there for the next three nights.

Saturday 9 November 2013

75. On Saturday 9 November, an officer told the investigator that he recalled speaking to the young man when he collected his lunch from the hotplate. The officer said the young man did not want to make a telephone call and did not ask if he could have a shower. The officer said he could not remember having any further contact with the young man.

76. That afternoon, an officer gave the young man his induction to the prison, individually in his cell. This was because the young man had to be kept apart from other prisoners in the induction unit as he was regarded as vulnerable to threats and attack. The officer told the investigator that the young man was calm, although a little quiet and appeared to be settling in quite well. The officer said he did not think that the shock of being

sentenced for so long, at such a young age, had sunk in. The officer said he was unaware of any history of self-harm and that the young man said he had no thoughts of harming himself.

77. Other than the young man's induction session with the officer, there is no written record of any staff interaction with the young man on his first day at Belmarsh. While he would have been unlocked to collect his meals, it does not appear that he came out of his cell at any other time for exercise and association periods as he was not able to mix with other prisoners.

Sunday 10 November 2013

78. There are no written records to indicate that any staff had any contact with the young man on Sunday, 10 November and none of the staff the investigator interviewed recalled having any interaction with him that day. He appears to have spent the day locked in his cell and there is no record that he was offered a period of time in the open air (a statutory requirement) or an association period with other vulnerable prisoners.

Monday 11 November 2013

79. On Monday, 11 November, a clinical nurse specialist at the Old Bailey's mental health liaison scheme, sent the psychiatric assessment, completed at the Bluebird Unit, to an administrative assistant in the prison's mental health in-reach team. She uploaded the report to the young man's medical record.

80. Later that morning, a mental health nurse saw the young man for a secondary health screen (a more in-depth assessment than the first reception health screen). The nurse had noted in his medical record that the young man was cheerful, communicative and co-operative. The nurse told the investigators that he did not look at the previous entries made in the young man's medical record, either before or after his assessment. The nurse said he would have assessed the young man for any mental health concerns, but this is not recorded. At first, he told the investigator that he was unable to recall the young man, but later said the young man was jovial and that he seemed calm and did not appear to be low in mood. The nurse said he did not see the self-harm warning form but, had he done so, it would have changed his opinion of the young man.

81. That morning the young man's YOT worker telephoned a social worker based at Feltham to enquire how the young man had been over the weekend. The social worker told the YOT worker she could not confirm whether the young man had returned to Feltham, but would try to find out. Due to a personal emergency, the social worker was unable to make further checks, but the YOT worker was unaware of this. The YOT worker then contacted the young man's father to see if he had heard from his son, but he had not.

Tuesday 12 November

82. On 12 November, the young man's stepmother rang the YOT worker to thank her for the support she had provided to her family and said they had still not heard from him. Later that morning the YOT worker, who had now learnt that the young man had been sent to Belmarsh, informed his family. The YOT worker said she had telephoned Belmarsh twice to try to speak to someone from probation about him, but there was no answer or option to leave a message. The YOT worker then made an appointment to visit the young man at Belmarsh on 20 November.

83. That morning, the young man was transferred from the induction wing HB3 to a spur on HB4, which was being used to hold an "overspill" of vulnerable prisoners as the vulnerable prisoner unit was full.

84. Later that morning, the young man's offender supervisor went to see to explain her role. She asked how he was dealing with his sentence, about his family and issues surrounding his offence. The young man told her that he did not want to be moved from one prison to another and felt it was important to settle and get involved in education. The offender supervisor said she did not consider opening an ACCT as she thought there was nothing to suggest that the young man needed such support or was at risk of suicide or self-harm. The offender supervisor said that when she left the young man he thanked her for coming to talk to him and seemed quite happy to return to his cell.

85. Because the nurse from the Old Bailey had forwarded the Bluebird Unit's psychiatric report, the young man was discussed at the prison's mental health team's weekly referral meeting that day. The prison's psychiatrist was present and it was agreed that the young man should have a mental health assessment and a routine referral was made.

86. An officer recalled unlocking the young man that afternoon to give him the opportunity to spend some time out of his cell. The officer said that the young man was the only vulnerable prisoner on the vulnerable prisoner overflow spur that day. The officer said that the young man left his cell to collect his meal, but then wanted to go back to his cell. The officer said he was surprised that the young man had declined association because as a vulnerable prisoner there was little opportunity for him to have time out of his cell. The officer said the young man appeared quite happy and settled. Another officer said he recalled the young man collecting his evening meal, at around 5.30pm, but he did not speak with him. The officer said he did not see the young man after that.

87. An officer who had been assigned to work on HB4 Spur 2 on 11 and 12 November, could not recall having any contact with the young man.

88. The prisoner who was in the cell next to the young man said that he neither saw nor spoke to the young man during his time on HB4 Spur 2.

He said that he had heard nothing on the night of his death.

89. A prisoner who occupied the other cell next to the young man said that, although he did not know the young man, he had been let out of his cell at the same time to collect his food and shower. (Although not designated as vulnerable prisoners, he and another prisoner on the spur were subject to a more restricted regime for their own protection.) The prisoner said the young man shied away from others when he collected his food and appeared very nervous. He did not take part in association with other prisoners. The prisoner said that he had spoken to the young man at around 7.00pm that evening, by shouting through the windows. He asked the young man if he was all right and said that the young man had said he was not and said he was nervous about coming out of his cell. The prisoner told the young man that he should not have been nervous when he had passed him earlier and told him not to be scared. The prisoner said he heard nothing else from the young man's cell that evening or night.

