

**Investigation into the circumstances surrounding the  
death in custody of a male trainee at a hospital  
in January 2005**

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

**October 2006**

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## **1. Introduction**

This is the report of an investigation into the death of a trainee in hospital in January 2005. The trainee was only 16 years old. He was found hanging in his care and separation cell at HMYOI Lancaster Farms in January 2005. The trainee was transferred to hospital but died there the next day. His family were at his bedside.

A post mortem examination concluded that the trainee's death was caused by hanging. The toxicology report indicated that he had consumed no illegal drugs or alcohol. The drugs he had in his system were all consistent with prescribed medication or the drugs used in the attempts to resuscitate him.

I am particularly saddened by the death in custody of someone so young. I offer my sincere sympathy to the trainee's family and many friends.

The investigation was carried out by my colleagues, who were assisted by two members of staff from the Youth Justice Board.

I commissioned an independent clinical review of the management of the trainee's health needs while he was at Lancaster Farms. This review was carried out by a qualified nurse, who works in my office.

This report incorporates local management reviews carried out by County Durham Youth Engagement Service and a placement report from the Youth Justice Board.

As the trainee was a child when he died, and in line with Part 8 of 'Working Together to Safeguard Children' a Serious Case Review by the Area Child Protection Committee (known as the Local Safeguarding Children Boards - LSCBs - since 1 April 2006) will take place. The LSCB Committee responsible in the trainee's case has secured the services of a former Director of Social Services to prepare an Overview Report. My report will be provided to LSCB in order to assist them in their obligations.

I would like to thank the Governor and staff at Lancaster Farms for their ready help and co-operation during the investigation. Particular thanks are due to the establishment liaison officer.

This is a long and detailed report, reflecting the seriousness I attach to the death of someone so young. Some of the details make painful reading. Given that the trainee was a child when he died, and the involvement of the Youth Justice Board and other agencies, the recommendations in this report are addressed to various parties in addition to the Prison Service.

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

**October 2006**

## 2. Summary

The trainee was a young man from a large family. He witnessed his brother hanging when he was just 12 years old. This had a profound effect on him and his behaviour started to deteriorate from this point. The trainee got into trouble with the police and the courts and one of his good friends died after a car accident. The trainee had been driving the car and was charged with death by dangerous driving. In February 2004, he spent some time living with his older brother. Whilst on holiday with his brother, the trainee raped a 17 year old young woman. He was remanded into HMYOI Lancaster Farms on 6 September 2004. Lancaster Farms was the closest establishment to the court in which his offence was being heard, but a long way from his home in County Durham. The trainee had never been in prison before.

There should have been a remand planning meeting for the trainee, involving staff at the prison, his Youth Offending Team supervisor or seconded YOT worker and his family. This did not take place. County Durham Youth Engagement Service say that they did not refuse to attend a planning meeting. A remand worker from the YOT said she had invited them to attend a few times but that they had declined, stating distance to travel as the reason. A meeting was not arranged in their absence, as it should have been. This meant that the trainee's time on remand lacked any proper direction or focus. The remand plan should have been reviewed each month that the trainee was on remand. This did not happen.

The trainee struggled to cope with being in prison. Within a week of arriving, he had placed a ligature around his neck. He was subject to closer monitoring via the F2052SH system (the Prison Service procedures for supporting those who are deemed to be at risk of suicide or self harm) on four separate occasions. The last form was closed on 22 December 2004.

The trainee's behaviour in prison varied. At times, he was quiet and polite and attended both the gym and education on a frequent basis. During other periods, he lost control of his temper and would behave rashly after having a punishment imposed on him for something, or being told information he did not want to hear. These temper outbursts sometimes led to him being taken to Ullswater, the care and separation unit. The trainee had several governor's adjudications against him, some for fighting with other young people, others for damaging cell furniture or fittings. He was also subject to sanctions imposed via the Incentives and Earned Privileges Scheme. These sanctions resulted in his losing his television and association on the wing for several nights during September, October, November and December. The new Incentives and Earned Privileges Scheme which stopped such sanctions was not introduced until 24 January 2005.

The trainee made self harm attempts on several occasions. He was either already subject to the F2052SH procedures at these times or a form was opened immediately. This is correct procedure. The F2052SH forms in general showed an appropriate level of staff observations and case reviews were conducted regularly. The case reviews suggested good, sensible support plan targets. Unfortunately, there was no clear system of follow up to ensure that action was taken to implement the targets. This meant that some key support plan initiatives, such as arranging a visit from the trainee's YOT supervisor and organising a Community Psychiatric Nurse appointment did not happen. An important assessment by the psychologist about the trainee's likelihood to self harm, his risk factors and steps that could be taken to make self harm less likely, were not acted upon or properly considered by Lancaster Farms. There was no system in place for the trainee's family or his YOT

supervisor to be told of his self harm attempts. The trainee's parents were not told about the F2052SH system nor about their son's behaviour in prison. Knowledge that the trainee was not coping would have led to a visit by his parents. I make several recommendations concerning the breakdown of communication and failure to act, both across departments within Lancaster Farms and with the trainee's parents and YOT supervisor.

The trainee's YOT supervisor visited him only once during the whole remand period. This was on 22 October and was for the purpose of completing a pre-sentence report. He did not talk to wing staff or managers about the trainee and did not know that he had self harmed. The supervisor said that the staff who took him to the legal visits area seemed knowledgeable about the trainee and told him that he had been getting into fights. A further visit by a member of staff from County Durham Youth Engagement Service (CDYES) took place in November. During the visit, the trainee said that he had self-harmed, but this information was not passed on to the supervisor or his parents. Again, there was a breakdown in communication, both within CDYES and with the trainee's parents and I make a further recommendation about this.

I am also unhappy with the regime that I found operating in Ullswater, the prison's care and separation unit. Record keeping was poor and activity fell below the standard required for the care of young people in terms of exercise and meaningful time out of cell. People do not usually prosper in conditions of close confinement. Young people are even more vulnerable in these conditions. The positive intervention programme that was designed to operate in the unit had lapsed and the mini gym was not being used.

It is not clear whether the trainee intended to take his own life on 19 January 2005. His previous self harm episodes had been discovered by staff in time to offer support and help and, often, a move into the Healthcare Centre. The Ullswater staff who found the trainee on 19 January responded immediately and appropriately. Healthcare staff were on the scene quickly and the ambulance was called for and arrived without delay. There was confusion about the next of kin information that the prison held. This led to a delay in the trainee's parents being told the news. They are angry about this. His parents travelled to the hospital, but sadly he died the following day.

I have concluded that people inside the prison, and those in the community who were together charged with ensuring proper care, did not put into place the processes and safeguards which would have provided a comprehensive teamwork approach to the trainee's care. Remand planning meetings were not held and this meant National Standards for Youth Justice were not followed. Reviews of the trainee's condition, although undertaken regularly at the prison, led to incomplete follow through. There was too much use of the disciplinary system, and too great a reliance on punishments such as loss of association, loss of tobacco, and loss of television. The trainee's family were not aware of his deteriorating behaviour and his several acts of self harm. Consequently, they were not involved in his life at Lancaster Farms. Notwithstanding the undoubted good qualities of many individuals who dealt with the trainee, there was a lack of co-ordination at the prison. Many people made initiatives. Nobody co-ordinated the work and set clear direction. I acknowledge it was difficult to work with the trainee. Nevertheless, there was room for much improvement in the way he was looked after.

### **3. Investigation methodology**

The investigation was opened on 21 January 2005 when the head of my office's Fatal Incidents Investigation Team met the Governor of HMYOI Lancaster Farms.

Before the arrival of the main investigation team, notices were issued to staff and trainees announcing the investigation and inviting anyone with information relevant to the trainee's death to make themselves known to a member of the team.

My investigators commenced their work at Lancaster Farms on 8 February 2005. They familiarised themselves with the establishment's layout, ethos and regime, particularly that of Ullswater Unit and the Healthcare Centre. They also saw the cell in which the trainee was found hanging.

The investigation team received copies of all the police statements that had been taken. I am grateful to the police for their co-operation in releasing these statements to the team. The statements meant that some staff were not required to have duplicate interviews. Several staff and trainees were interviewed by members of the investigation team. Some interviews were taped and transcribed and others were conducted in a more informal manner. Unfortunately, no members of staff at the County Durham Youth Engagement Service were interviewed.

An independent clinical review of the management of the trainee's health needs was carried out by a qualified nurse who works for my office. She visited Lancaster Farms on 9 February and returned for two further days in March, with one of the investigators, in order to complete the necessary interviews with nursing staff.

Another of my investigators, together with one of my Family Liaison Officers, visited the trainee's parents in Durham on 18 February 2005. The nature and scope of the investigation was explained to the parents. Concerns and questions that the family wanted the investigation team to address were also raised at this meeting.

My lead investigator and the nurse to whom I have referred above, visited Lancaster Farms again on 4 May to conduct some further interviews, and to inspect relevant records and policies.

#### 4. HMYOI Lancaster Farms

Lancaster Farms, located near the town of Lancaster, is a closed Young Offender and Juvenile Remand Centre run by the Prison Service. At the time of the investigation, the prison could hold up to 527 sentenced and remanded offenders, although its normal capacity was 480. At any given time, the population comprises about 50% juveniles (aged between 15 and 18) and 50% young offenders (aged between 18 and 21).

Lancaster Farms opened in March 1993 and originally comprised three residential units for remanded and sentenced young adults aged 18 to 21 years. A fourth residential unit, Buttermere, was added in 1996. This originally held young adults but was re-roled to take 120 juvenile trainees in April 2000. Buttermere is funded by the Youth Justice Board. Windermere, one of the original residential units was re-roled to take 120 juvenile trainees in April 2002 and is funded by the Emergency Accommodation Unit under the Street Crime Initiative. Ullswater fulfils the function of a care and separation unit (segregation unit). Five of the 12 cells in Ullswater are designated intervention programme cells, where young people should receive one-to-one case management, education and gym.

Both Buttermere and Windermere are divided into two units, each unit having 60 cells. Buttermere 2 is the induction unit for the under 18's. Windermere 2 is a non-smoking unit and holds all 15 year olds and those who are older who choose not to smoke.

On 19 January 2005 when the trainee was found hanging, the number of people held in Lancaster Farms was 488. The number of juvenile trainees was 213. On 8 February, the day the investigation team arrived, the establishment had 471 young people in its care, 202 of whom were juveniles.

The establishment caters for a high proportion of offenders with mental health problems. Healthcare is provided by Morecambe Bay Primary Care Trust (PCT). The Healthcare Centre comprises an in-patient unit with 14 beds, as well as a separate outpatient department. The centre is located immediately above Ullswater Unit.

The last death of a trainee at HMYOI Lancaster Farms was that of a 20 year old who was found hanging in a residential unit cell on 20 February 2004. Most of the recommendations from that investigation relate to changes needed in the night state procedures. A number of recommendations are, however, relevant to this investigation. They are as follows:

**Recommendation K1.4** "Implement a system to inform Healthcare of the type of emergency they are being requested to attend to." This recommendation was explored and subsequently rejected by Lancaster Farms as they felt that a code system might create problems with staff remembering which 'code' related to which type of emergency. They instead have a system of alerting medical staff to the fact there is an emergency and the staff take one bag that contains the necessary equipment for all situations likely to be encountered.

Police statements taken from nurses involved in responding to the discovery of the trainee give cause to suggest Lancaster Farms should reconsider their rejection of this recommendation. Three nurses refer to the need to return to the outpatients department to collect more equipment or drugs during the trainee's resuscitation.

**Recommendation K2.2** “The Personal Officer Scheme should be reviewed to ensure: (a) staff are aware of their responsibilities (b) staff are appropriately trained (c) wing files contain a record of meaningful staff / trainee engagements.” An update report from the prison (dated 8 February 2005) states that the Personal Officer Scheme has been reviewed. It adds that staff are aware of their responsibilities and that they have the tools to ensure all parts of the Personal Officer package are delivered.

The Personal Officer scheme is considered during this investigation. Whilst the scheme was re-launched, my investigators did not find that young people were always aware of the role of their Personal Officer or that they had regular or meaningful discussions with them. The investigation team found that some key work that would logically fall to Personal Officers was not being done. This includes the responsibility to keep young people’s families and their YOT supervisor informed of key events in that person’s life when in custody.

**Recommendation K2.3** “The role of ‘peer support’ should be clarified for staff and trainees. Consideration should be given to re-introducing a listener scheme and to include trainee representation on the Suicide Awareness Team”. This recommendation was accepted by the prison, but had not been implemented at the time of our investigation into the death of the trainee.

**Recommendation K2.4** “A quality assurance system should be introduced and rigorously applied to: (a) the induction process (b) the Personal Officer scheme (c) the monitoring of F2052SH.” According to the action plan update, the prison had implemented all of these checks by December 2004.

## **5. The Role of the Youth Justice Board and Youth Offending Teams**

The Youth Justice Board was created following the Crime & Disorder Act 1998 that came into force on 30 September 1998. The Act outlines the powers and responsibilities of the Youth Justice Board, including:

- To monitor the operation of the youth justice system and the provision of such services;
- To advise the Secretary of State on the content of any national standards that he may see fit to set with respect to the provision of the accommodation in which children and young persons are kept in custody;
- To identify, to make known and promote good practice in the following matters, namely:
  - the operation of the youth justice system and the
  - provision of youth justice services;
  - the prevention of offending by children and young persons; and
  - working with children and young persons who are or are at risk of becoming offenders.

The Youth Justice Board is also responsible for the purchasing and allocation of placements in secure facilities for young people in the criminal justice system. The Youth Justice Board is responsible for the monitoring of secure facilities to ensure that the welfare of a young person is at the centre of any such establishment's regime.

Youth Offending Teams (YOT's) are responsible for the assessment and identification of the specific needs of each young person who offends and for overseeing their statutory supervision in the community or in custody. YOT's are multi agency arrangements accountable to the local authority.

## **6. Policy instructions that apply to the care of young people in custody**

HM Prison Service and the Youth Justice Board have a strategic partnership to ensure the quality of services in all juvenile secure establishments. Until April 2005, this was achieved on an annual basis through an agreed Service Level Agreement (SLA). A three year commissioning agreement is in place between the YJB and the Prison Service from April 2005.

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

Within 'Service Standards', Prison Service Order 4950 and National Standards for Youth Justice are identified as two of a number of instructions which must be complied with in the delivery of the SLA. Prison Service Order (PSO) 4950 'Regimes for Juveniles' is the Prison Service's detailed instruction to prison governors about the systems and procedures that should be in place when looking after young people in a prison environment. It makes reference to other Prison Service orders and instructions that must be complied with, such as those relating to the segregation of young people laid down in PSO 1700. All of the requirements laid down in PSO 4950 are compatible with the overarching YJB National Standards. The management of prisons that hold juveniles rests with the Area Manager for the part of the country in which the prison lies. Lancaster Farms falls under the North West Area Manager.

An additional requirement of the SLA in 2005 / 2006 is that a number of other performance areas will be regularly monitored. In order to achieve this, the Youth Justice Board provides monitors to each establishment who are tasked with monitoring performance and compliance against PSO 4950, the National Standards for Youth Justice and the Key Performance indicators using the Effective Regimes Monitoring Framework. The monitor prepares and submits this report to the Governor of the establishment, Juvenile Group at Prison Service Headquarters and the Youth Justice Board. It is the responsibility of the establishment Governor to advise the Youth Justice Board Regional Manager of any comments or clarifications to the report, and provide details of corrective action where required, within ten working days of receipt of the report.