90. The night officer told the investigator he did not recall the young man. He said that he could not remember when he did his evening roll check, but said it would have been between 7.45pm and 9.00pm. The night officer said that he had no contact with the young man during the night. He could not recall when he conducted the morning roll check except that it would have been sometime between 2.00am and 6.00am. (The roll check is expected to be completed at around 6.00am.)

Wednesday 13 November 2013

91. The early start officer, on 13 November, told the investigator that he arrived on the unit at around 6.40am, for an official start time of 7.15am, and the night officer handed over to him. The early start officer told the investigator that he was not required to carry out a full morning roll check, but had to check prisoners being monitored under suicide prevention procedures, those regarded as high risk of escape and category A prisoners. No additional check of vulnerable prisoners was required.

92. At around 9.20am, the officer who found the young man began unlocking the top landing on Spur 2. Several minutes later, he reached the young man's cell. He was not due to be unlocked, as he was a vulnerable prisoner and could not mix with the others, but the officer said he stopped to tell him that he would be unlocked later. He looked into the cell and saw the young man in what he described as a "press up position" with a twisted bed sheet around his neck, attached to the window bars of the cell.

93. The officer who found the young man called for assistance by pressing the general alarm, which was about 20 feet away and shouted to colleagues. (He said that although he had been allocated a radio he was not carrying it as there was a shortage of radio pouches.) The officer who first found the young man went into the cell followed by another officer, who had

been unlocking cells nearby. He cut the ligature from around his neck and the officers, assisted by a SO, lowered the young man to the floor and placed a blanket beneath his head. Both officers told the investigator that it was clear that the young man had been dead for some time, as rigor mortis had set in. (None of the officers were carrying a radio, two of then said this was due to the lack of pouches.)

94. At 9.23am, a nurse who was working on HB4 said he had heard a shout for assistance before the general alarm was sounded. He went to the young man's cell and took an emergency response bag with him. A healthcare assistant (HCA) accompanied him. When they arrived at the cell two minutes later, both officers who had found the young man left. The nurse checked the young man for signs of life, but there were none. The nurse said rigor mortis had set in and that the young man was very cold. The nurse began to attempt cardiopulmonary resuscitation (CPR) and used a defibrillator that the HCA had collected from the central office of HB4. They both continued CPR until paramedics arrived at 9.43am.

95. At 9.25am, the prison's orderly officer called an emergency code blue, but an ambulance was not called until 9.29am. Paramedics arrived at the young man's cell at 9.43am and pronounced him dead at 9.45am.

96. The young man left a note in his cell addressed to his father and other family members.

Family Liaison

97. The young man's father was notified of his son's death in person at 1.30pm. Earlier attempts to contact him had been unsuccessful. The prison offered funeral expenses in line with national policy.

98. The young man's mother told the investigator that she felt she had been treated badly by the prison because they did not contact her directly or return her call when she telephoned the prison. Although he was not in contact with his mother, we believe that the prison should have made an effort to contact her and we have brought this to the prison's attention for the future.

ISSUES

The young man's allocation to Belmarsh

99. We do not consider that Belmarsh was an appropriate allocation for the young man. There appears to have been a series of errors in his management, which led to his arriving there. These are set out below, together with the background to events.

100. In January 2013, a Governor's Notice, GN005/2013, was issued at Feltham outlining procedures for the transition of young people from Feltham A (the juveniles unit) to Feltham B (which holds young adults between 18 and 21.) The policy stated that two to three months before their 18th birthday young people would be identified so that planning for their transition to Feltham B could begin. Young people who reached their 18th birthday in Feltham A would remain there until the conclusion of their trial, to ensure stability at a difficult time. To ensure that young people from Feltham A came back to Feltham when they had appeared at court, staff were told to mark the front of their PERs so that escort staff were aware that they were to return to Feltham.

101. In the summer of 2013, the National Offender Management Service - London Area made preparations for all young adult remands to be held at London local prisons rather than at Feltham B which had previously been the case. Representatives from the London prisons, including Belmarsh attended. The NOMS population management unit were represented, but the YJB were not involved as no changes for under 18s were proposed. To avoid a young person aged 18 from leaving Feltham A and being allocated an adult prison from court, the following principle / protocol was agreed:

> "YJB's transition to adult protocol will remain in place - the assumption being any 18 year old due to transfer into the adult estate from Feltham A (Young People) will return from court to Feltham B where they will be assessed and given a risk based allocation at a later date when / if deemed appropriate."

102. On 8 November, the young man left Feltham A for sentencing at the Old Bailey. In line with Feltham's own Governor's Notice and the agreed principle / protocol, the intention was for him to return to Feltham for a period of assessment before a decision about his future could be made.

Transition

103. The young man reached the age of 18 on 11 October, after being convicted on 7 October when he was 17. However, there is nothing to suggest that the transition process to help prepare him for the life in the young adult estate had started. He had been at Feltham since 17 September and, while we recognise that he was unconvicted at the time, we consider the likelihood that he would receive a very long sentence

should have been anticipated and plans made for what would happen when and if he did. When the young man was convicted of murder on 7 October, only one sentence (detention at Her Majesty's Pleasure) was possible, yet there is no evidence that planning for his future began during the month between his conviction and sentencing.

104. In a publication issued by the Youth Justice Board in February 2014, (Deaths of Children in Custody: Action Taken, Lessons Learnt) the YJB recognised it had a role and responsibility to ensure effective transition between youth and adult justice services in order to help promote the safety of young people moving to young offender institutions for young adults. It said it was working with NOMS to improve transitions and referred to a protocol that NOMS had published in September 2012, for transitions from youth to adult custody with guidance about how the process should work.

105. The introduction to the NOMS guidance recognised that transfers of young people from the under 18 estate to the young adult estate was a particularly vulnerable time and it was therefore essential that the transition should be completed as smoothly as possible with particular consideration given to issues of safety and security. The guidance recognised that planning is more difficult when a young person is on remand, but that much of the guidance was equally applicable.

106. The specific objectives of the protocol were listed as to :

- provide a clear and structured process for transition which is understood by young people and staff alike;
- provide guidance on roles and responsibilities for those involved in the transition process;
- provide guidance on identifying needs and sharing information during the transition process;
- encourage co-operation between under 18 YOIs and young adult YOIs to ensure that young people are quickly and appropriately allocated, and
- help build relationships between Youth Offending Teams and young adult YOIs to support continuation of care.

107. It does not appear that any of the stated objectives of the protocol were achieved in the young man's case or that any formal plans for his move were made. The guidance is written on the assumption that proper planning would allow an appropriate move to a young adult young offender institution from the under 18 estate and not that a young adult would end up in an adult local prison for an allocation to a young offender institution to be considered. In any event, we consider it would have been an appropriate option, as part of proper transition planning, for the young man to have returned to Feltham A for a while after sentencing to allow him to come to terms with his sentence in an environment and with staff he was familiar with. There was an assumption at Feltham A that the young man would move to Feltham B after his 18th birthday and after he

was sentenced. This might have been a reasonable and well-meaning assumption, but it was not backed up by proper structured preparation and planning. Had this been done, we consider it would have been much less likely that the young man would have been sent to Belmarsh. If population pressures meant that a move to Belmarsh could not have been avoided on the day of his sentencing, then the existence of such plans would have alerted Belmarsh staff that he needed to return to Feltham and should have prompted Feltham staff to arrange it. We make the following recommendation:

The Chief Executive of the National Offender Management Service and the Chief Executive of the Youth Justice Board should ensure that there are appropriate transition plans for all young people likely to transfer from the under 18 estate to the young adult estate. Plans should allow the possibility of 18 year olds returning to the juvenile estate for a period of stability after sentencing.

Completing the PER form at Feltham

108. The operational support grade, who completed the Person Escort Record (PER) form on the 7 November in preparation for the young man's appearance at court the next day, did not indicate on the form that he was to return to Feltham as would normally have been done. This was unfortunate, but essentially this was an administrative error that does not appear to have had a major impact on subsequent events. The purpose of writing on the front of the PER was to act as a backstop to alert escort staff. However, even without the alert on the front of the PER, the escort staff at court recognised that, at that time, someone in his position would usually return to Feltham. They queried this with Serco control staff who apparently checked with Feltham and confirmed that they wanted him to return to Feltham A and that he would transfer to Feltham B the next day. It is well documented that this requirement was then discussed at length between representatives of the YJB placements team and Serco control room staff.

109. Even if the PER form had indicated that the young man was to be returned to Feltham A, Serco staff would still have needed a placement order from the YJB placements team. We do not therefore consider that the failure to note the PER contributed to him being sent to Belmarsh. Commendably, Serco escort staff identified that a return to Feltham would be usual so checked the position. However, in other cases escort staff might not be so alert. We therefore make the following recommendation:

The Governor of Feltham should ensure that PER forms appropriately identify prisoners leaving to attend court who need to return to Feltham.

Communication about the young man's allocation on 8 November

110. It is apparent that Feltham intended that the young man should return to Feltham A on the day he was sentenced and that he would subsequently move to Feltham B, the young adult side of the prison. To return to Feltham A, the Youth Justice Board had to agree a placement order, but declined to do so as the young man was now 18 and sentenced The YJB placements team told Serco staff that it was now for the NOMS' population management unit (PMU) to place the young man. We have been unable to establish why it was not possible for the young man to go to Feltham B directly that day, but PMU suggested that it was likely there were no places available. Again, proper transition planning would have avoided this, particularly as it had been known for some time that the young man was being sentenced on 8 November.

111. We have been unable to establish who, at Feltham, was responsible for the decision that the young man should return to Feltham. However, we are concerned that, on 8 November, no one at Feltham took action to ensure it happened. On learning that there was a problem about the young man returning, no one from Feltham took the initiative to telephone the YJB placements team to clarify the situation. Had this been done, and the reasons explained, the young man may well have returned there.

112. Similarly, we are concerned that no one from the YJB placements team spoke to a manager at Feltham about the position. They were aware that the young man had left Feltham A on 8 November and Serco staff had notified them that he needed to return to Feltham B via Feltham A. The YJB would not approve the young man returning to Feltham A as he was now a sentenced 18 year old and they regarded his allocation as a matter for PMU. Strictly speaking this was the case and we appreciate that the YJB placements team would not usually place 18 year olds into Feltham A, unless senior managers had agreed specific arrangements. However, the response does not suggest a commitment to effective transition between the juvenile and young adult estate to which the YJB professes, or that there was any formal transfer of responsibilities.

113. We recognise that the transition arrangements were not the responsibility of the YJB placements team, but we are surprised that they did not identify that the placement of an 18 year old, who had been until that day the responsibility of the youth justice system - and had just been sentenced to prison for a very long time - was a matter of concern. At the very least, we would have expected them to have discussed the position with Feltham to see how best the young man's needs could be met.