Both the Prison Service and the Youth Justice Board recognise that there may be times when there will be a demand for additional beds and this will affect the regime. It is therefore agreed that the Prison Service will advise the Youth Justice Board of the standards which cannot be met immediately and agree, subject to relevant levels of funding, when such standards should be achievable.

## **8. Events prior to 19 January 2005**

- **General note about the day to day activities that the trainee participated in whilst in Lancaster Farms**

A typical weekday on Windermere would start with staff arriving on the unit at 7.30am. After a roll check, the young people would be unlocked for breakfast. They would eat breakfast around tables. (Tables are set out on the ground floor and trainees eat here each meal time). At 8.30am, the trainees go to their morning activity. At 11.45am, the trainees return to the unit and have lunch between 12 and 12.30pm. The young people are then locked in their cells for one hour whilst the staff take their lunch break. At 1.30pm, the trainees go to their afternoon activity, returning at 4.45pm. There is a 30 minute staff tea break at 5pm, when the trainees are locked in their cells again. Tea is at 5.30pm and the trainees then go to an evening activity or have association. Association is normally split into two periods. This is to enable young people to have a fair opportunity to use the telephone, the pool and football tables. The trainees get a hot drink just before being locked in their rooms for the night at 8.30pm. The night staff are on duty from 8.45pm. Trainees generally do not share cells, and all except those on the lowest incentive level have a television in their cell.

The investigation team sampled four random weeks over the period that the trainee spent in Lancaster Farms and explored the sort of activities he took part in. We found that he attended education every weekday. The only exceptions were those days when the trainee was either in Ullswater Unit or the Healthcare Centre. Education classes are provided 'in house' on those two units. The trainee studied a range of classes from maths and English, to parentcraft, IT and cookery. The trainee also enjoyed PE and the gym. He attended a football course during October, but was removed from it for fighting with one of the trainees. However, the trainee continued to attend the gym regularly. The trainee made frequent telephone calls to a number of people including his mother, brothers, sisters, cousins and a couple of friends.

- **The trainee's initial period in custody on Buttermere Unit - 6 September 2004 to 27 September**

On 6 September 2004, a placement order was issued by the Youth Justice Board for the trainee to be held on remand at Lancaster Farms after he had appeared at the Magistrates Court that day charged with a sexual offence. The trainee was due to appear again in court the next day. The placement booking form indicated that the trainee was vulnerable because of his alleged offence. It also highlighted that he had discussed self harm in 2003.

The trainee arrived at Lancaster Farms at about 7pm and went through the normal reception procedures. He gave his brother's name and address as his next of kin. He was seen and assessed by staff in reception, including a nurse, and was not identified as being at risk of suicide or self harm. It appears that the nurse did not know of the vulnerability alert when assessing him. He was located on Buttermere 2, the induction unit for under 18's.

The officer who was the first to deal with the trainee when he arrived on Buttermere that evening remembered that he came on the unit late, when the other trainees had already been locked in their rooms, and that he (the officer) was tasked with

completing the appropriate induction form. The officer spoke to the trainee for some time. He described him as fairly talkative, but also anxious. The officer explained that one can soon recognise if a young person has been in custody before: they have a certain amount of familiarity with the system and therefore some level of coping skills. He did not sense at that time that the trainee had these skills and that this was why he was anxious. The trainee was happy to talk to the officer and told him about the distressing family deaths that had occurred in the past few years, mentioning in particular his brother and his friend. The officer specifically asked the trainee if he was thinking about hurting himself. The trainee said he was not thinking of doing that. The officer could not recall the trainee referring to his distance from home or family as being a problem. The relevant part of the Cell Sharing Risk Assessment was completed by the officer. He rated the trainee as a young person who may not be suitable for a shared cell, partly because of his offence (which involved another person under 18 years of age) and partly because the trainee told him that he sometimes got angry or frustrated quickly. The trainee went into a single cell with a 'smokers' pack and a newspaper and settled for the night.

The officer and the other staff on duty that night checked the trainee on a regular basis. The officer told the investigation team that the trainee was asleep throughout the night.

On 7 September, the trainee was taken back to a Magistrates' Court for a further remand hearing. A new placement order was issued for him to be held in custody and he returned to Lancaster Farms in the evening. This time, the order was accompanied by a vulnerability warning, indicating that the trainee was upset and had been charged with a serious offence. The trainee returned to the induction unit, Buttermere 2. There was nothing to indicate that the trainee received further health screening on return from court as he should have done.

The next morning, the trainee began his induction programme on Buttermere. He was interviewed by the unit manager, who recorded that the trainee had been living with his brother at a caravan site, that he had phoned home and did not need anyone contacting. The section entitled 'mindset' stated that the trainee was okay but that he felt unsettled. The trainee was also asked if he needed to speak to the Samaritans or the chaplain and his response was recorded as 'not yet'. The next part of the assessment is intended to highlight any 'problem' areas. There were three ticks in this section; the first was in relation to car crime and includes a reference to the trainee having caused death by dangerous driving. The second tick is about anger and the explanation box says that the trainee is short tempered. The final tick is in the 'family' section and it states that the trainee does not speak to his father or older brother.

The trainee was also assessed by the psychology department. They carried out a Juvenile Psychological Needs Assessment. He scored within normal ranges on the emotional behaviour scale. This suggested that his level of aggression, anxiety and self esteem in social situations was what would normally be expected. The score for his 'hopelessness levels', which is related to suicide ideation, indicated that the trainee was feeling moderately hopeless. The recommendation to staff was that he might need extra support as he was currently experiencing some negative feeling towards himself, the future and the world.

No post reception health screening was undertaken with the trainee. It normally forms part of the routine procedure for all newly received trainees during their first week in custody.

## **Suicide and Self Harm form number 1 opened**

At 8.40pm on 12 September 2004, the trainee pressed his cell bell. The officer who responded to the alarm told us that he found the trainee standing by his cell window with a ligature around his neck. The ligature, made from a bedsheet, was attached to his neck and to the cell window bars. When the officer entered the cell, the trainee removed the ligature himself and said he would be okay if he could have a cigarette. The history sheet reports that the trainee may have been getting 'taunts' off other juveniles out of the windows.

There is no evidence that a F213SH was completed after this incident or that a nurse or doctor was informed. The officer did raise a F2052SH at about 9:30 that evening. The night Orderly Officer was informed of the incident. He told us that he had no recollection of the events of that night.

The next morning, the trainee refused to get out of bed and was hiding under the covers. An officer who spoke to the trainee later in the morning wrote that he was close to tears and said his main problem was being so far away from home. He wanted a transfer so that he could get visits. The trainee was seen by a nurse at 9.30am on 13 September. She judged that he could be managed on normal location, with regular or irregular supervision. A senior officer, who signed page 2 of the F2052SH at 4pm on 13 September, decided that the trainee should remain on normal location but that he would need to be monitored for a few days. Healthcare staff were to be consulted about the possibility of relocating the trainee to the Healthcare Centre should he be unable to cope on normal location. The doctor's assessment was not completed until 23 September. Within the F2052SH itself, there are instructions showing that the doctor's assessment should take place within 24 hours of the opening of the form.

Also on 13 September, the trainee applied for permission to be visited by his two nieces who, at the time, were aged three and four respectively. His application was decided on 27 October.

On 15 September, the trainee was warned about mis-using his cell bell. The first F2052SH case review was held on 15 September 2004, attended by a Senior Officer an officer and the trainee. There was no one present from healthcare. The record of that review shows that the trainee was considered to be a very poor copper who suffered mood swings. It was decided that the F2052SH should remain open. A support plan was drawn up. All staff were to monitor the trainee at regular intervals. His personal officer was to keep in close contact with him. Healthcare staff were to give support if necessary. The trainee was advised to make an attempt to associate with others in the wing and to speak to staff whenever his mood was low. There was no evidence that healthcare were alerted to their proposed role in the support plan. That evening, the trainee played pool and mixed with the other young people during association. Over the next few days, he seemed to settle and staff report that his mood had improved. On 18 September, it was noted that the trainee was quite upbeat, that he had made a few friends and was feeling confident in himself.

On returning from the gym about 10.00 in the morning of 20 September, the trainee wandered around the wing and, when challenged, apparently became argumentative. He lost his television and one night's association for this. At around 1pm, he blocked his observation panel in his cell and it took about 20 minutes for an officer to persuade him to remove it. When unlocked for the gym a short while later, the trainee had a noose at the window and had set fire to his bin.

The second case review was conducted at 2.30pm on 20 September 2004. This meeting was attended by a senior officer, a staff nurse and the trainee. The tone of the review summary was markedly different from the entries up until this time. It recorded that the trainee was a 'very manipulative individual who uses the 2052SH and threats of suicide as a means to get his own way...' It went on to say that the trainee had 'made numerous threats and nooses on various occasions after being told no by staff...' Presumably these references were to the events of earlier that afternoon. The F2052SH was to remain open with a support plan almost identical to that drawn up at the case review held on 15 September. The trainee got his television back the next day and immediately became more talkative and happy.

On 23 September, the trainee was seen by a locum psychiatrist who noted on page 5 of the F2052SH that he had felt tense and agitated as this was his first time in prison. However, the trainee now felt more settled and had experienced no further thoughts of self harm. The doctor felt that he could continue to be managed on normal location. In the trainee's medical record, the psychiatrist wrote that the main precursor to the self harm was missing his family and not having enough credit to ring them. He recorded that the trainee was not trying to end his life, and was glad to be alive. He diagnosed him as a poor copier, having an adjustment reaction. He did not arrange follow up and thought the F2052SH monitoring could be considered for closure.

A further case review was held on 24 September 2004. On this occasion, the review was attended by a Senior Officer, a Staff Nurse and the trainee. The case summary contained a far more positive picture of the trainee's state of mind. It was recorded that he was more settled, was mixing with peers, attending the gym often, and taking part in unit based association. The trainee told the staff that he had found things tough initially, but that he no longer felt like harming himself. He agreed to seek help if his mood changed. The Staff Nurse was to arrange for him to see a Community Psychiatric Nurse (CPN) by way of support. He made an entry in the CPN diary on Wednesday 29 September asking for the trainee to be seen. There is no evidence that the CPN saw him. The panel decided that the F2052SH could now be closed.

An IEP review on 25 September, resulted in the trainee remaining on the Silver level of privileges. On 27 September, the trainee received two 'poor' marks in relation to the IEP scheme, one for being in bed at unlock and one for not having cleaned his toilet properly. These infringements led to his losing a total of two nights' association. The trainee moved onto Windermere 1 unit later on 27 September.

### **Windermere Unit - 27 September 2004 to 26 October**

The trainee remained overnight on Windermere, before leaving for a Magistrates' Court on 28 September. He was out of the prison from 7.15am to 8pm.

At the end of September, the trainee was awarded a 'Gold' medal for completing a GPFW course (Generic Preparation For Work course) but this was not enough for him to be upgraded to Gold level on his next IEP review on 2 October. The trainee got another 'poor' mark for being late returning to his cell at lock up time and a further loss of one period of association. The trainee had an hour and a half visit from his solicitor on 1 October.

On 6 October, the trainee was assaulted by another trainee. Both young people were restrained by staff, but then the trainee who is the subject of this report broke away and assaulted his peer. Both were locked in their cells. Both were placed on a

Governor's Adjudication, charged with fighting. The adjudication was heard on 8 October by a governor. The charge was found to be proved and the trainee was punished with seven days loss of canteen, seven days loss of his television and five days loss of association. His parents knew nothing about this incident.

On 7 October, the trainee spoke to PE staff and told them that he was being threatened and bullied by two named trainees. The PE staff acted appropriately and informed the Security Department. Anti-bullying procedures were implemented against both of the trainees and they were not permitted to attend the gym together again.

Between 9 October and 22 October, various entries were made in the wing history sheet about the trainee's behaviour. There are positive comments from the education department, but more negative comments from wing staff about minor rule infringements such as watching television when not permitted to do so and being in bed at unlock in the morning. The trainee spent 12 October at a Crown Court and returned to the prison convicted but unsentenced.

The trainee's supervising officer from the YOT visited on 22 October in order to compile a pre-sentence report. The visit lasted just over an hour. The supervising officer reported that the trainee was 'very chatty' during this visit and admitted lots of previous anti-social behaviour. The supervising officer described him as feeling 'very guilty' and 'philosophical about his future'. The trainee apparently discussed his plans for when his sentence ended and agreed to meet his supervising officer after his transfer (upon sentence) to HMYOI Castington. The supervising officer met the trainee in the legal visits area. He did not speak to his personal officer nor managers in the prison but did talk to the staff who escorted him to the legal visits area. He described them as knowledgeable about the trainee. They told him only that the trainee had been getting into some fights and was known as a 'fighter' to staff.

On 24 October, the trainee was found fighting with a trainee during association and they were both sent to their cells. The Governor's adjudication the next day resulted in stoppage of earnings for the trainee, seven days loss of association and seven days loss of his television. An additional punishment of being 'removed from the wing' was suspended for one month.

#### **Ullswater Unit - 26 October 2004**

On 26 October at 2pm, the trainee damaged a locker and toilet seat in his cell and tried to erect a barricade in Windermere Unit as a reaction to the punishment given to him by the governor at the disciplinary hearing the day before. He was subsequently relocated to Ullswater Unit, the prison's segregation facility, in handcuffs. The appropriate use of force forms were completed by staff. On arrival in Ullswater, the trainee blocked the observation panel on his cell door. When staff entered his cell to ascertain what he was doing, he grabbed an officer's shirt. The trainee was restrained by staff using Control and Restraint techniques and placed in a special cell (one with no furniture) for about ten minutes from 2.45pm. The appropriate use of force forms were completed by staff. Prison Service Order 1600 requires the Independent Monitoring Board to be informed of the use of a special cell. There is no evidence that they were informed in this case.

A nurse wrote in the trainee's medical record that she carried out an examination of him in the segregation unit on 26 October following his being restrained by staff. He had full movement of his right hand and wrist despite some redness and slight swelling. No treatment was needed. Form F213 (Injury to Trainee form) was

completed. It was the trainee's right hand that had been damaged in the car accident in January 2003. He had undergone several operations and skin grafts to this hand.

A governor later carried out the adjudication for the cell damage and imposed a punishment of seven days' loss of association and seven days' loss of television. The investigation team found no evidence that a Segregation Safety Algorithm had been completed.

### **Suicide and Self Harm form number 2 opened**

Around 9.30pm that evening on Ullswater, an officer answered a cell bell pressed by the trainee, and found that he had placed a noose around his neck. The officer raised a F2052SH and wrote on page 2 that the trainee had told her that he was 'fed up with the noise and being kept awake by other inmates'. The officer contacted the Healthcare Centre and recommended that he should be admitted straightaway. The trainee was admitted to the Healthcare Centre as an in-patient by a nurse. He told the nurse that he could not stand the noise and disturbances on Ullswater. A nursing care plan was formulated. This recommended one to one counselling with the trainee's named or associate nurse.

### **Healthcare Centre – 26 October to 1 November 2005**

The trainee was examined by the nurse who recorded on page 5 of the F2052SH that he had "slight reddening of the neck and throat and was very low in mood". The trainee was located in a safer cell (a specially designed cell with minimal ligature points that could be used by someone in a self harm attempt). Form 213SH was completed as required. The trainee quickly settled and was observed every hour until 7am the next day.