114. Ultimately, Serco escort staff had no option but to contact the NOMS population management unit (PMU) to allocate the young man. PMU said they were not aware that the young man had left Feltham A that morning, but that in any event as a sentenced 18 year old an allocation to Belmarsh from court was appropriate. We acknowledge that the PMU is not responsible for detailed placement decisions about individual prisoners.

However, we consider that they ought to have been aware that the young man had come from Feltham A and that it had been agreed as part of the changes for allocating young adults in London that there was an assumption that any 18 year old prisoner due to transfer into the adult estate from Feltham A would return from court to Feltham B for assessment. PMU indicated that it was likely that Feltham B was full that day, but there is no record that these issues were considered. We consider that PMU should also have made further enquiries with Feltham before allocating the young man to Belmarsh.

115. The lack of formal plans for the young man's move led to confusion about his allocation on 8 November. However, this could have been salvaged on the day by more effective communication between Feltham, the YJB placements team and the PMU. We are concerned that, other than the Serco escort staff, none of those involved made active attempts to resolve the situation to help ensure that the young man, a vulnerable young adult leaving the juvenile estate, was appropriately allocated. We make the following recommendation:

The Head of the YJB placements team, the Governor of Feltham and the Head of PMU should ensure that, where there is any doubt about the allocation of a young person or young adult who has come from Feltham, a correct and safe allocation is made, and that they return to Feltham if appropriate.

116. As Feltham had intended that the young man should return there, after he had been sentenced, we would have expected someone to have noted this and made enquires to establish where he had been sent. Had this been done, important information about his background, vulnerabilities and needs could have been communicated to the receiving establishment or alternative arrangements made. An enquiry by Feltham might have resulted in the young man being able to return there the next day or shortly afterwards. We make the following recommendation:

The Governor of Feltham should ensure that enquiries are made promptly when a prisoner from Feltham A, expected to return from court does not do so, and that appropriate action is taken to ensure their safety.

Belmarsh

Identification of the young man's risk of suicide and self-harm on arrival

117. Serco staff at court appropriately completed a suicide self-harm warning form about the young man to alert the prison to concerns about his risk. His adverse reaction to sentencing, low mood, volatility and that he might "kick off" were noted (although the comment from his legal team that he might turn this in on himself was not included.) The concerns were phoned through to Belmarsh reception before he arrived. When interviewed, the SO said he recognised that, because the young man's

age and his reaction to sentence, the court staff had acted correctly in completing the form, but that the information that he might "kick off" or be volatile was an inappropriate use of the form. The SO said the nurse agreed and wrote "very inappropriate" on the form.

118. Both members of staff appear to have placed too much emphasis on the comment that the young man might "kick off" which they interpreted as unrelated information about conduct, rather than meaning that someone who was volatile might pose a risk of harm to themselves. They made no other reference to information on the warning form that the young man might be at risk of suicide and self-harm, for example that he had just turned 18, was low in mood and had reacted adversely to his sentence. Although they noted that the young man's sentence had not "sunk in" and that he had an underlying mental health problem, neither opened an ACCT. We do not consider that either the SO or the nurse gave sufficient weight to the information in the suicide and self-harm warning form, which they seem to have discounted as 'inappropriate'.

119. The SO said that he left a decision about whether to open an ACCT to the nurse, as he believed she was better qualified to understand someone's medical and mental health issues. He also suggested that he was too busy to open an ACCT and, if he did so, it would hold up the reception process for other prisoners. We are concerned about the SO's understanding of his responsibilities. Prison Service Instruction (PSI) 64/2011, which outlines procedures for safer custody, clearly indicates that 'the identification and management of prisoners at risk of suicide and /or self-harm is everyone's responsibility'. All reception staff are ACCT trained and should be able to identify risk and manage it appropriately

120. A nurse also saw the suicide self-harm warning form, but agreed with the other nurse's view that the warning form had been opened inappropriately. He believed that the warning form was about behaviour rather than self-harm. When interviewed, it was apparent that the nurse was unsure about the purpose of the form and failed to recognise its significance. He did not confirm, by signing the form, the action he had taken and did not appear to understand who was responsible for doing so.

121. No other member of staff in reception or the first night centre saw the suicide and self-harm warning form to inform their assessment of the young man's risk. However, its existence was indicated in the PER and other officers appeared not to notice this. We are concerned that those who did see the warning form did not attach sufficient weight to the information it contained, or ensure that the information was shared with others. Within two hours of arriving at Belmarsh five different people had seen and interviewed the young man including three officers, two nurses, the prison GP and duty governor and no one identified him as at risk of suicide and self-harm. Even without the benefit of the suicide and self-harm warning form, we consider that his risk factors should have been apparent.

122. All of the staff seemed to have relied on their assessment of the young man's personal presentation rather than an objective assessment of his risk factors. The fact that their views of his demeanour differ so widely either raises questions about their accuracy or suggests swift changes in his mood, which in itself should have caused concern. The officer described him as in "high spirits", yet shortly afterwards he told another officer that he felt down after receiving his sentence. The nurse said he was smiling and chatting, but the duty governor said that he came across as angry and dismissive. A doctor simply noted that he said he felt okay.

123. The staff who assessed the young man's risk of suicide and self-harm placed a lot of reliance on he saying he had no intention of harming himself. The officer, who assessed the young man the day after he arrived, said that nine times out of ten he would only open an ACCT if a prisoner actually said he was feeling suicidal.