The Chaplain saw the trainee in the Healthcare Centre at 8.20am on 27 October and recorded on page 7 of the F2052SH that he was subdued, quiet and introspective. He was not engaging with his peers. The trainee told the Chaplain that he was missing his family. He was very low in mood. Later that morning he was seen by a doctor who recorded on page 5 of the F2052SH, "Impulsive DSH (deliberate self-harm) attempts. Difficulty coping in banging up. Not pleased.- No ongoing suicidal ...but does have thoughts of life not worth living." The doctor decided that the trainee should remain in the Healthcare Centre. In the clinical record, the doctor described the trainee as feeling down and angry, missing phone calls and association due to punishment for fighting. The trainee had tried to hang himself but took the noose down himself then started to scratch his wrists. The doctor recorded that the trainee was in a low mood secondary to 'bang up'. He described the suicide attempt as impulsive behaviour, not a planned attempt. He found that the trainee was having difficulty coping in stressful situations. The doctor suggested monitoring his mood and sleep, continuing self harm monitoring and recorded that no medication was prescribed.

On 27 October, the earlier application by the trainee to be visited by his two nieces was considered and denied. The trainee had been classified as a Schedule One offender because of the nature of the charges against him. Any application for contact with children had therefore to be scrutinised in keeping with the provisions of the Child Contact section of the Public Protection Manual. Soundings were taken from departments within Lancaster Farms. Lancaster Farms YOT also telephoned the trainee's YOT supervisor to ask for his opinion. He responded by letter shortly after. The trainee's application was refused by a governor after a public protection

meeting had been held in the prison to discuss the visiting arrangements for several young people.

Between 27 and 30 October, the trainee's morale began to improve, although he still tended to look subdued on occasions. He joined an education class within the Healthcare Centre and began to associate with his peers. He told staff that he found the hospital environment less stressful than the wing, where he felt isolated and subject to verbal abuse. On 29 October, a nurse recorded in his care and support record that he had been referred for grief counselling.

On 30 October, a case review was carried out as a result of which the F2052SH was closed by a nurse. The review noted that the trainee was open about his feelings and that he admitted being angry over concerns about his family being so far away. The trainee apparently also said that he intended his actions on Ullswater on 26 October to have resulted in admission to healthcare and that he had no ideation of suicide. The review concluded that the trainee would stay on healthcare until 1 November before being discharged to Windermere. The closing remarks concerning support for the trainee were two-fold. The first entry stated that wing staff would attend the trainee's discharge meeting on Monday 1 November. The second was that a nurse would contact the trainee's YOT supervisor on 2 November and arrange a visit.

#### **Windermere Unit - 1 November to 17 November**

The trainee was discharged from the Healthcare Centre to Windermere Unit on 1 November. A doctor noted in the clinical record that the trainee was settled in hospital, was socialising, and was phoning his mother which made him happy and hoping for a visit from his brother. The doctor found the trainee fit to return to the wing. He noted that the trainee thought he would be ok on a wing but he was concerned about the noise and shouting. The trainee was discharged to Windermere Two that day. There is no evidence that any form of handover between healthcare and discipline staff took place, despite the previous day's closing F2052SH support plan indicating wing staff would attend the hospital discharge meeting. There is also no evidence that the YOT supervisor was contacted and certainly no visit subsequently took place.

During the first part of November, the trainee received some warnings about his behaviour on Windermere. On 8 November he had an introductory counselling session.

The trainee had a visit from a worker from County Durham Youth Engagement Service on 9 November in order to assess whether he might be a suitable person to go on the Intensive Supervision and Surveillance Programme (ISSP). This sentence was not deemed to be an appropriate disposal to recommend to the court because of the seriousness of the trainee's offence. The worker said the trainee was resigned to a sentence in custody and talked about future plans. The trainee did tell the CDYES worker that he had self-harmed whilst in Lancaster Farms and they spoke briefly about this. At the end of their session, the trainee was 'slightly down, but generally fine'. The CDYES worker was sufficiently concerned, however, to inform both wing and gate staff of concerns about the trainee's vulnerability because of the news about ISSP. The CDYES worker did not tell the trainee's supervising officer that he had admitted to self harm whilst in Lancaster Farms, nor about any other concerns about him.

On 16 November, the trainee broke the glass in the observation panel in his cell door in reaction to a decision by a senior officer to give him loss of association and loss of television after kicking his door and being disruptive on the wing the previous day.

A governor carried out the ensuing adjudication during the morning of 17 November in Ullswater and found the trainee guilty of damaging his cell. He was given seven days no television, no canteen, no earnings and no association. The punishment of no television was later rescinded by the same governor.

### **Suicide and Self Harm form number 3 opened.**

At 1pm on 17 November, a F2052SH was opened by an officer because the trainee again broke the glass in his observation panel, and this time used the glass to cut his wrists. On page one, the officer wrote that the trainee was removed to Ullswater immediately after the incident. He was admitted to the Healthcare Centre around 2.30pm. Form F213SH and Form 213 were completed.

### **Healthcare Centre - 17 November to 19 November**

A nurse wrote in the F2052SH that the trainee had been admitted from Ullswater after a further self harm episode. The nurse recorded in the nursing notes that there was no evidence of mental health problems. A registered mental nurse (RMN) undertook the admission assessment of the trainee, which he signed as the named nurse. A specialist psychiatric registrar saw the trainee in the company of the RMN. The registrar made the following entry, "Says he has been mistreated on the normal wing, as he lost his television and association for 7 days for minor mischief. According to him he was 'wound up' by a few inmates and he kicked the wall and got a 'P' mark plus loss of television for 3 days. Feels angry, frustrated. Past history of self harm plus attempted hanging a few weeks ago here. Family history of suicide. One brother and one cousin committed suicide. Mental state examination- at present talks relevantly, good eye contact, clinically not depressed but frustrated, no psychotic symptoms, no thought disorder, cognitive functions normal. Management advice given – observe in hospital wing."

The RMN and the registrar made entries in the F2052SH, completing page 5. The RMN noted, "Has poor coping abilities. Gets easily frustrated. His concerns past 3 years. RTA his friend died. Lost his brother- (suicide). Cousin died recently. Anxious over court appearance and expecting lengthy sentence." Later that day, the registrar noted on the same page, "Says feeling frustrated and angry as he lost his television and association for seven days from wing. Feels being mistreated in wing by officers for months. Superficial scratches to both hands. Past history of self-harm and f h (sic) suicidal acts. At present feels 'all right' Denies risk of self harm."

The registrar did not tick a box on page 5 to show which location he decided upon. The RMN wrote in the daily supervision pages at 2.30pm and 4pm, confirming there were no mental health issues and that a principal officer had arranged for the trainee to have his television back, following its removal as a disciplinary punishment. He described the trainee as being 'happy with decision'.

A governor carried out the adjudication hearing on 18 November and considered the charge of the trainee smashing his observation panel. The punishment of 'Removal from Wing' was suspended for one month.

At 2:10pm that day, the registrar completed a discharge report on page 6 of the trainee's F2052SH. He wrote, 'Observed in hospital wing. No evidence of mental

health issues. He got his television back and hence been happy..’ He recommended: ‘Transfer to wing after liaison with wing officer. To involve in Activity. CPN support. Follow up in seven days or earlier if necessary.’ The registrar completed the follow up outpatient appointment section on page 6 with the date “25/11/04” and “To be seen by the registrar”.

In his medical record on 18 November, the registrar wrote, “Had adjudication this morning – reported governor suspended time for two months and allowed to have television. Very happy about it. At present, calm, co-operative, talks relevantly, not depressed, no ideas of self harm. Been warned if he misbehaves he will be moved to Ullswater wing for five days – he knows about it. Management - transfer to wing, continue 2052SH, CPN (community psychiatric nurse) follow up and review by me in seven days.” There is no record of the trainee seeing the registrar on 25 November. He later told my investigator that the day after he saw the trainee, he, the trainee, was discharged from the healthcare centre to a wing. The registrar said he then asked the nursing staff to make an entry in the appointments diary and to ensure that the trainee was called across to the healthcare centre to see him on 25 November. The registrar assumed that the nursing staff did not call the trainee forward on that day.

When the CPN diary was checked to confirm the referral was made, there was no entry on 18 November but one had been made on 11 November, i.e. same day of the week but a week earlier. The Healthcare Manager wondered if this was a clerical error, the referral being entered on the wrong page. There is no record of a CPN assessment taking place following the registrar’s recommendation though.

On 19 November, a F2052SH case review was carried out in the Healthcare Centre. The review was attended by a senior officer and was chaired by a staff nurse. The trainee was present. The panel were aware of the fact that the registrar had already decided that the trainee was to be discharged from the Healthcare Centre. The senior officer told us that, had she felt that it would have been inappropriate to return the trainee to a wing at that point, she would not have hesitated to challenge the doctor’s decision.

The review summary recorded that the trainee felt happy to return to the wing. He expressed a wish to be allocated a single cell and was told that this was possible. The F2052SH was to remain open. The support plan directed that there should be unspecified personal officer involvement, and secondary help from the Healthcare Centre if required. It is not clear whether the support plan was made available to healthcare or the personal officer, who was identified as a key figure. We can find no clear information as to who was to monitor the support plan.

The trainee was discharged to Windermere Unit at about 2:40pm that day. The senior officer accompanied the trainee to the unit.

### **Windermere Unit - 19 November to 4 December**

The trainee seemed to settle quite well back on Windermere. He went on association several times, playing pool and having a laugh and a joke with some of the other young people. The trainee was also chatty to staff and seemed happy and relaxed.

On 22 November, the trainee had a second appointment with a counsellor. On 23 November, he kept a razor that he had been given to shave with in the morning. He hid the blade in his cell. One of the trainee’s two personal officers persuaded him to

say where the blade was hidden. The officer told the investigation team that the trainee would not say why he wanted the razor blade. The trainee then got quite annoyed and seemed to be upset that his bar of soap had been broken in two when staff were searching for the blade. An entry made just before 12pm states that the trainee was lying on the bed and did not respond, but that it looked as though he had been crying. The trainee threw his lunch at the door and kept pressing the cell bell.

The next morning, a senior officer spoke to the trainee and recorded that he could not explain why he had kept the razor but admitted he may have kept it to use on himself. The trainee said he was still finding things difficult due to waiting to be sentenced. The trainee was expecting to be sentenced on 13 December. The senior officer reminded him that the chapel, Samaritans phone and his personal officer were all available for him to talk to. It was decided that the trainee would be supervised whilst shaving from now on. A governor heard the subsequent adjudication for the trainee possessing an unauthorised article during the afternoon of 24 November. The governor was concerned about the trainee's demeanour during the adjudication and asked the psychology department to carry out an assessment of his risk of suicide and self injury. The governor said that the trainee was very withdrawn during the adjudication, that he would not maintain eye contact and said very little throughout the process. This was the first time that the governor had met the trainee. She gave him a punishment of four days loss of association and loss of his television for four days. This latter punishment was suspended for one month.

A review of the trainee's F2052SH took place at 2.45pm, attended by a senior officer, a nurse, an officer and the trainee. The review noted that the trainee initially showed negative body language but that, as the review progressed, he became more open. He told staff that he had felt suicidal the day before, but did not today. He was reminded of the various support services available. The trainee appeared to be more settled at the end of the review when the decision was made that the F2052SH was to remain open. The support plan entailed continued support from the healthcare staff, his personal officer and the chaplaincy, if required. The trainee was also to speak to his personal officer.

On 26 November, a consultant psychiatrist from Durham visited the trainee. The psychiatrist had been asked by the trainee's solicitor to assess him. He saw the trainee within the legal visits area, not within the Healthcare Centre, as would be normal practice. The trainee was recorded as being in a 'legal visit' from 2.15pm to 3.50pm. The psychiatrist said that he had written to the prison to book the visit asking for a whole afternoon interview and for the interview to take place in the Healthcare Centre. He was most unhappy that the visit he was given did not provide him with the opportunity to do a complete psychiatric history, risk assessment or mental state examination. Lancaster Farms were not able to explain to my investigators why the visit had been arranged to take place in the legal visits area rather than healthcare. It appears to have been an oversight on the part of staff at the prison.

On 28 November, the trainee talked to an officer. The entry in the F2052SH indicated that the trainee was positive about his chances of getting ISSP and that he was due in court before Christmas. The trainee seemed positive and upbeat and hoped to stay with a friend before getting his own place. On 29 November, the trainee kept an appointment with the counsellor, which she confirmed at interview. The next day, another entry in the F2052SH indicates that the trainee said he was not feeling suicidal any more and that he wanted to try and settle down. The trainee said that he would feel more settled once he had been sentenced.

The F2052SH was closed after a case review on 1 December, attended by a senior officer, a staff nurse and a nurse practitioner. The review recorded that the trainee appeared calmer and that he was coping better. There was still little contact with his family, but he was not experiencing thoughts of self-harm or suicide. The support plan entailed unspecified continuing support from staff of all disciplines.

On 3 December, the trainee was found in possession of a bottle of fermenting liquid. Two days later, he attended an adjudication for this offence. The adjudicating governor found him guilty of the charge and imposed seven days' forfeiture of canteen facilities, association and tobacco. The record of the hearing that was presented to my investigators did not make clear what type of fermenting liquid was found and how the trainee acquired it.

#### **Suicide and Self Harm form number 4 opened.**

At about 5.30pm on 4 December, the trainee rang his cell bell and told an officer that he had tried to harm himself by strangulation with a sheet. The officer said the trainee was crying and had some red marks around his neck. The trainee said his mother had told him on the phone that his 14 year old cousin had been killed in a car accident. The trainee told the officer that he could not cope with the situation and that this was the second death in his family within two weeks. The officer opened a F2052SH and the trainee was referred to the Healthcare Centre. The trainee's parents have told my investigators that there was no car accident involving a 14 year old cousin and cannot understand the reference to this. There was no 'second death'.

The trainee was admitted to the in-patient unit by a nurse who also completed page 5 of the F2052SH: 'The trainee has had distressing news from family and feels there's no point in going on and wishes he was dead. Presented as low in mood with minimal eye contact.' He was located in a safe cell at 7pm. The entry by the nurse records that the reason for location in the safe cell was that the trainee had reported tying a sheet around his neck earlier. A care plan was formulated but again it was not signed and no named nurse was identified. The plan included a mental health assessment to be carried out by a nurse and by a doctor.

#### **Healthcare Centre - 4 December to 5 December**

The trainee was observed at irregular intervals by day and night. He initially settled down and his morale seemed to improve. He watched television and had a settled night.

The next day, the trainee went to the gym, had association in the hospital and spoke for some time to the chaplain. In the afternoon, he had a visit from his brother, returning to the hospital at 4.45pm and appearing settled. During the evening meal, shortly before 5pm, another trainee threw some rice pudding at him. The trainee remained calm and did not react. Later at 7.40pm he became aggressive because his television set was only receiving one channel. The set was removed from his cell, apparently with his agreement. The trainee then set his sweatshirt alight. From this point his behaviour deteriorated significantly. For nearly 45 minutes he kicked and banged on his cell door and pressed the cell bell. He then removed his notice board and broke the glass in the cell door. The trainee used the glass to scratch his arms superficially. He was placed on report for damaging the observation glass in his cell door. At 9.20pm he went to Ullswater unit.

### **Ullswater Unit - 5 December to 6 December**

Once in Ullswater, the trainee continued to be upset, crying and being wound up, banging his cell door and demanding his tobacco from the hospital. The orderly officer spoke to him shortly before 11pm, after which he calmed down and slept through the night. The next morning, the trainee demanded that staff get him a cigarette from his belongings in the Healthcare Centre. Staff spoke to him and told him that if he stopped shouting and demanding then someone would go and get him his tobacco. A short while later, he was given one of his cigarettes. The investigation team could find no evidence that a Segregation Safety Algorithm had been completed.

The adjudication for the fermenting liquid was heard on 6 December by the in-charge Governor. She found the trainee guilty of the charge and gave him seven days' forfeiture of canteen facilities, association, and tobacco. A further charge was also heard by the Governor. This was in relation to the trainee smashing the observation panel of his cell in the Healthcare Centre on 5 December. The Governor found this charge proved and gave a punishment of seven days removal from unit.

### **Healthcare Centre - 6 December to 14 December**

The trainee was readmitted to the Healthcare Centre at 4.15pm as he was deemed unfit to undergo the punishment of removal from unit at that time. At 7.40pm the registrar wrote, "Says he was stressed out - death of another nephew in family - also says been losing his temper soon - at present talk relevant, good eye contact - guilt feelings re losing his best friend and so on. Denies ideas of self harm."

In the clinical record, the registrar wrote, "History of setting fire to his clothes - one mark on his clothes (neck of jumper) where he attempted hanging - reported following another death in the family, being adjudicated and loss of television, association and canteen for seven days. He said he is losing his temper very soon. Mental state - at present talks relevantly, good eye contact, not depressed, feeling guilty at present, denies ideas of self harm, no psychotic symptoms, cognitive functions intact. History of short temper, mood swings. Advise close observation - tablet carbamazepine 100mg twice daily - review in 2 weeks".

The trainee slept well that night, but the next day his behaviour again deteriorated. At 8.35am on 7 December, he was told that he might not be allowed to attend education in view of the punishment imposed at his adjudication. At this, the trainee threw his stereo equipment against his cell door and tried to set fire to his cell. He later tried to barricade himself inside the cell and made a further attempt to set fire to the cell contents. Despite this behaviour, he was kept in the Healthcare Centre and, at 11.30am, allowed to attend the education department. At lunchtime he mixed with peers. At 3.45pm, he stood on the toilet in his cell in an attempt to remove the sink from the cell wall. He told staff that he could not cope with being locked up 24 hours a day. Staff told him that they were trying to give him some concessions, but that his behaviour did not warrant any more at present. At 4.20pm he spoke for some time to an officer and told him, 'I wish I was dead'. By 8pm the trainee had settled more. Staff had given him some art work to do in his cell and the newspaper to read. He then had an undisturbed night's sleep.

On 8 December, a F2052SH case review was completed at 9.40am. This was attended by two staff nurses and the trainee. The review summary recorded that the trainee had recently been prescribed medication to stabilise his mood, (carbamazepine). It was decided that the F2052SH should remain open. The

support plan laid down that the trainee should be subject to regular and irregular observations, given continuing support by healthcare staff, encouraged to attend therapeutic activities and time to discuss issues of concern. It was also stipulated that his medication should be monitored on a regular basis.

The counsellor had an appointment with the trainee in her diary. At interview, the counsellor said that she did not see the trainee when he was an in-patient. This was usual practice when a young person was in healthcare. It could be that an individual was already experiencing a number of other interventions which would make it inappropriate for a counselling session to take place.

During the remainder of that morning, the trainee was settled and relaxed. However, at lunchtime he and others began to misbehave by throwing margarine around in the Healthcare Centre dining room. At 2.30pm, the trainee once again tried to remove the sink from the wall of his cell out of frustration that he still had no television set. At 6.00pm he ate his evening meal in his cell. At 6.15pm, he asked if he could make a phone call to a member of his family and became abusive when he was told by a nurse that this was not convenient. An entry by the nurse at 8pm said, "Continued to be quite demanding for the rest of the evening wanting to make yet another phone call". The pin phone records indicate that the trainee made one phone call on 8 December at 3.53pm.

At 8.30 the following morning, the trainee told staff that he was frightened about his impending appearance at court the following Monday and that he was hoping his victim would drop the charges. He attended education classes in the morning and spent some time in the afternoon cleaning his cell. At 3.15pm, it was suggested to him that he no longer needed to be in a safer cell and he was relocated to a normal cell in the Healthcare Centre.

At 4.45pm, the trainee became frustrated at having no television set and began to bang on his cell door. Staff explained to him that he could not have his television set back because of the punishment given at the adjudication on 6 December. However, the Governor confirmed that she did not give removal of television as a punishment for either adjudication she heard on 6 December. It seems that the punishment for possessing the fermenting liquid was written up incorrectly in the trainee's history sheet as '7 x no TV, 7 x no association, 7 x no canteen'. In fact, the punishment was seven days no tobacco, not seven days no television. Healthcare staff were therefore unwittingly enforcing an incorrect punishment on the trainee. At 7.30pm, the trainee's mood changed for the worse, as a result of which he was moved back into a safer cell. A nurse wrote in the F2052SH, "...Threw his tea (meal) over a staff nurse. Officers gave assistance - has flooded his cell and pulled notice board off wall. Currently with officers in cell 11 [a safer cell in the Healthcare Centre] in strips [special protective clothing] and still unsettled." The trainee apparently went on to sleep well during the night.

On the morning of 10 December, the trainee came out of his cell chatty, pleasant and co-operative and had breakfast at 8.45. He then spent some time in his cell preparing written work for his education class and appeared to staff to be settled. However, by 11.30 am he was flooding his cell again by blocking the plughole in his sink. He told staff that he was very angry and felt that he was being "stitched up". The trainee admitted that he had a temper problem that got him into trouble both inside prison and out.

At 3.10pm, while writing Christmas cards, the trainee was told that he could have his television set during the evenings if his behaviour continued to be reasonable. A

case review was held at 6.30pm. The review discussed his anger problems because of losing his television and noted that he was due to go to court for sentencing the following Monday (13 December). The trainee was extremely anxious about court due to the seriousness of his offence. It was decided that he would stay in healthcare until after his court appearance and that another assessment would be carried out then. That evening, he got his television back and watched it until after midnight.

Over the next few days the trainee's demeanour continued to improve as a result of the television set being returned to him. He was more cheerful and polite. On the morning of 13 December, he went to the education department and then had a legal visit. At this visit the trainee was told that his case had been deferred until 20 January 2005. The appointment with the counsellor on 13 December did not go ahead due to his being in the Healthcare Centre.

The trainee was seen by the registrar and a charge nurse on 13 December. The registrar wrote, "Biological functions normal. Co-operative, mixing with other inmates, no psychotic symptoms. Management – advice given – continue carbamazepine, continue F2052SH form. Also suggested to find out from normal wing regarding how long he should be away from normal wing. Possible transfer to normal wing 15 December." A nursing entry reported that the trainee was finding carbamazepine helpful. An entry also indicated that a principal officer was trying to get him onto Buttermere unit, but they declined. The trainee spent the evening of 13 December watching television. At 8pm he was seen by the Samaritans as they were doing their rounds of the prison.

Shortly before midday on 14 December, the trainee was seen by a senior psychologist, in response to the request made by a governor on 24 November. The purpose was to assess the trainee's risk of suicide and self injury and to be able to assist with his management via the F2052SH system. The psychologist also attended the F2052SH case review later on 14 December. Her report was structured so as to outline the factors that might protect the trainee from subsequent self injury and suicide attempts (protective factors) and those factors likely to place him at risk of engaging in such behaviour in the future (risk factors).

Whilst exploring protective factors, the trainee talked about gaining employment on leaving prison and was animated about this area, more so than any others. The trainee explained that he had been trained in how to lay block paving and that this area of employment appealed to him. Within the prison environment, he was initially negative, but then he did say he enjoyed the gym and, to some extent, education. The trainee said he had some support from his family but he felt that this was mainly through his siblings. He felt his parents had disowned him, having not spoken to his father, in particular, for some months. The trainee initially said that within prison, he did not know who he would talk to if he had a problem. He went on to say he attended chapel regularly and was able to talk to the chaplain there. He was not able to say who his personal officer was. The trainee had been on new medication for about one week and felt that it was helping him 'relieve his brain' and was beneficial for him.

Risk factors included the trainee's previous attempts at self harm or suicide. Having engaged in such behaviours previously meant he was more likely to do so again in the future. The psychologist wrote that, because the trainee's previous self harm incidents had been impulsive, it might be difficult to predict or foresee when he was likely to engage in such behaviour in the future, and it was therefore difficult to intervene. The trainee was experiencing possible post traumatic stress symptoms

and the heightened emotions from this increased his likelihood of self harm. Her recommendations for managing the trainee in prison were:

- activities to keep him busy, such as gym and education.
- anger management work in order that he could learn more appropriate techniques to manage the angry emotions he felt.
- being supported by continuing to talk to the chaplain and getting to know his personal officer
- contact with in-reach support in order to minimise the potential post traumatic stress symptoms.
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The psychologist summarised by saying that the trainee did not have any thoughts of suicide or self harm at the time of her assessment, but that there were some factors that made him at risk of engaging in such behaviour in the future. She wrote, 'although this would be difficult to predict due to the impulsive nature of his behaviour. The risky time for the trainee in the near future will be the time around his court appearance, for which he is currently feeling very anxious...'

At 3.30pm on 14 December, a F2052SH case review was conducted. Present at this review were a principal officer, the senior psychologist, an officer and a nurse. The trainee was also present. The review summary records that the trainee had "flash back" thoughts about his offence and about the car crash. His mother had not been able to visit him because of the number of children she had to look after. It was the view of the panel that the trainee was least able to cope with these issues when they all flooded into his mind. He was advised to continue to see the counsellor and the chaplain, to continue with the Healthcare Centre education classes each morning for the rest of the week and to use the gym. A particular officer was designated as his personal officer. Another element of the support plan agreed for the trainee was for his personal officer to arrange a visit by his mother. The case summary made no mention of any decision to discharge the trainee to a wing and actually said in the support plan that he should continue with education in the Healthcare Centre for the rest of the week. However, the trainee was transferred to Windermere One at 4pm that day. A healthcare discharge report had already been signed by the registrar on 13 December, the day before the case review took place. The healthcare discharge report refers to CPN (Community Psychiatric Nurse) follow up. There is no record that the trainee was seen by a CPN.

#### **Windermere unit - 14 to 22 December**

The trainee appeared comfortable to be back on Windermere. Staff entries indicate that he unpacked his belongings, made a phone call, had association and then watched television in his cell until falling asleep. The next day he went to education in the morning and gym in the afternoon.

The trainee was sent back from education on 16 December and was agitated about the fact that he might get a 'P' mark or be placed on adjudication but calmed down after an officer spoke to him. In the afternoon, he went to the gym, had association in the evening and then went to bed after watching television. On 17 December, the trainee attended chapel group and then did the usual wing activities in the evening. The next few days passed normally. The F2052SH daily log did not seem to indicate that staff took any real time to talk to him about how he was feeling until an entry by the acting senior officer at 11am on 19 December. This entry stated that the senior officer had had a lengthy chat with him and that he said he was feeling a lot better since being on medication and the visit he had from his brother. On 20 December the trainee went to education in the morning and saw the counsellor in the afternoon. He did his normal activities of education and gym over

the next few days. A principal officer spoke with him on 21 December and commented that he looked visibly better and that he said he was the most settled he has been in prison. She commented that he told her he did not want Lancaster Farms to arrange a visit with his mother as she would see him when he had been sentenced. The principal officer went on to say that the personal officer was working well with the trainee and had organised education to suit his needs. Later that evening, the trainee attended the Christmas carol service in the chapel.

On 22 December, an entry in the continuous medical record mentioned that the trainee attended the discussion group in the chapel and this was mentioned as part of his 2052SH support plan. Records show that he attended the group for vulnerable boys run by the chaplain and an occupational therapist from the mental health in-reach team. The trainee was recorded as attending on 3, 17 and 31 December. His participation did not elicit much, if any, comment from the facilitators.

A F2052SH case review was held on 22 December chaired by a senior officer. The trainee was described as having an 'upbeat attitude' in the review, made eye contact and said that he was much more relaxed. A decision was made to close the F2052SH form. The support plan entailed ongoing support from healthcare staff, attending the chapel discussion group, encouragement for the trainee to discuss any areas of concern with his personal officer, and for him to continue to see the counsellor. The wing observation book asked wing staff to monitor the trainee closely over the festive season.

#### **Windermere - 22 December 2004 to 18 January 2005**

Because the trainee was no longer on the F2052SH system there are fewer written documents about his behaviour and feelings over the next month. He had a visit on 27 December from his brother and another visitor. He received yet another family visit on 3 January. The trainee's wing history record states that he was a quiet young man, difficult to have a conversation with, but that he had said he was happier and had no problems. That entry, dated 28 December, went on to say that staff were aware that he could change quickly and that staff closely monitored him. One officer wrote on 9 January 2005 that the trainee was doing really well and that he had no 'P' marks on the wing since 18 December. The officer went on to say that the trainee very nearly achieved the 'gold' level of the Incentives and Earned Privileges Scheme and that it was only a 'P' mark from education on 5 January that prevented him doing so. The trainee apparently said he was okay with this and that he would try to get onto gold. On 10 January, the trainee saw his counsellor. The next day, the trainee was awarded a 'Gold medal' mark for having completed his Entry Level 2 City & Guilds award in English.

The trainee was seen assaulting another trainee in the education department via CCTV on 14 January. A governor conducted the adjudication the following day. The trainee pleaded guilty to the assault and was given two days loss of association and television, and seven days removal from the wing. This latter punishment was suspended for one month.

The trainee saw his counsellor again on 17 January. She recalled that the hand injury he had sustained in the car crash in which his friend died had been giving him some pain, and that she had asked a nurse to look at it. Later that day, the trainee was placed on governor's adjudication again, this time for refusing to leave a classroom in the education department. The circumstances were that he had been asked to leave the classroom as he allegedly refused to work.

At the ensuing adjudication on 18 January, the trainee said he had been unhappy because he had to work when others were playing games. He said he had finished his work book and had nothing to do. At that point he was asked to leave the classroom. He agreed that he had refused to do so. The adjudicating governor decided that the case against him was proved and imposed loss of television and association for three days. The trainee then went back to Windermere, but was placed on report again after throwing water into the face of an officer at 12:20pm. The trainee said he had done this because he was upset about the adjudication punishment he had just received.

Shortly after, at 12:55pm, the trainee set fire to the bedding in his cell in Windermere Unit. When staff intervened, he refused to leave the cell and was removed using Control and Restraint techniques (C&R). A 'use of force' form was completed. All staff made statements describing how the trainee refused to leave his cell, and the part each of them played in removing him, using only minimum force. The trainee was taken to Ullswater Unit and placed in a special cell where his handcuffs were removed. Staff explained to him that he had to be searched before he could be located in an ordinary cell. The trainee had been a resident in Ullswater on other occasions and he complied with the instructions given to him. Within a few minutes he was placed in cell 11. A nurse saw him in Ullswater and said that he had no injuries. She had seen from a window in the Healthcare Centre that Control and Restraint (C&R) staff were taking someone to Ullswater unit and had attended on her own initiative.

A segregation safety algorithm was raised by the nurse who completed part A. This contained a significant inaccuracy. Section 2 asks the writer to identify whether the person had previously self-harmed. The nurse recorded that the trainee had not. In fact, he had already self-harmed several times. This mistake on the form led to the algorithm following a predictable course towards presumption in favour of safe segregation. Part B, which should have been completed by the duty governor, remained incomplete. Part C, which provides for a decision on appropriateness or otherwise of segregation was not completed. Neither was Part D.

At 8:15 that evening, the trainee damaged the tap in his segregation unit cell. The next morning he told staff that he had done this because he had become unhappy at having no tobacco. Although there were no other reported incidents that night, another juvenile, the occupant of cell 7 in Ullswater Unit, spent a good deal of time shouting to the trainee. At interview, the juvenile admitted that he had shouted "dirty rapist" at the trainee and had made a sustained verbal attack on him. When asked what reason he had to believe that the trainee had committed a sexual offence, the juvenile said that he had been told by "a lad who was being shipped out".