124. We consider that the man's risk of suicide and self-harm should have been evident as soon as he arrived at Belmarsh. He had a range of risk factors for suicide: he had just been sentenced for the notorious murder of an elderly woman and received an indeterminate sentence with a minimum period to serve of 18 years; he had just moved from the youth justice estate to a daunting high security prison; he had just turned 18; he was recorded to have had a history of mental health problems and to have previously self-harmed. In addition, he had arrived with a suicide and self-harm warning form from the court identifying concerns about his demeanour that day. Against this background, it is difficult to see why an ACCT was not opened immediately and appropriate procedures started to support him.

125. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), and PSI 74/2011 (Early Days In Custody), both list a number of risk factors and potential triggers for self-harm and suicide. These include early days in custody, impulsiveness, previous self-harm, a life sentence, young age, being charged with a violent offence and history of mental health problems. A change in status, such as moving from remand to sentenced, court appearances especially for sentencing and transfers between prisons are listed as possible triggers for suicide and self-harm. All of these factor applied to the young man, yet there is no evidence that staff considered them.

126. Staff judgement is fundamental in assessing whether suicide self-harm prevention procedures should be opened. At its core, the system relies on staff using their experience and skills, as well as local and national assessment tools to determine risk. We appreciate that it is not an exact science. However, we are particularly concerned that staff appear to have relied so heavily on their perceptions of the young man's demeanour and what he told them, when it was evident that he had a number of risk factors which should have caused concern. A prisoner's presentation is obviously important and reveals something of their level of risk. However,

it is only a reflection of their state of mind at the time they are seen by the staff and should be considered as a single piece of evidence. All risk factors must be collated and considered to ensure that a prisoner's level of risk is judged holistically.

127. We are concerned that staff at Belmarsh did not place sufficient weight on the concerns noted in the suicide and self-harm warning form, did not fully share information about risk, did not fully understand their responsibilities for opening ACCTs and did not fully consider and document all known risk factors when making their assessments. Even without the suicide and self-harm warning form from court, it is evident that an ACCT should have been opened to support the young man. The deficiencies in assessing his risk when he arrived at the prison and a lack of understanding about roles and responsibilities suggests a need for improved procedures, which all staff understand and follow. We make the following recommendation:

The Governor of Belmarsh should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, this should ensure that reception and first night and induction staff:

- **Have a clear understanding of responsibilities and the need to share all relevant information about risk.**
- **Note and consider all information from suicide and self-harm warning forms and PERs.**
- **Consider and record all the known risk factors of a newly arrived prisoner when determining their risk of suicide or self-harm.**
- **Open an ACCT when a prisoner appears at high risk, irrespective of his stated intentions.**

The young man's location in Belmarsh

128. The young man spent his first four nights at Belmarsh in the induction unit, HB3. On the morning of Tuesday 12 November, he was moved to Spur 2 on HB4 as there was no space in the vulnerable prisoner unit, on Spur 1. Because of the young man's vulnerable prisoner status, he had a very limited regime and spent very little time out of his cell. As he arrived at the weekend, the regime was in any event limited and, as a new arrival, he had no access to education or employment on the Monday and Tuesday. He was not yet able to make telephone calls, as it appears that his list of telephone contacts had not yet been approved. There is no evidence of any first night checks for new arrivals.

129. During the three days that the young man spent on HB3 he was not given the chance to have any time in the open air, which the prison has a statutory duty to provide. When he moved to HB4, Spur 2, there is no evidence that he was offered the opportunity to take part in association or exercise periods in the open air with prisoners on Spur 1, the designated vulnerable prisoner unit, as was supposed to happen. Other than to

attend a meeting with his offender supervisor the day after he arrived and for a secondary health screen on Monday 11 November, the young man seems to have spent four full days, from Saturday to Tuesday, locked alone in his cell and only left it to collect his meals. We note that in a 2011 HM Inspectorate of Prisons reported concerns about the use of spur two for vulnerable prisoners. Inspectors noted that, although they were told the prisoners could participate in the regime on spur one, this did not happen and that in practice vulnerable prisoners spent most of the time locked in their cells and were often subject to abuse from other prisoners through their doors and windows. Although the Inspectorate made recommendations about this, it does not appear that much had changed by the time the young man was held there.

130. We are concerned that a young person such as the young man was effectively isolated in his cell for such lengthy periods, just after receiving a very long sentence. Such restrictive conditions would not have been conducive to good mental health. It amounts almost to segregation without the safeguards that would be in place in a segregation unit such as a daily healthcare assessment of fitness, daily time in the open air and frequent checks by officers, healthcare staff and managers. No manager went to check on the young man's welfare during his time at Belmarsh.

131. The investigator spoke to many of the officers who were on duty on the spurs that the young man lived on at Belmarsh, but none could recall any specific or meaningful contact with him and very little is recorded in his prison records. Although the young man had not been assessed as at risk of suicide and self-harm when he arrived, we are concerned that, taking into account his evident vulnerabilities, there was so little staff interaction with him afterwards. This meant that no one would have been able to identify whether there had been any deterioration in his mood and there is no record that anyone checked how he was feeling. For an 18 year old who had until then been held in the better resourced young people's unit at Feltham, where he had apparently settled well, this was likely to have been an frightening experience. The young man was effectively forgotten during the short time that he spent at Belmarsh.