## **9. Events on 19 and 20 January 2005**

On the morning of 19 January, the trainee's property arrived from the wing. He discovered that some of his belongings were missing, including a photograph of his brother. He became angry and started to throw items of property around the cell. An officer spent some time talking to the trainee, but he continued to be agitated.

At about 9:30am, the trainee pressed his cell bell. An officer responded. He asked the trainee to clean up his cell, but the trainee remained angry. The officer talked to him for about a further 15 minutes, after which he agreed to tidy up his cell. The officer told the trainee to make out a list of what he thought was missing so that enquiries could be made after lunch. The trainee agreed to do so and subsequently calmed down.

Later that morning an adjudication was carried out by a governor to deal with the three offences for which the trainee had been placed on report the previous day. The trainee was given seven days removal from the wing for throwing water at an officer. The circumstances were that the trainee had been banging on his cell door. The officer went to see what the matter was. The trainee said that he had been 'stitched up' on the adjudication the previous day and that he was unhappy at losing his television. The officer tried to reason with him, but the trainee had thrown cold water at him. The second charge about the trainee setting fire to his bedding was referred to the police. The third charge was for damaging the tap in his segregation unit cell for which the trainee was given 14 days' stoppage of 50% of his earnings. The adjudication ended at about 10.30am. Afterwards, the trainee returned to cell 11.

A member of staff knew from talking to the trainee that morning that his case was listed for 'mention' in court the next day (20 January). The trainee would not have been taken to court on this occasion.

The trainee took his lunch meal at midday and appeared to be alright. At 12:10pm, he was seen by an officer eating his meal. The officer asked if he was alright. The trainee replied that he was.

A senior officer was on duty in Ullswater during the lunch period. At 12:30pm, as part of his routine observation of those young people located in the unit, the officer looked through the observation panel in the door of the trainee's cell. He saw that the trainee was suspended in a sitting position by a ligature made from his bed sheet. The ligature was anchored to a handle in the cell window. The officer noticed that there was spittle oozing from the trainee's nostrils and could see urine around his groin and on the floor.

The officer shouted to a colleague who was in the unit staff rest room. He and another member of staff who was in the vicinity ran to the cell. Together, they supported the trainee's body weight and untied the ligature from the window. They laid the trainee on the floor of the cell and removed the ligature from his neck. The ligature was described as a rolled up bed sheet. It was easy to loosen from the trainee's neck. At this point, approximately 12:32pm, an officer used his radio to call for medical assistance.

One of the staff in attendance checked to see if the trainee's airway was blocked. He found it clear. He could find no pulse or any sign that the trainee was breathing. He placed a vent aid on the trainee's mouth and commenced cardio-pulmonary resuscitation (CPR). The officer routinely carried a vent aid on his belt as he was first aid trained. The item is not on general issue to other staff. Neither do any staff carry a belt-borne emergency cutting implement, available in some other establishments.

There were some staff in the nurses' office in the Healthcare Centre, located above Ullswater Unit. At about 12:32 they heard the message sent over the radio and four of them ran down to the trainee's cell. They initially took one emergency bag, but one or two went to the outpatients department (on the same floor as Ullswater) within a minute to collect more equipment and drugs. On arrival in the cell, a nurse inserted an airway and applied an ambubag (attached to a portable oxygen cylinder) to the trainee. She could not detect a carotid pulse. Another member of staff continued with artificial respiration while two others assisted with chest compressions. Whilst CPR was in progress, one of the nurses ensured that the oxygen supply from the cylinder to the ambubag was secure, and monitored the trainee's chest movements. The airway was then replaced with one of a larger size to see if this would improve

the trainee's oxygenation. The trainee's head was repositioned slightly to improve airway potency. The ambubag mask was held in place on the trainee's face in order to achieve an optimum seal whilst manual ventilation was applied. This had the effect of improving the trainee's chest expansions. This left one of the nurses free to insert a canula (a tube which allows the administration of drugs into a vein) into the trainee's arm in readiness for the arrival of the paramedic crew. She also made sure that a supply of adrenalin and other drugs was made ready. Although a defibrillator was available in the Healthcare Centre it was not used. It had been bought sometime before 20 January, but no one had been trained in its use. My investigator was told that a defibrillator should only be used to regulate the heartbeat of someone with disordered cardiac activity (fibrillation). It would therefore not have been appropriate to use it to assist in the resuscitation of the trainee, because his heart was not fibrillating.

Meanwhile, a large number of staff and managers had assembled in the unit. They were anxious to ensure that the trainee and the staff were duly supported and cared for.

At 12:33 an ambulance was called. The statements submitted by those staff who were directly involved in the incident record that the ambulance crew arrived at the cell at about 12:50pm. One member of staff checked her watch before the ambulance crew arrived and said to the others 'it's been 15 minutes now'. The Patient Report Form completed by the Lancashire Ambulance Service shows that the call for an ambulance was received at 12:33:41. The same form shows that the ambulance was at the prison gate at 12:38:59. An Operational Support Grade (OSG) was on duty in the gate-lodge at the time. He ensured that both the outer and inner gates at the gate-lodge were opened simultaneously so that the ambulance could drive into the inner compound without delay. He escorted the ambulance via the shortest route to Ullswater Unit, a distance of approximately 100 metres. The ambulance had to pass through two further vehicle gates which the OSG unlocked and then secured as the ambulance passed through. The ambulance crew left their vehicle in a lay-by adjacent to a gate leading to the rear of Ullswater Unit and carried their emergency equipment to the trainee's cell. All the pedestrian gates through which the crew had to pass in Ullswater Unit had already been opened. The OSG estimated that it would have taken no more than two to three minutes for the ambulance crew to travel from the gate-lodge to the cell. This would suggest that the crew arrived at the scene at approximately 12:41, and not at 12:50 as some staff statements suggest. The Communications Room timed video tape-recording of the events at the gate on 19 January was deleted either on the same day or on the following day.

On arrival in the cell, the paramedics administered adrenalin through the canula and applied a cardiac monitor to the trainee's chest. Initially the monitor showed no signs of a heart beat. After a short period, at about 12:50pm, a cardiac output was obtained. The trainee was then transferred to the Accident and Emergency Department of the local hospital, arriving about 1:10pm. He was escorted by an officer and a principal officer.

The Duty Governor of the day informed the Governor of the incident shortly after its occurrence. Once the trainee had been transferred to hospital, the duty governor ordered that the cell should be sealed. No suicide note was found amongst the belongings left in the cell.

At the Accident and Emergency Department it was found that, although the trainee's heart was beating, he was unable to breathe unaided. He was transferred to the

High Dependency Unit where it was planned that he should remain for at least 24 hours under sedation on a life support machine. Thereafter he was to be re-assessed.

During the early part of the afternoon, one of the senior managers at Lancaster Farms was anxious to inform the trainee's next of kin of what had happened. A check was made on the LIDS system (Local Inmate Database), but it was not until it became fully functional that it was established that the trainee's listed next of kin was his brother, for whom no contact telephone number was available. The establishment also wanted to ascertain whether or not the trainee was a 'looked after child' as the vulnerability alert had indicated he was. Contact was therefore made with the trainee's supervising YOT officer to see if further next of kin, or family details were available, as well as to ascertain the trainee's status. The YOT supervisor advised that the trainee's mother was the next of kin and gave her telephone number. The supervisor then telephoned the solicitors representing the trainee in his court case, to advise them not to travel to court the following morning.

The solicitor contacted the prison immediately and said that he was expecting a phone call from the trainee's mother at any time. The prison explained that they were going to contact her after they had checked his cared for status but that if he spoke with her before then, the solicitor should ask her to contact the prison. The trainee's mother did telephone the solicitor and was given the message to get in touch with Lancaster Farms. When she did so, she initially got through to an answer machine. She kept ringing the number she had been given (which was the number for the governor's secretary), and was then put through to the duty governor at about 2.30pm. The trainee's mother thought that this was after some 15 to 20 minutes of her trying. The duty governor told her what had happened to her son. Another governor also spoke to her. The governor told her that the doctor was currently with the trainee and that she would ask the doctor to ring her as soon as he had finished examining the trainee. The doctor subsequently rang the trainee's mother and spoke with her.

About 2:30pm, a post-incident meeting was held in Ullswater Unit for the staff who had been involved. The meeting was chaired by one of the senior managers at Lancaster Farms. The Governor was present at the meeting. Some staff were particularly distressed. Support was offered by the establishment care team. Those who had been very directly involved were not given an opportunity to be debriefed separately. Two members of staff have since received specialist counselling. The other young people in Lancaster Farms who were subject to F2052SH procedures at the time were reviewed and offered support.

The trainee remained in a critical condition. Although his heart continued to beat he could not breathe unaided. An update given to the establishment suggested that there was a strong possibility that he had suffered brain damage. At 3pm a decision was made to reduce the trainee's escort to one officer.

The trainee's parents travelled to be at his bedside, arriving at the hospital about 5pm. They were told that their son was not brain dead, as the prison had thought, but that he had low blood pressure and acid in his blood. The trainee's family stayed with him all night. The Governor and the prison family liaison officer visited the trainee that evening and spent some time with his parents. The chaplain also spent some time in the hospital with them. The parents were critical of Lancaster Farms for not putting their son on a 'full time suicide watch'. The trainee spent the night sedated and on a life support machine in the High Dependency Unit.

The Governor and the prison's family liaison officer visited the hospital at lunchtime on 20 January. The trainee's condition had deteriorated and his brain had begun to swell. Just before 1pm his parents were asked to leave the room and then the trainee died. The trainee's father advised the Governor that he wanted no further contact with her.

## **10. Events after the trainee's death in hospital**

Two of the members of staff who were first on the scene were told of the trainee's death over the telephone at home.

The trainee's father was met at Lancaster Farms by both the Governor and Deputy Governor on 25 January. He was given his son's belongings, including the photograph of his son's brother that had gone missing after his transfer to Ullswater on 18 January. The trainee's father was particularly concerned to recover some items that the family wanted to bury with him. The Governor invited the father into the prison to see the cell but he declined. The Governor offered to assist with the father's travelling expenses but the offer was not taken up.

The trainee was interred after a Roman Catholic funeral service in Durham on 2 February. His funeral was attended by five staff from County Durham Youth Engagement Service, at the request of the family who expressed a wish that no one should attend from Lancaster Farms. Instead, the Governor arranged for a card and flowers to be sent to the funeral directors. She also offered to assist the family with the funeral expenses. This offer was subsequently taken up via correspondence with the family solicitors and Lancaster Farms met the cost in full.

## 11. Consideration of the emergent issues

- **The time lapse between the trainee pleading guilty and the planned sentencing date**

The trainee appeared at Crown Court in October 2004. This was his first appearance following committal. The trainee pleaded guilty to the charge of rape. The court ordered pre-sentence reports and listed the sentence date for the week commencing 29 November. The family solicitor commissioned a psychiatric report. Because the fee would be in excess of £2,000, the solicitor sought permission from the Legal Services Commission to incur such cost and got permission to do so on 4 November. The psychiatric report would not have been prepared by 29 November and so the solicitor asked the court to delay sentencing by two weeks until the week commencing 13 December.

A psychiatrist visited the trainee on 26 November and submitted his report to the solicitor on 7 December. In his report, the psychiatrist stated that he was only able to interview the trainee for one and a half hours in the legal visits area of the prison. The psychiatrist said that he had written to the prison to book the visit asking for a whole afternoon interview and for the interview to take place in the Healthcare Centre. He was most unhappy that the visit he was given did not provide him with the opportunity to do a complete psychiatric history, risk assessment or mental state examination. The psychiatrist's report recommended a further specialist psychiatric review. Lancaster Farms were not able to explain to my investigators why the visit had been arranged to take place in the legal visits area rather than healthcare. It appears to have been an oversight on the part of staff at the prison. Given the potential consequences for the trainee, counsel and the solicitor agreed to seek the permission of the court to carry out this further report and to incur the additional expense.

The court gave permission for this further report and the solicitor duly wrote to a child and adolescent psychiatrist to ask her to carry out the review. That psychiatrist indicated that her fee would be £2,500. The solicitor again sought the agreement of the court and further time to obtain and analyse the report. The court therefore agreed a new date of 20 January.

The child and adolescent psychiatrist visited the trainee on 5 January in the Healthcare Centre. She assessed him for two and a quarter hours in the unit. Her report arrived at the defence solicitor's office on 12 January 2005.

Notwithstanding that delay is never a good thing, given the fact that the stakes were very high and that the trainee might have been facing a lengthy period in custody, the defence team and the court needed all relevant information about him before making a sentencing decision. This time lapse did of course mean that the trainee stayed longer at Lancaster Farms than might otherwise have been the case.

**Lancaster Farms Recommendation 1:** *The governor should remind all staff involved in arranging visits, either legal or medical, of the need to book an appropriate location and allocate enough time for that visit to take place.*

- **The trainee's placement at HMYOI Lancaster Farms**

**The trainee's Initial Placement**

On 6 September 2004, the trainee was received at Lancaster Farms, 85 miles from his home. The distance from his home and family, and the lack of direct transport links between home and Lancaster, may have prohibited his family from visiting the trainee during his time on remand and therefore may have contributed to a feeling of isolation.

The trainee had appeared in a Magistrates' Court on 6 September 2004 charged with rape. The Court required that he be remanded into Prison Service accommodation. In such instances, the placement is made according to court committal directions, that is, according to the geographical area in which the court is located, unless the appropriate Young Offender Institution is full, in which case the young person is diverted to the nearest YOI that has a vacancy. This arrangement is intended to facilitate court appearances for young people, so that they do not have to be escorted long distances to appear in court.

The trainee was on remand for offences that he committed whilst away from his home area. As a result, he appeared in court and was remanded into Prison Service accommodation at Lancaster Farms in the Merseyside area, according to the court committal directions of the Magistrates' Court. The YJB Placements Team did not determine the Prison Service accommodation to which the trainee was initially remanded.

Even though the trainee's placement allocation was not determined by the Youth Justice Board Placements Team, a Secure Facilities Booking form must still be sent to the Placements team with a suggestion for the most appropriate location. A Secure Facilities Booking form was sent to Placements by the Youth Offending team on 6 September 2004, who acted as an appropriate adult for the trainee while he was being questioned by the police. The YOT indicated on the Secure Facilities Booking form that the trainee was vulnerable. The Placements Team faxed a Vulnerability Alert form regarding the trainee on 7 September 2004 citing his risk factors as age, emotional upset, the fact that he was a looked after child (an over-simplification of the facts) and the nature of his offence. This information should have been obtained from an Asset form, an assessment tool utilised by Youth Offending Teams to identify a young person's risk and protective factors through a number of evidence sources. In this instance, the Placements team did not receive an Asset from the YOT until later on 7 September and the Vulnerability Alert form was faxed using information obtained via telephone interview with the trainee's YOT Officer. The Asset form indicated that the trainee was not at risk of self-harm or suicide.

**Lancaster Farms Recommendation 1:** *Where a young person is assessed as vulnerable on a Secure Facilities Booking form, action should be taken immediately by the secure facility to ensure that Asset is obtained. This will enable the secure establishment to fully assess the risk that the young person presents.*

**The trainee's continued placement at Lancaster Farms**

The trainee pleaded guilty in October 2004, but had still not received a sentence at the time of his death in January 2005. The delay in sentencing was outside the control of the YOT, the Placements team and Lancaster Farms.

Recommendations for transfer to a different prison establishment would normally arise from discussions between a YOT and the prison, perhaps in a Remand Planning meeting. No Remand Planning meeting took place for the trainee. A

recommendation for transfer could be made on the grounds of risk or the need to achieve a placement close to home. No application was made to transfer the trainee during his stay at Lancaster Farms. However, it is unlikely that the trainee would have been transferred to an establishment near his home. He needed to be close to Liverpool in order to attend court. The court escort contractors would not have been able to transport him from an establishment such as Castington, nearer his home, to Liverpool in time for a court appearance.

The Head of Juveniles at Lancaster Farms suggested a lack of confidence in the operation of the transfer system by the YJB Placements Team. She reported a sense that transfer applications made on the grounds of discipline would be acted on more readily than a transfer request on the grounds of vulnerability. This was her view, despite a revision of the YJB Placements Policy to ensure that vulnerability concerns would be sufficient to request a transfer.

**YJB Recommendation 1:** *The Youth Justice Board should publish the criteria by which decisions are made to transfer young people in order to increase confidence in the placement transfer process.*

**YJB Recommendation 2:** *The YJB should consider the collation and publication of data regarding the number of transfer requests received and the number actioned on a regular basis.*

### **The trainee's likely placement after sentence**

The trainee was likely to have been transferred after sentencing. In the Placement Report written by the YJB Head of Placements, it is stated that, after sentencing, a young person is usually returned to their original establishment for a short period, in order to minimise disruption in what is accepted as a distressing time. After the young person has adjusted to their sentence, every effort is made to move that young person to a location closer to home.

It is a sad fact that the trainee's placement away from home could well have contributed to his sense of loneliness and isolation from his family. However it would not have been feasible to transport him to his court appearances from establishments closer to his home such as Castington or Wetherby YOI. It was therefore unfortunate, but reasonable, that the trainee was to stay at Lancaster Farms until after sentencing.

### • **The trainee's Remand Planning**

Remand Management has been identified by the Youth Justice Board as one of the Key Elements of Effective Practice. The remand process begins at the point of arrest and decisions made at each stage of the process can impact on whether or not the young person remains in custody until the completion of their case.

The YJB is aware that many YOT's are unable to prioritise remand management within their services and therefore YOT provision will vary widely across England and Wales. YOT's outline to the YJB within their annual YJ Plan any focus they intend to have on remand management services within their local authority.

### **Bail Asset assessment**

The YJB guidance states: "A full assessment using a Bail Asset assessment form should be carried out at a young person's first court appearance to ensure that interventions are appropriate to that young person's risk and protective factors." It is intended to help practitioners identify and collate relevant information into a detailed

picture of a young person's situation, circumstances and history in order that the court can make an informed decision when determining the young person's appropriate bail or remand status.

The trainee committed the offences for which he was remanded while he was away from home. A YOT officer completed a Bail Asset in respect of the trainee. The author made a judgement not to include the Core Asset provided by CDYES as it was several months old (dated 24 November 2003). The author therefore completed the Bail Asset on the basis of what he considered to be current information, including highlighting that the trainee was vulnerable. It also highlighted that he was 'very anxious' and noted, 'CDYES informed me that the trainee discussed self-harm and was referred to CAMHS [Child and Adolescent Mental Health Services] Service in 2003'

However, not including the Core Asset meant that the Bail Asset was only sparsely completed. It would have been preferable for the author to include the information from the Core Asset but to have marked on the Bail Asset that certain information was outdated. Alternatively, the author could have verified that information in the Core Asset was still current by talking to the trainee directly. Unfortunately, page four of the form was not faxed which meant that the name and signature of the author was omitted, as well as the date the form was completed.

**YOT Recommendation 1:** *Bail Asset should be linked to the Core Asset of a young person in order that all relevant information is captured in the former document, especially where a young person is in a court away from their home area. In this way, a comprehensive picture of a young person can be communicated to a judge to enable them to make an informed decision about the remand status of a young person.*

The home YOT responded to this recommendation by saying that they would:

- Introduce appropriate managerial oversight of Bail Assets and Post Court reports completed for all young people remanded into custody. Where issues do arise, they will be addressed with the receiving custodial establishment within 24 hours.
- Further individual mentoring of YOT court staff to reinforce both the Youth Justice Board guidance and the Home YOT's own standards for the completion of Asset forms.

### **Initial Remand Planning meeting**

The National Standards for Youth Justice Services (2004) stipulate at 2.56:

"A planning meeting must be organised by the secure establishment within five working days of arrival. The YOT worker from the home YOT (or a YOT worker seconded to the secure facility, if such arrangements have been agreed) must attend. All relevant parties must also attend this meeting. Parents/carers should be encouraged to attend."

The purpose of the planning meeting is twofold. First, it should determine whether a bail support programme could be offered in application at the next Court hearing. Secondly, a Remand Plan should be developed that will identify a programme of work to address the needs of a young person for the length of their custodial remand period.

In the trainee's case, no remand meeting was organised or took place at Lancaster Farms. An Initial Remand Plan, which focuses on bail applications, should be completed by a YOT remand worker, using as much information as is available, including either meeting or speaking with the YOT officer who has supervised the young person. There was no evidence that such a document had been completed. After the bail applications options have been exhausted, the YOT remand worker must set up a Remand Planning meeting to ensure that the young person's remand programme accurately reflects their individual needs and is agreed by that young person, their parent or carer and the YOT officer. The home YOT is central to the Remand Planning and Review process. YJB guidance and National Standards state that a member of staff from the home YOT, or seconded YOT worker, must attend the planning meeting. Lancaster Farms YOT out-reach team, based at Lancaster Farms, state that they did, on a number of occasions, attempt to contact CDYES to initiate the meeting. It was reported that CDYES declined the request, citing the distance to travel as the problem. Video conferencing was also suggested but declined, because CDYES voiced concerns over the sensitivity of the information that would need to be discussed, given the trainee's offence. Lancaster Farms YOT said that the last request for such a meeting was on 4 January 2005. County Durham Youth Engagement Service do not agree with the version of events given by Lancaster Farms YOT. They state that they have no record of having received an invitation to attend a remand planning meeting and had never refused to attend or said that the distance to travel was a problem. CDYES said the possibility of video conferencing was discussed during one telephone call and that both parties voiced concern over the sensitive nature of what would need to be discussed. A YOT supervisor states they agreed on the telephone that the Lancaster Farms YOT person would enquire of their colleagues as to usual practice and get back to him. The supervisor said he did not hear anything further.

Had such a meeting taken place, it would have given the YOT officer (seconded or home), the trainee's personal officer and the trainee's parents, the opportunity to contribute to a well-informed plan which recognised the trainee's specific needs and the traumatic events he had experienced in his life. It is clear in the trainee's case that the lack of such a plan hindered effective communication. A Remand Planning meeting is vital in addressing a young person's individual needs during their period on remand. It also gives that young person the opportunity to express any anxieties with their YOT officer, with whom they already have an established relationship. Moreover, the young person will feel involved in the process.

However, it is worth noting that preliminary findings from the Youth Justice Board's audit of National Standards in early 2005 show that compliance with Standard 2.56, the facilitation of a Remand Planning meeting within five days of arrival at a secure establishment, is less than 50% in seven out of ten regions in England and Wales, with overall compliance averaging 30.4%. This figure may reflect the difficulty that YOT's and establishments have in working together, sometimes over great distances in such a short time frame. It also reflects real resource difficulties that many YOT's face with remand management planning and the YJB is aware that often a case is not allocated to a YOT until a PSR is requested. There is other evidence that YOT's are reluctant to consider a video-conference remand planning meeting, which the YJB is addressing.

Both CDYES and seconded YOT staff in Lancaster Farms were not proactive in their responsibilities to develop a Remand Plan. The Remand Management Plan could have set targets and milestones regardless of home YOT involvement. However it was the responsibility of both YOT's to ensure that a Remand Plan was completed and both YOT's failed in this respect.

**YJB, CDYES and Lancaster Farms Recommendation 1:** *YJB National Standard 2.56 is the shared responsibility of the home YOT and the establishment.*

- *CDYES should ensure any decision by a supervisor not to attend a remand management meeting is documented and has line management approval.*
- *Lancaster Farms seconded YOT staff should ensure that remand planning meetings go ahead without the involvement of the home YOT supervisor if necessary.*
- *In the absence of attendance from the home YOT, the host YOT should secure all relevant information from the home YOT.*
- *The YJB should consider revision of this National Standard as part of its response to the findings from the National Standards Audit 2005.*

**Ongoing remand management**

After the remand plan has been agreed, National Standards for Youth Justice Services provides at 2.61 that the plan should be reviewed by the YOT officer and the remand worker on a monthly basis or 'where there is a significant change of circumstances'. Where YOT's find difficulty in maintaining this level of contact in person, the YJB expects that an appropriately drawn up plan be presented to line management as part of regular assessment, planning and review processes.

The trainee's YOT officer liaised with seconded YOT staff at Lancaster Farms. Seconded YOT staff were not told when a young person went onto an F2052SH nor any acts of self harm and therefore this information could not be passed onto the YOT officer. I understand that this situation has now been rectified at Lancaster Farms. It would have been better therefore if the YOT officer had relevant contact details for the trainee's personal officer or his unit senior officer or principal officer. This would have enabled meaningful discussions to take place about how the trainee was coping with life in the prison. Over the five month period that the trainee was held on remand at Lancaster Farms, he was visited only once by the YOT officer. This visit, on 22 October, was for the purpose of completing a pre-sentence report, after the trainee had pleaded guilty to his offence.

In the Local Management Report by County Durham Youth Engagement Service, a senior manager for the South of County Durham records: 'At the time of the trainee's remand into custody, staff in South Area (CDYES) were instructed, by their manager, to reduce contact, outside of National Standards, with those young people not considered high risk to the public or high need. This was due to excessive workloads as a result of a high level of staff sickness. Due to being remanded into custody, the trainee was deemed by his supervising officer to be neither a high risk to the public nor high need, as he would be receiving care and support as required.'

The purpose of National Standards for Youth Justice Services is to provide youth justice services with a framework for the delivery of strategic and operational business in order to prevent and reduce further offending and safeguard young people. It is made clear in the introduction to this guidance document that: 'Any departure from these standards as they relate to the delivery of youth justice services needs to be appropriately authorised by the YOT Manager, Governor or Head of establishment and reasons recorded.' The Local Management Board agreed to the derogation of National Standards.

There was a decision by the trainee's YOT supervisor that being remanded into custody reduced both his risk levels and his need for support from sources outside the establishment. This is not always the case. Whilst the YOT supervisor did send some information about the trainee to Lancaster Farms YOT (his last pre-sentence report, Asset document and a psychiatrist's mental health assessment), the expert knowledge that the YOT supervisor had about the trainee and his situation was lost. This was because of the lack of effective communication between appropriate staff in Lancaster Farms and the YOT supervisor.

**YJB recommendation 3:** *The Youth Justice Board should consider the possibility that any derogation from National Standards should be authorised by the relevant YOT Management Board with a clear record of the decision, justification for the decision and an action plan to reinstate the National Standard.*

**County Durham Youth Engagement Services recommendation 1:** *CDYES should consider developing and revising the risk management policies they have, taking into account the YJB's recently published guidance on the management of risk in the community (March 2005).*

**County Durham Youth Engagement Services recommendation 2:** *CDYES should consider planning appropriate training in risk management and assessment, planning and review, to take account of the supervision of young people on remand or in custody.*

**County Durham Youth Engagement Services recommendation 3:** *CDYES should ensure that appropriate information about young people they have worked with is provided to prisons. If the YOT supervisor cannot visit and meet with staff at the prison or attend a remand planning meeting, they should ensure key information is passed by telephone, e-mail or letter.*

The trainee was visited by his supervising YOT officer on 22 October 2004 to complete a pre-sentence report. He was also visited later in November by another member of staff at CDYES to assess his suitability for ISSP. At this meeting, the trainee disclosed the fact that he had self harmed. This information was not shared or discussed with the trainee's supervising officer or with his parents.

**County Durham Youth Engagement Services recommendation 4:** *Staff from CDYES should be reminded of the importance of communicating with each other and of sharing relevant information from their work with young people.*

- **Lancaster Farms' compliance with YJB National Standards and PSO 4950 Regimes for Juveniles**

The Service Level Agreement (SLA) for 2004/5 identified that the Youth Justice Board purchased 130 beds from Lancaster Farms, 58 of which were for those young people on remand. This figure does not include the 120 beds resulting from the Government Street Crime Initiative which is funded directly by the Home Office.

Lancaster Farms had indicated informally to the YJB that they felt the use of Street Crime Beds was stretching their capacity to deliver a full regime to all 250 young people. Lancaster Farms did not however seek any derogation in regard to its SLA responsibilities as they did not want to implement a two-tier system of care, dependent on where the money for each place came from. There are a number of areas of the SLA, PSO 4950 and National Standards for Youth Justice that were not complied with in relation to the trainee. A number of these areas had a significant

bearing upon the trainee whilst on remand. Some of these standards are interlinked with failed responsibilities by CDYES.

### **Parental Contact**

Throughout a young person's stay in a secure establishment, it is crucial that a young person is kept, where appropriate, in regular contact with his family and primary caregivers. It is also stipulated in PSO 4950 and National Standards for Youth Justice that parents should be notified of any significant events which directly affect the young person during their stay in custody. Examples are:

- Periods of time in which the trainee was admitted into Healthcare
- Attempts of self harm
- Periods when the trainee was subject to F2052SH and reasons why they were opened and closed
- Notification that the trainee had been prescribed Carbamazepine (Carbamazepine is primarily a medication used for epilepsy, however in this case it was used as a mood stabiliser)
- Time spent on Ullswater in Care and Separation

It was clear from my colleagues' meeting with the trainee's parents that knowledge of how their son was struggling to cope with custody would have prompted a family visit to make sure that he was safe. (This was a family bereaved of an older son through suicide only three years prior). Recommendations relating to this area are detailed in the personal officer section of the report.

### **Time Out of Cell**

National Standards for Youth Justice state that, as a minimum, a young person must be given the opportunity for fresh air for at least one hour a day. The Ombudsman's investigation found evidence that there were periods when this standard may not have been met, for example, on Ullswater Unit.

### **Record Management**

It is stipulated in National Standards for Youth Justice that clear records must be kept of any work undertaken with a young person. The investigators found that the personal history file for the trainee was not completed on a frequent basis, often leaving several days between each entry. The result is that anyone reading his file would not be able to gain a clear overview of his care, and any particular issues that would increase his vulnerability. Whilst he was subject to F2052SH arrangements, staff did complete daily logs, but there was no crossover between these and the trainee's wing history sheet.

**Lancaster Farms recommendation 3:** *The Governor should encourage unit staff, and personal officers in particular, to complete frequent entries about each young person.*

### **Home YOT Visits**

National Standard 2.60 states that it is the responsibility of the home YOT manager to ensure that a young person under their supervision is visited at least monthly in the secure facility where they are placed.

The trainee's supervising officer visited him on 22 October. The purpose of this visit was to complete his pre-sentence report. The visit lasted just over an hour and took place in the legal visits area. My investigators were told that it was more usual for YOT supervisor visits to take place on the residential units. It is not clear why this

was not facilitated. The supervising officer did not talk to the staff closely involved in looking after the trainee such as his personal officer or unit manager but he did talk to the staff who took him to the legal visits area. The supervising officer described these staff as 'knowledgeable about the trainee'. The only information of note passed to him was that the trainee had been getting into many fights and that he was known as a 'fighter' by staff. In fact on 22 October, the trainee had only been involved in one fight, earlier that month. This is clearly not as satisfactory as a meaningful discussion with staff who knew him properly.