132. We consider that the arrangements for vulnerable prisoners, on both the induction unit and vulnerable prisoner overflow on HB4, Spur 2 do not provide an acceptable regime to safeguard prisoners. It is unacceptable that a young adult aged 18 could be left so isolated for such long periods during the early days in custody, which are a particularly vulnerable time, without appropriate support. We make the following recommendation:

The Governor of Belmarsh should ensure that vulnerable prisoners in the induction unit and for whom there is no room in the vulnerable prisoner unit have a full regime, equivalent to other prisoners, and are checked regularly by a nominated officer to ensure their wellbeing, particularly during the early days in custody.

Preparations for receiving young adults at Belmarsh

133. In preparation for London local prisons taking young adult remand prisoners as a result of a change of function at Feltham, a Belmarsh operational manager and representatives from other areas of the prison, including reception, first night centre and induction staff, visited HMP Chelmsford and HMP Highdown to understand how other local prisons, who already received young adults prisoners from courts, dealt with them. The operational manager told us that they found that Chelmsford had some different processes for managing young adults, but Highdown treated them the same as older adult prisoners. There was no specific learning from the visits and Belmarsh decided that they would make no distinction between young adults and other prisoners. She told the investigator that the rationale was that Belmarsh treated all prisoners according to their individual needs, irrespective of their age, and that staff at the prison were aware of the different vulnerabilities in all age groups.

134. Staff were given no additional training or advice about managing young adults, except Governors order 168/13 of August 2013 which noted that the only significant change when young adults arrived would be that their adjudication rules (offences against prison discipline) differed and that young adults were not allowed to share cells with older adult prisoners. The notice said that a young offenders' policy would be available which would document the changes.

135. It does not appear that a young offenders' policy was produced, but Belmarsh issued a document called a Young Prisoners' strategy. This comprises a series of objectives for meeting the needs of young adult prisoners, but contains no instructions or advice about how the objectives should be met.

136. We were concerned that these arrangements did not adequately reflect the different approach that might be needed to identify the specific differences, needs and vulnerabilities of young adults – particularly those who had only recently transferred from the young people's estate. Belmarsh managers originally decided that, except for some legal requirements, there would be no changes to procedures or local policies. However, since the young man's death the prison has introduced two changes.

137. At reception, all young adults now have their age checked and any prisoner under 18 years and six months who has arrived from Feltham A or from another part of the young persons' estate is identified. The duty governor is then informed to ensure that the placement is correct and takes account of the young adult's safety and any particular vulnerabilities or needs. The second change is that any young adult arriving at the prison and identified as a vulnerable prisoner is located directly to the vulnerable prisoners' unit and not to the induction unit or overspill spur.

138. We welcome that Belmarsh has recognised some of the particular vulnerabilities that apply to young adults, but note that the two changes are limited to addressing just two of the fundamental failures in safeguarding the young man. We consider it is important that all the particular needs of young adults and their specific vulnerabilities should be identified and met. We note that in 2006, HM Inspectorate of Prisons published a short thematic report on young adult prisoners, which noted that this was often a group for whom no specific provision was made. Particularly in adult male local prisons, there was rarely any recognition or assessment of their special needs. The report found that young adults were well-served only in establishments which had developed specific policies and procedures. We make the following recommendation.

The Governor of Belmarsh should introduce a policy for managing young adult prisoners which recognises their particular needs and vulnerabilities and that staff are trained and supported to work with them.

Morning roll check

139. Belmarsh's Local Security Strategy states that the early morning roll check should be conducted at 6.00am before the handover from night staff to day staff. The officer who was on duty through the night of 12 / 13 November on HB4, said that he did not notice anything untoward in any of the cells he checked. He was unable to say what time he had conducted the check, but said only that he had done it sometime between 2.00am and 6.00am. We do not consider that this is a credible account and calls into question whether the roll check was done at all. We recognise that a roll check in the early morning is primarily a security check to count prisoners to ensure that they are all present in their cells, but it is also an opportunity for any concerns about the safety of prisoner to be spotted and acted on. It is concerning that, not only could the officer not say what time he had checked the prisoners, but also that he believed it appropriate that he could carry out the roll check as early as 2.00am. We make the following recommendation:

The Governor of Belmarsh should ensure that night staff complete the early morning roll check in line with the Local Security Strategy.

Emergency response

140. When the officer discovered the young man hanging he immediately pressed the general alarm, called for assistance from colleagues nearby and went into the cell. However, because he was not carrying a radio he was unable to call an emergency code blue. He said that he was unable to carry his radio because of a shortage of radio pouches. It was not until another member of staff arrived at 9.25am, about two minutes later, that a code blue was called.

141. Although the emergency code blue was called at 9.25am, an ambulance was not called until 9.29am, four minutes later. Prison Service Instruction (PSI) 03/2013 - Medical Emergency Response Codes, issued at the beginning of February 2013, required governors to have a medical emergency response code protocol based on the instruction by the end of February 2013. This should instruct staff how to communicate the nature of a medical emergency using agreed emergency codes and ensure that the control room calls an ambulance automatically as soon as an emergency code is used.

142. Belmarsh had issued a Governor's Notice to Staff (36/13) in February 2013, Emergency Response Codes, stating that the emergency control room (ECR) will respond to an emergency code by calling for an ambulance. It is apparent that staff did not follow that instruction and there is no clear explanation for the delay. We note that in the investigation into two other deaths at Belmarsh earlier in 2013, we also made recommendations about this issue. This lack of progress is unacceptable. It is evident that the young man was dead when he was found, so the delay in calling for an ambulance did not affect the outcome for him. However, in all life-threatening emergencies a swift response is vital. We make the following recommendation:

The Governor of Belmarsh should ensure that all staff issued with radios are able to carry then at all times and that control room staff request an ambulance automatically when a emergency code blue or code red is called.