YJB National Standard 2.63 states, 'When a young person has been convicted and a report ordered, there must be a discussion or meeting between the report writer and secure establishment staff. This will ensure that the PSR reflects the progress made by the young person whilst on remand and assist in formulating the proposal in the report...' It is clear that CDYES did not meet the spirit of this YJB Standard during the 22 October visit.

The only entry in wing records regarding CDYES was on 9 November 2004. An officer wrote, "The trainee had a special visit today from his YOT worker. He has told him he will very likely receive a custodial sentence as he does not fit the criteria for ISSP. YOT worker wants us to know this information as he felt the trainee did not cope well when given this information". This entry refers to the visit made by CDYES. During this visit, the trainee disclosed that he had self harmed whilst at Lancaster Farms. This information was not passed onto CDYES or the trainee's parents, as already noted.

No home YOT visits took place in December or January. The failure to visit the trainee links back to the failure to facilitate his remand plan and is a breach of National Standards.

**County Durham Youth Engagement Services recommendation 5:** *CDYES should remind all supervisors writing pre-sentence reports on those held in custody to talk to or meet with appropriate staff (for example, the personal officer or unit manager) in the prison or secure training centre who look after the young person.*

- **Incentives and Earned Privileges Scheme**

HM Chief Inspector of Prisons carried out a full inspection of Lancaster Farms in January 2004. In her report, reference is made to the Incentives and Earned Privileges Scheme launched during 2003 (IEP 2003). There was praise for the scheme stating that 'there was a good system for awarding and taking away marks from individual young people and most of those to whom we spoke felt that the scheme was both fair and having a positive effect.' However, HM Chief Inspector's report went on to say, 'A revised procedure for imposing sanctions had been developed and integrated into the scheme. This devolved responsibility for deciding on and imposing sanctions for misbehaviour to wing senior officers, which was inappropriate. Some of the sanctions were as severe as punishments after adjudication: for example, removal of association for up to one week, removal of television for the same length of time and fines. While we appreciated the importance of the immediacy of sanctions, this amounted, in effect, to informal punishments without appropriate safeguards.' The investigation team agree with HM Chief Inspector. We were told by a member of staff that sometimes the decision about a sanction, such as loss of television for one night, would be taken by officers.

The proper channel for rule infringements that do not amount to a full governor's adjudication is the Minor Report system. Trained principal officers (PO's) are

permitted to carry out Minor Reports in accordance with the Prison Discipline Manual. Minor Reports are a 'mini' adjudication. The young person is charged with a specific offence, they are permitted to plead guilty or not guilty and to call witnesses in their defence. Once the PO is satisfied that they have heard all relevant evidence they will make a judgement about whether the charge is proven. If the person is found guilty, the PO can impose punishments such as forfeiture of television, association or gym up to a maximum of three days. Lancaster Farms did not run a Minor Report system on the juvenile units in 2004. The scheme was introduced on 24 January 2005, after the trainee had died. All of the trainee's wing sanctions were therefore imposed under the IEP 2003 scheme.

Lancaster Farms produced a paper about a new Incentives and Earned Privileges on 1 October 2004 (IEP 2004 - 05). This new scheme does not permit a senior officer to impose 'unofficial sanctions'. Movement between levels is determined by the number of negative 'P' marks and positive 'G' marks over a time period. Wing senior officers review all files weekly. The revised policy looks comprehensive and well structured. IEP 2004 - 05 states that YOT supervisors and family will be informed if a young person is demoted to red level, the lowest level of privilege. It is not clear whose duty it is to inform these parties. Although details of this new scheme were in circulation from October 2004, it was not actually introduced onto the juvenile units until 24 January 2005. It was not therefore in place during the trainee's time in Lancaster Farms.

An entry in the trainee's history sheet on 16 November indicates that the smashed locker and spy glass for which he received a punishment of seven days no association, no canteen and no earnings at an adjudication the next day, was triggered by the sanction of one night's loss of television and association given for kicking his door on 15 November.

The trainee had imposed on him the following sanctions on his association time and television during his time at Lancaster Farms. These sanctions flowed from both the operation of the IEP scheme and from punishments imposed by the Governor at adjudications.

Date	Sanction	Reason
12 September	1 LOA (loss of association)	pressed cell bell and kicked door
13 September	caution	in bed at breakfast
20 September	1 LOA 1 no television	argumentative on return from gym
27 September	1 LOA	in bed at breakfast unlock
27 September	1 LOA	poor cell cleanliness – spit in toilet
3 October	1 LOA	late behind door at lock up
<i>8 October Governor's adjudication punishment including 5 LOA and 7 no television</i>		
21 October	1 no television	in bed at unlock & watching television
<i>25 October Governor's adjudication punishment including 7 LOA and 7 no television</i>		
<i>27 October Governor's adjudication punishment including 7 LOA and 7 no television</i>		
15 November	1 LOA 1 no television	pressing cell bell and then kicking door
16 November	1 LOA 1 no television	kicking cell door
<i>17 November Governor's adjudication 7 No television (rescinded) and 7 LOA</i>		
<i>24 November Governor's adjudication 4 LOA</i>		
1 December	1 LOA	ignored staff when told to go to his

		door
5 December	7 LOA (loss of association)	Found in possession of fermenting liquid
<i>15 January Governor's adjudication 2 LOA</i>		
<i>18 January Governor's adjudication 3 LOA and 3 no television</i>		

	Number of days with no association	Number of days with no television
9 September to 19 January (IEP 2003)	8	4
Governor's adjudication awards	42	24
Total days of loss	50	28
Number of days the trainee was in custody	133	133
Percentage of time without	37%	21%

- **The disallowed visit request for the trainee's nieces**

On 13 September 2004, the trainee applied to be visited by his two nieces who were, at the time, aged 3 and 4. These nieces lived with and were being raised by the trainee's parents as the children's mother had died in a car crash. The trainee was close to his nieces and they were, in effect, part of his immediate family.

The trainee was classified as a Schedule One offender because of the fact that his offence was against a 17 year old (regarded as a child). Any application for contact with children had therefore to be scrutinised in keeping with the provisions of the Child Contact section of the Public Protection Manual and PSO 4400. These provisions require that trainees who present a risk to children do not have any contact with children prior to the completion of a full risk assessment. They also make clear that contact with children will only include contact with the trainee's own immediate family or own children.

Between 13 September and 27 October 2004, soundings were taken from the Healthcare Centre, the trainee's personal officer, a psychologist, and from the trainee's YOT supervisor. No opinions were expressed by any of the internal departments consulted as to the risk to children the trainee presented. The response from the YOT supervisor said there was no evidence, factual or unfactual that the trainee posed a risk of 'significant harm' to children. He said he therefore had no concerns, but advised caution and suggested that any contact should be supervised. The supervisor was not clear that the nieces were living with the trainee's parents at that time. On 28 October, a Public Protection Committee meeting discussed the trainee's application. The meeting did not know that his nieces were living with the trainee's mother. No address for the nieces had been written by the trainee on his application form and the YOT supervisor had not indicated in his letter that the nieces were living with the trainee's parents. The Committee therefore refused the visit on the grounds that the application did not meet the criteria laid down in the PSO and that there did not appear to be any exceptional circumstances to allow the visit to go ahead.

The chair of the Committee completed the appropriate form and asked unit staff to tell the trainee that his application for the visit had been refused. The form (incorrectly dated) indicated that the decision could be appealed using the Request

and Complaints Procedure. It is not clear whether the reasons for the refusal were explained to him verbally. The locally produced form 'Child Visitors Declined by Governor' does not include any space for the Governor to write the reasons for the refusal.

The consequence of the decision was that the trainee's mother was unable to visit him in Lancaster Farms as she was the full time carer of the nieces. It is unfortunate that the full facts were not brought to light, prior to the Public Protection Committee meeting.

**Lancaster Farms recommendation 4** - *The Governor should remind managers that decisions in relation to Child Protection issues are to be made after as full a risk assessment as possible. The impact of not permitting visits to take place must be factored carefully into this assessment. Decisions to reject an application should be explained to the trainee verbally and in writing.*

- **Psychology report on the trainee**

The governor who was the Deputy Head of Resettlement carried out an adjudication on 24 November. The trainee had been charged with possessing an unauthorised article, namely a razor blade. The governor explained that the trainee had been very withdrawn and uncommunicative during the adjudication. She told my investigator that he would not keep eye contact with her and would not explain why he had kept the razor blade. The governor had not met him before, but felt that his behaviour was concerning enough to ask for an assessment to be done by the psychology department. Her intention was to use the report to guide the prison in the appropriate management of the trainee, particularly in relation to self harm prevention.

A senior psychologist carried out an assessment. The key points have been covered earlier in this report. The assessment recommended appropriate steps that could be taken in order to try to help the trainee cope with his period in custody. Unfortunately, none of the recommendations were given due heed and acted upon by the prison. The governor did not see a copy of the assessment and it is unclear who actually read the report, much less who acted on it. The Safer Custody PO did not recall having read it. It would seem that there is no system in place to ensure that findings and recommendations from such assessments are taken into account in the management of a particular young person.

The closing paragraph in the assessment states that the trainee possessed 'some factors that would indicate he is at risk of engaging in such (self harming or suicidal) behaviour in the future, although this would be difficult to predict due to the impulsive nature of his behaviour. The risky time for the trainee in the near future will be the time around his court appearance, for which he is currently feeling very anxious'.

I am saddened that there was no mechanism in place to act on the information and recommendations contained in her report. The trainee was found hanging the day before his court appearance at which he was due for sentencing. I have made a recommendation concerning this issue within the next section of this report.

- **Self Harm and Suicide Prevention Policy & Procedures**

Lancaster Farms has a comprehensive policy concerning the management of self harm and suicide prevention. It covers the specific responsibilities of certain groups of staff in the prison.

PSO 4950 'Regimes for Juveniles' states at para. 5.43, 'Governors must make arrangements which promote the positive contact and involvement of the families of the young people where appropriate and ensure that information is passed to families on each of the following occasions: significant events such as illness, self harm or transfer.'

Lancaster Farms' statement of policy on suicide and self harm states, 'After consultation with the trainee, the nominated next of kin must be notified' and 'where appropriate, after serious incidents of self harm, consideration should be given to allowing the trainee themselves the opportunity to notify the next of kin by a phone call and/or extra exceptional visit'.

The trainee's parents were not informed of any of the acts of self harm that he made whilst in Lancaster Farms. The trainee's supervising YOT officer was not informed either.

The Suicide Prevention Team meets bi-monthly and has a multi-disciplinary membership and includes a representative from the Samaritans. There are no young offenders or juveniles on the team, which may in large part be due to the fact that there is no peer support scheme operating at Lancaster Farms. The team reviews those young people who are deemed to be at risk. The trainee is mentioned in the minutes of the meeting that took place on 16 December. At each meeting the team also look at the audit compliance mark, first night care, child protection and training matters.

#### **The application of F2052SH procedures in relation to the trainee**

The trainee had four periods of monitoring via the F2052SH system. The detail of these forms has already been covered earlier. After the trainee's self harm attempt on 12 September an F213SH should have been completed by staff, but none was done.

The trainee's reviews were carried out at appropriate times and generally consisted of at least a senior officer, a nurse and the trainee himself. The quality of daily entries was variable, but often demonstrated a genuine level of interaction and interest in how the trainee was coping and feeling.

The case review outcomes suggested appropriate support for the trainee. However, there were several occasions when the 'support plan' remained only as a plan. On 24 September, the case review support plan asked a member of healthcare to arrange for the trainee to see a Community Psychiatric Nurse (CPN), but there is no entry in the trainee's medical records to indicate that he saw a CPN. On 30 October, the plan included a commitment for a member of healthcare to contact the YOT supervisor in order to arrange a visit. This was not followed through. This case review also stated that wing staff would attend the trainee's discharge meeting from the hospital. No one from the wing attended. On 14 December, the support plan stated that the trainee would continue to go to education in the Healthcare Centre for the rest of the week, but the next day he was transferred to a wing.

The very significant assessment report written about the trainee by the psychologist was not appropriately acted upon within the prison.

#### **The general application of F2052SH procedures**

On the day that the trainee was found hanging, there were five trainees subject to open F2052SH booklets in the prison. On 19 December 2004, there were seven and on 19 November there were six.

In the month prior to the investigation team's visit, 24 new F2052SH booklets had been opened, nine booklets had been closed on young people deemed not to be at risk any longer and two young people had been transferred out of the prison.

We analysed all records of self harm attempts by young people in December 2004 and January 2005. In December, there were three incidents of young people cutting themselves. Two were already being monitored under the F2052SH procedures and a booklet was correctly opened on the third young person. In January, there were five incidents of self harm, four cuttings and one attempted strangulation. Three of the incidents were by one trainee. This young man was being cared for in the Healthcare Centre. An F2052SH booklet was correctly opened in the case of a young person who self harmed whilst on the induction unit, Buttermere. The other trainee was already being given support via the suicide and self harm prevention procedures.

One of my investigators attended an F2052SH case review in order to observe the process. The trainee was living in the Healthcare Centre at the time. He was a young man charged with a sex offence. He had been bullied and was fearful of his impending trial because he anticipated that he would receive a long sentence. The case review was attended by a multi-disciplinary team, including a member of staff from the unit where it was hoped the young person would go after leaving healthcare. The purpose of the review was explained to the trainee and he took an active part in the proceedings. The team agreed that the aim was to gradually move towards the trainee returning to a unit, gaining confidence in the staff and the regime step by step. My investigator thought that the style, structure and purpose of the review was impressive. His only suggestion was that the young person could have been given more notice of the intended review, as he had arrived a little unprepared for the discussion.

One of my investigators reviewed eight open F2052SH booklets at the time of this investigation in order to assess appropriateness of the support offered and compliance with laid down procedures. The quality of reviews and observations recorded by staff were generally good. Regular management checks were evidenced. However, some of the case reviews were not multi-disciplinary, for example, when someone was in the Healthcare Centre. My investigator did not follow through individual support plans to see if they had been actioned.

During the weekend prior to the investigation team arriving at Lancaster Farms, a young person had made a serious attempt to hang himself in the shower area of the Healthcare Centre. A vigilant member of staff arrived in time and the young person did not lose consciousness. After this incident, the trainee was put onto a constant watch, whereby a member of staff sat outside his cell 24 hours a day. A multi-disciplinary meeting was held a few days later in order to talk about what had happened, and what might be done to support the young man through this crisis period. The outcome was that the young man was moved to an establishment closer to where his mother lived. This would enable her to visit him more regularly. The support and action taken by staff at all levels demonstrated care and concern. There was a clear commitment to listen to the young person and to act to improve the situation he was faced with.

My impression is that Lancaster Farms has an active suicide and self harm prevention system. Those identified as being at risk of suicide or self harm are put onto the monitoring procedures and have their needs individually assessed. Multi-disciplinary reviews decide on appropriate support plans. The care and concern of staff is genuine. However, I think there are two areas that could and should be

improved upon. The first concerns communication between different departments within the prison and follow up of support plan entries. The second concerns communication with those outside the prison such as family and youth offending teams.