Healthcare

143. In his clinical review the clinical reviewer concluded that the care the man received at Feltham was comparable with that he would have expected to receive in the community.

144. Although the man was at Belmarsh for a very short time, the clinical reviewer concludes that the clinical care given to the young man at the prison was not comparable to that he would have received in the community. The clinical reviewer was concerned about the failure of nurses at the prison to assess adequately the level of the young man's risk of suicide and self-harm and about the capability of some members of healthcare staff. The Head of Healthcare will need to address the clinical reviewer's findings and recommendations.

RECOMMENDATIONS

1 The Chief Executive of the National Offender Management Service and the Chief Executive of the Youth Justice Board, should ensure that there are appropriate transition plans for all young people likely to transfer from the under 18 estate to the young adult estate. Plans should allow the possibility of 18 year olds returning to the juvenile estate for a period of stability after sentencing.

2 The Governor of Feltham should ensure that PER forms appropriately identify prisoners leaving to attend court who need to return to Feltham.

3 The Head of the YJB placements team, the Governor of Feltham and the Head of PMU should ensure that, where there is any doubt about the allocation of a young person or young adult who has come from Feltham, a correct and safe allocation is made and that they return to Feltham if appropriate.

4 The Governor of Feltham should ensure that enquiries are made promptly when a prisoner from Feltham A, expected to return from court does not do so, and that appropriate action is taken to ensure their safety.

5 The Governor of Belmarsh should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, this should ensure that reception and first night and induction staff:

- Have a clear understanding of responsibilities and the need to share all relevant information about risk.
- Note and consider all information from suicide and self-harm warning forms and PERs.
- Consider and record all the known risk factors of a newly arrived prisoner when determining their risk of suicide or self-harm.
- Open an ACCT when a prisoner appears at high risk, irrespective of his stated intentions.

6 The Governor of Belmarsh should ensure that vulnerable prisoners in the induction unit and for whom there is no room in the vulnerable prisoner unit have a full regime, equivalent to other prisoners, and are checked regularly by a nominated officer to ensure their wellbeing, particularly during the early days in custody.

7 The Governor of Belmarsh should introduce a policy for managing young adult prisoners, which recognises their particular needs and vulnerabilities and that staff are trained and supported to work with them.

8 The Governor of Belmarsh should ensure that night staff complete the early morning roll check in line with the Local Security Strategy.

9 The Governor of Belmarsh should ensure that all staff issued with radios are able to carry then at all times and that control room staff request an ambulance automatically when a emergency code blue or code red is called.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	NOMS & Youth Justice Board The Chief Executive of the National Offender Management Service and the Chief Executive of the Youth Justice Board, should ensure that there are appropriate transition plans for all young people likely to transfer from the under 18 estate to the young adult estate. Plans should allow the possibility of 18 year olds returning to the juvenile estate for a period of stability after sentencing.	Accepted	NOMS has developed revised policy and process in relation to transition from under 18 YOIs to the adult estate. This builds on and strengthens the guidance published in 2012. We intend to issue a PSI on transitions and we will be consulting with stakeholders on this shortly. This includes a specific section on young people on remand and transitions via court. We are planning to implement this revised policy at the end of October 2014. In the interim a letter was sent on 29 November 2013 by the Head of Young People's Group to Governors of under 18 YOIs to ensure the following are in place for individuals who are transitioning via a court: 1) That the PER is clearly marked to state either for the individual to return or which establishment the individual is to transition to, with a named individual at the receiving establishment who has agreed to accept them. 2) That on the morning of the court appearance the relevant PMU manager for the area is informed, so that they can ensure that space is	October 2014	

			available at the receiving establishment.		
2	HMYOI Feltham The Governor of Feltham should ensure that PER forms appropriately identify prisoners leaving to attend court who need to return to Feltham.	Accepted	Notices have been placed in Reception stating that "All prisoner's from Feltham A regardless of age are to return to Feltham unless otherwise instructed by YJB Placements." Custodial managers who are responsible for the discharge process were briefed following the death of the young man, and now the Person Escort Records of all Young People leaving Feltham are checked to ensure that they are marked to return to Feltham.	Completed	
3	Youth Justice Board, Head of PMU & HMYOI Feltham The Head of the YJB placements team, the Governor of Feltham and the Head of PMU should ensure that, where there is any doubt about the allocation of a young person or young adult who has come from Feltham, a correct and safe allocation is made and that they return to Feltham if appropriate.	Accepted	The steps being taken by NOMS in response to Recommendation 1 and by Feltham in response to Recommendations 3 and 4 will achieve the outcome and it is not considered that further action is required by PMU or the YJB.		
4	HMYOI Feltham The Governor of Feltham should ensure that enquiries are made promptly when a	Accepted	A system has now been put in place to ensure any Young Person who does not return to Feltham from court is followed up: The Reception Desk Officer checks daily to	Completed	

	prisoner from Feltham A, expected to return from court does not do so, and that appropriate action is taken to ensure their safety.		ascertain the whereabouts of any young people who were expected to return, using NOMIS and where necessary contacting SERCO and/or the YJB placements team. In most cases the outcome will have been a release from court or a transfer to another under 18 YOI. If the prisoner has been transferred to an adult establishment, the Duty Governor at the receiving establishment is contacted to ensure that they are aware of the prisoner's history. The name of the Duty Governor is recorded in the observation book. This information is recorded on the daily handover information in the audit trail.		
5	HMP Belmarsh The Governor of Belmarsh should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, this should ensure that reception and first night and induction staff: a) Have a clear understanding of responsibilities and the need to share all relevant information about risk.	Accepted	All staff in Belmarsh will attend suicide prevention awareness refresher training. This training covers all the issues raised in this section a – d. Staff working in Reception, First Night Centre and HCC have been identified as being high priority to be detailed to attend. The rest of the staff in Belmarsh will also attend this training to ensure that all staff are reminded of the importance of their observations and actions are in this area	March 2015	

	b) Note and consider all information from suicide and self-harm warning forms and PERs. c) Consider and record all the known risk factors of a newly arrived prisoner when determining their risk of suicide or self-harm. d) Open an ACCT when a prisoner appears at high risk, irrespective of his stated intentions.				
6	HMP Belmarsh The Governor of Belmarsh should ensure that vulnerable prisoners in the induction unit and for whom there is no room in the vulnerable prisoner unit have a full regime, equivalent to other prisoners, and are checked regularly by a nominated officer to ensure their wellbeing, particularly during the early days in custody.	Accepted	A local policy is now in place that covers this issue. All new vulnerable prisoners who are segregated for their own protection are located in the correct area that allows them to have full access to the regime. The exception to this is when a vulnerable prisoner is identified on reception as requiring detox. In these cases the prisoner remains on the stabilisation wing on house block 3, and is monitored by nursing staff and discipline staff throughout the day and night. When the doctor is content that the prisoner is fit and stable, he is moved to the correct location and able to take part in the full regime.	Completed	
7	HMP Belmarsh The Governor of Belmarsh should introduce a policy for	Accepted	A selection process is in place to ensure that staff working in the First Night Center are able to demonstrate the skills required to recognise the needs and vulnerabilities	Completed	

	managing young adult prisoners which recognises their particular needs and vulnerabilities and that staff are trained and supported to work with them.		of all new prisoners and to support them during the early days in custody. Reception managers now call the Duty Governor when they receive a new prisoner under the age of 18 years 6 months. The Duty Governor attends reception to interview the prisoner, considers all the available information and ensures that the prisoner is suitably located, and that any additional action necessary to ensure the prisoner's safety is taken.	Completed	
8	HMP Belmarsh The Governor of Belmarsh should ensure that night staff complete the early morning roll check in line with the Local Security Strategy.	Accepted	A Notice To Staff will be issued to remind staff of the requirements of the Local Security Strategy with regard to roll checks and the safer custody guidelines on the conduct of checks on the prisoner's well-being.	September 2014	
9	HMP Belmarsh The Governor of Belmarsh should ensure that all staff issued with radios are able to carry then at all times and that control room staff request an ambulance automatically when a emergency code blue or code red is called.	Accepted	Additional radio pouches are being purchased to ensure there is a pouch available for each radio. A new radio system is also going to be implemented and all staff will be issued their own radio pouch to keep so they will always be able to draw a radio and have it on their person as and when they need one. A notice to staff will be published to remind them on actions required to be taken when dealing with a medical emergency as required by PSI 03/2013.	Completed October 2014 Completed	

Recommendations directed at the YJB

Recommendation	Headline Response	Comment
The Chief Executive of the National Offender Management Service and the Chief Executive of the Youth Justice Board should ensure that there are appropriate transition plans for all young people likely to transfer from the under 18 estate to the young adult estate. Plans should allow the possibility of 18 year olds returning to the juvenile estate for a period of stability after sentencing.	Partially accept	The YJB plays a direct role in the transition plans for girls (who are no longer placed within the under 18s YOI estate) and at times boys who transition directly to the adult estate from Secure Training Centres (STCs). Within the under 18s YOI estate transitions is the responsibility of NOMS and the holding establishment. The actions described in the Transitions Protocol (which is a NOMS owned document) are for NOMS and establishments to take and are not requirements for the YJB. The YJB does however recognise the importance of an effective transition process for the safety and wellbeing of those moving to the young adult estate and supports planned transitions for individuals, and where it is identified to be in the individuals best interest can facilitate an extended period in the juvenile estate. The YJB remains committed to continuing work with NOMS to support how to transition effectively and in a way that meets the needs of each individual. We will also continue to share good practice about transitions in the community and custody. We consider that this recommendation would be more appropriately directed at NOMS.
The Head of the YJB placements team, the Governor of Feltham and the Head of PMU should ensure that, where there is any doubt about the allocation of a young person or young adult who has come from Feltham, a correct and safe allocation is made, and		The YJB would ask for further clarity before providing a headline response. It would be beneficial to understand where the recommendation is intended to apply to Feltham A and where it is intended to apply to Feltham B. The dual nature of HMYOI Feltham effectively means that two establishments operate on one site with differing policies and practices, commissioning arrangements and expectations. It follows that the remit

that they return to Feltham if appropriate.		for placement into each is also separate with the under 18 side, Feltham A placements made by the YJB and the over 18 site, Feltham B placements made by the NOMS Population Management Unit. Effective and timely transition planning are essential. The YJB will continue to support NOMS in developing and implementing effective transition policies and practice to meet the needs of those individuals moving into the adult estate.