*Lancaster Farms recommendation 5 – The Governor should oversee a review into the suicide and self harm prevention procedures at Lancaster Farms.*

*The review should include:*

- *measures to ensure that those people with parental responsibility and the YOT supervisor are informed of significant events such as a young person going onto the ACCT system and acts of self harm.*
- *measures to ensure an F213SH is completed whenever a young person self harms.*
- *measures to ensure that support plans are communicated to relevant staff in the prison and that commitments in support plans are followed through.*
- *measures to ensure that specialist assessments and reports regarding young people deemed to be at risk of suicide or self harm are communicated to an appropriate manager in order that the learning and recommendations from such reviews are acted upon and monitored.*
- *measures to ensure that prior to a case review, each young person feels that they have had sufficient notice of the meeting.*
- *consideration of whether to re-introduce a peer support scheme and to include trainee representation on the Suicide Prevention Team (repeat of recommendation stemming from an earlier investigation)*

I understand that Lancaster Farms is now running the ACCT (Assessment Care in Custody and Teamwork) procedures for those who are deemed to be at risk of suicide or self harm.

#### • **Personal Officer Scheme**

One of the recommendations from the investigation into the previous death in custody at Lancaster Farms was that ‘the Personal Officer Scheme should be reviewed to ensure: (a) staff are aware of their responsibilities (b) staff are appropriately trained (c) wing files contain a record of meaningful staff / trainee engagements.’ An update report from the prison (dated 8 February 2005) stated that the Personal Officer Scheme had been reviewed, that staff were aware of their responsibilities, and that they had the tools to ensure all parts of the Personal Officer package are delivered.

The Personal Officer Scheme was considered again during this investigation. Whilst the scheme was re-launched using a ‘colour coded’ Personal Officer identification system, my investigators found that young people were not always aware of the role of their personal officer, nor that they had regular or meaningful discussions with their nominated member of staff. The trainee told the psychologist during his assessment in December that he did not know who his personal officer was.

A general observation of my investigators was that staff referred to young people by their surname alone. This is poor and inappropriate practice that has been discouraged by both the YJB and Prison Service for some time.

Wing staff had been reminded that one of their duties as a personal officer was to complete ‘detailed, good quality comments’ in young people’s wing history sheets.

My investigator was not given any other documents detailing the role or expectations of a personal officer however. Some key work that could logically fall to personal officers was therefore not being done. This includes the responsibility to keep young people's families and their YOT supervisor informed of key events. A sheet detailing the relevant family and supervising YOT officer telephone number for each young person could be attached to the front cover of the wing history sheet. This would ensure personal officers had ready availability of the contact numbers they need to carry out their role fully. Personal officers should be the key link between a young person in custody and their family and YOT in their home area. It should be common practice for dialogue to take place. It would also help to ensure that the prison, via the personal officer, were aware of family circumstances and culture. The fact that the trainee was from a travelling culture was not demonstrably taken into account by the way that staff at the prison dealt with him.

I am therefore recommending a further revision of the Personal Officer Scheme.

**Lancaster Farms recommendation 6:** *The Governor should oversee a further review of the Personal Officer Scheme. This review should clearly state the role of a Personal Officer. It should also identify a system to ensure that YOT supervisors and families of young people are appropriately informed about incidents and events that occur whilst the person is in custody in line with YJB National Standards and PSO 4950. The new scheme should promote general dialogue between the prison and the family of the young person so that their particular circumstances and culture can be better understood.*

- **Child Protection Procedures**

Lancaster Farms have Child Protection arrangements in place which have been agreed by the local social services department. The policy includes definitions of a child in need and covers both physical and emotional abuse or neglect. The policy goes on to inform the reader that child protection issues can be recognised by both a direct statement from the young person or from indirect statements. Examples of abuse given include verbal abuse, bullying, sexual abuse and physical abuse. Staff are told clearly in the document to report any concerns about the welfare of a young person at Lancaster Farms immediately to the duty governor or child protection co-ordinator. A decision can then be taken about making a referral to the local authority social services department.

The criteria for referrals to Lancaster social services or the police are laid out in the policy document.

- A referral should be made (to the home social services department) where there has been a disclosure around historical abuse.
- Where an allegation of abuse has been made against another young person at the prison, the duty governor must carefully consider whether the incident could be considered to be 'normal childhood behaviour or sexual exploration' or 'sexual or physical assault or intimidation which is abusive and which should invoke Child Protection measures'. The guidance goes on to say that incidents of assault and serious or persistent bullying should be the subject of Child Protection Procedures.
- Where an allegation of abuse has been made against a member of staff, the governor should decide whether the alleged incident might

represent acceptable professional behaviour, unacceptable professional behaviour or abusive behaviour and act appropriately.

As far as my investigation team are aware, the trainee did not report any form of historical abuse or abuse by members of staff at the prison whilst in Lancaster Farms. The trainee did have some fights with other young people in the prison and made one report about being bullied to PE staff. This latter report was appropriately handled by the prison and anti-bullying procedures were implemented. Although the trainee was involved in some fights with other young people, I do not think that the fights would fall into the category of 'serious or persistent bullying'. The fights were not with the same young person and it is generally unclear which person started the fight. I do not think that either the fights or the one report of bullying should have invoked a referral under the Child Protection Procedures.

- **Ullswater Unit**

**Purpose**

Ullswater Unit is set up as a 'separation and care' facility. Its function is twofold. First, the accommodation and staff within it combine to provide a skilled resource which assists in the care and management of trainees who, by reason of being disturbed or disruptive, are unable to remain within the mainstream units. Intensive work can be done, and specialist resources can be used in order to assist trainees to return to their units. This facility has fallen into disrepair and has not been used for some time. The Governor hopes to reinstate the programme when it becomes possible. Secondly, Ullswater unit serves as a segregation unit. In fulfilling this role, it holds those who are sent there as a result of the adjudication punishment called 'removal from unit', for their own protection, and those it is deemed necessary to separate to preserve the good order of the prison.

**Layout**

There are 12 ordinary cells within the Unit and one cell is designed for trainees who might hurt themselves or others if they were to be located in an ordinary cell. This cell is hardly ever used. Between September and December 2004 the average trainee occupancy in Ullswater was five. An average of nine adjudications each day took place during the same period.

The Unit is well decorated, clean and bright. Facilities are good and the environment, although built as a traditional prison wing, has a good atmosphere.

**Working arrangements**

The Unit is run by a special staff team, of about ten. They manage the care of the trainees located there, and they are responsible for the administration of the adjudication process which takes up a significant part of the working day. A senior officer is team leader on each working shift. A principal officer, as part of wider duties, has a supervisory role, as does a unit governor. The governing Governor makes regular visits.

We were able to interview all staff within the Unit, and to observe their work. We were favourably impressed by their level of commitment, and the way they went about their work. They showed obvious care for their charges, and demonstrated good humour and forbearance in circumstances which were often testing and difficult.

## **Regime**

The regime, set up to provide a dynamic environment for trainees, falls far short of its targets. Exercise is cancelled regularly, association is non-existent and access to education, physical education and television is severely limited. We checked records over nearly five months and found that exercise was either cancelled or not recorded as being provided for 49% of the time. Education, although a regular feature, accounted for only a small number of those housed in Ullswater. Removal from unit is a punishment meant to facilitate activity and near-normal life. In practice, it usually amounted to cellular confinement, trainees spending almost all their time in cell with little or no activity taking place. Physical education was available only on weekend days, and did not take place on some of these. As with education, when PE was available, records showed a limited take up, and it was unclear who had not been allowed to use the gymnasium and who had decided not to take up an opportunity which had been offered. We understand a small gymnasium within the Unit had been used in the past, but not for some time.

The general provision for young people punished by removal from unit, or segregated for their own protection fell well below the standards laid down by the Prison Service.

Record keeping was poor, and events, particularly those relating to trainee activity were either not completed properly or not completed at all. There were some days when records had not been kept. Even fundamental records in respect of who had been located in Ullswater Unit had not been completed. Management checks on activity were poor.

My investigators were told all the way up the line that the person below them 'always checked' the levels and appropriateness of the activity in Ullswater.

## **Issues pertaining particularly to the trainee**

A governor carried out an adjudication on the trainee for possessing an unauthorised article, a razor, during the afternoon of 24 November. The governor was so concerned about the trainee's demeanour during the adjudication that she asked the psychology department to carry out an assessment of his risk of suicide and self injury. She went on to give him a punishment of four days loss of association and the loss of his television for four days (suspended for one month). I am surprised that the trainee was charged with any offence and by the punishment of more time apart from staff and trainees. The trainee was on a suicide and self harm watch at this time, had indicated that he might have kept the razor in order to self harm, and was very withdrawn during the adjudication. A self harm case conference exploring why he had kept the razor and a decision to supervise his use of razors in future would have been more appropriate.

Two safety algorithms had been completed on the trainee dated 17 November 2004 and 18 January 2005. Both were incomplete. The investigation team could not find any segregation safety algorithms for when the trainee was in Ullswater unit on 26 October or 5 December. The one relating to the trainee's admission on 18 January was inaccurate, describing him as not previously having self-harmed when it is known that he had self-harmed previously several times. Only the first part of the form, which is set out in five parts, had been completed. The combination of inaccuracy and omission represents a serious failure by Lancaster Farms staff to perform a fundamental duty.

It was clear to my investigators that trainee A had enjoyed giving the trainee who died a hard time during the evening of 18 January. They found startling and regrettable his lack of remorse. It is unclear what impact this verbal bullying had on

the trainee's state of mind. It is reasonable to assume, though, that he would have been upset at the fact that another trainee knew why he was in custody. Up until that point, the trainee had successfully concealed his actual offence from the other trainees on Windermere.

This was the view of the trainee's personal officer and was confirmed by three other trainees whom the investigation team spoke with. They had all known the trainee quite well on Windermere and used to socialise with him, but none knew the offence he was awaiting sentence for. The trainee might have been concerned about returning to Windermere in case the other trainees had become aware of his offence.

**Lancaster Farms recommendation 7** – *Procedures, record keeping and management oversight of Ullswater Unit should be improved:*

- *emphasis should be given to correct completion of Segregation Safety Algorithms*
- *statutory functions such as exercise must be discharged*
- *activity levels should be improved to at least the minimum standards laid down in PSO 4950 and especially in relation to the amount of time young people are allowed out of their cells.*
- *managers should check records and note any regulatory action they have taken*
- *Ullswater Unit care programme should be reinstated and the gymnasium brought back into use*
- *the Independent Monitoring Board must be notified of the use of Special Accommodation*

**Lancaster Farms recommendation 8** – *The Governor should remind managers to ensure that young people are not over-charged with offences against prison discipline and that in determining punishments, governors take into account the individual circumstances of the young person including mental health issues and their level of vulnerability.*

**Lancaster Farms recommendation 9** – *The Governor should remind healthcare staff to attend all incidents where Control & Restraint techniques are used, both planned and spontaneous incidents.*

**Prison Service recommendation 1** *The Prison Service should provide clear guidance on the use of 'Removal from unit', detailing what this punishment entails. The guidance should ensure that the punishment does not amount to cellular confinement by another name.*

• **The prison response to discovering the trainee on 19 January**

The response of staff when they discovered the trainee hanging was quick and entirely appropriate. A senior officer summoned the assistance of colleagues immediately and there was no delay in entering the trainee's cell. The medical response was especially fast because healthcare is in the same building as Ullswater Unit. An officer, who was first aid trained, used his own vent aid on the trainee's mouth and commenced cardio-pulmonary resuscitation (CPR) as soon as possible. Vent aids are not on general issue to other staff. I think the governor should give consideration to issuing all staff with a vent aid that they can carry in a pack on their belts. Staff do not carry a belt-borne emergency cutting implement either. Although this did not hinder the trainee being brought down from the window, I think the governor should consider whether a cutting blade (such as a fish knife) should be carried by staff carrying out wing patrols.

Some nursing staff returned to the healthcare department to get more equipment and none of the staff had been trained to use the available defibrillator machine. Two recommendations in relation to this area have been included in the healthcare section of this report.

The ambulance was called for and arrived quickly. There was no delay in the ambulance reaching Ullswater. The communications room timed video-tape recording of the arrival and departure of the ambulance via the main prison gate was deleted as part of the daily routines either on 19 January or following day. Good practice would be for such tapes to be kept and sealed so that times could be verified.

When the ambulance left Lancaster Farms, the trainee had a pulse and was breathing with assistance. One of the officers should be particularly commended for his efforts to resuscitate the trainee.

Some of the staff who had been involved in the attempts to resuscitate the trainee felt that too many other staff had arrived in Ullswater, without an appropriate reason to be there. There was no control of staff entry into and out of Ullswater. It was also felt that a smaller debrief involving those who had directly been involved in the efforts to resuscitate the trainee would have been welcomed, after the main staff meeting. However, the staff did feel supported by the care team and the Governor in particular, and felt able to request further help if they needed it.

The trainee's parents were distressed at the manner in which they were told of what had happened to their son on 19 January. Given the difficulty the prison staff had in tracing them, and having regard to the trainee providing details of his brother's telephone number (which was not available when prison staff tried to phone him), I think staff did what they could in the circumstances. It was nevertheless upsetting for the parents to find out in the way they did. Contacting the YOT supervisor was a sensible way of obtaining the parents' telephone number. However, the prison should then have contacted them without any further delay, instead of waiting for an update from the hospital or further information about the family situation.

Although in most circumstances I think the responsibility should rest with the prison and not the police, Lancaster Farms could also have chosen to contact the police in the trainee's home area and asked them to break the news to the trainee's parents by way of a home visit.

**Prison Service recommendation 2** - *The Prison Service should consider requiring Governors to ask trainees and young people on reception for a 'back up' name, address and telephone number, in the event that the preferred person is uncontactable. Governors should also be asked to check periodically that next of kin details given at first reception are still correct.*

**Lancaster Farms recommendation 10** - *The Governor should consider issuing vent aids and cut down equipment to be worn on staff belts.*

**Lancaster Farms recommendation 11** – *The Governor should review post incident procedures for a death in custody. Consideration should be given to appointing a scene area controller and having a key group de-brief separate from the main de-brief.*

**Lancaster Farms recommendation 12** – *The Governor should review arrangements to ensure that the family or next of kin of a person who has made a*

*serious self harm attempt, or who has died in custody, are contacted by the prison or police as quickly as possible.*

**Lancaster Farms housekeeping point a** - *The Governor should ensure that video recordings of significant events or incidents are kept until after any investigation has been concluded.*

**Good practice** – *The immediate response and appropriate actions of Ullswater and healthcare staff upon discovering the trainee.*

- **Healthcare at Lancaster Farms**

Lancaster Farms has a type 3 healthcare facility which means it provides primary care and has inpatient beds and is staffed 24 hours a day. There are 14 in-patient beds. The ward and primary care function separately, although within the same building. All health care workers at Lancaster Farms are registered nurses - there are no health care officers or health care assistants. There are 19 whole time equivalent nursing posts and three nurse practitioners in training. The health care manager and nurse practitioners are employees of the Morecambe Bay Primary Care Trust (PCT). All the other nurses are prison employees. There is a mixture of RGN, RMN & RMNH nurses on the staff. There is also a recently established mental health in reach team managed by the local Child and Adolescent Mental Health Service (CAMHS) of the PCT. Two members of the team were interviewed to establish the relationship between their team and the prison employed team. It also served to clarify that the trainee had not been referred to their team for assessment. At the time of the interview, Lancaster Farms was training staff for the new Assessment, Care in Custody and Teamwork (ACCT) scheme due to be implemented on 4 April. Under ACCT, there is an automatic referral to in-reach if the individual has a raised or higher risk of self harm.

**The trainee's medical history**

Information regarding the trainee's medical history prior to his reception at Lancaster Farms has been gleaned from a psychiatric report by an Associate Medical Director, Child and Adolescent Mental Health Service (CAMHS) dated 5 February 2004 and the Asset form which was completed on 29 October 2004 by a Youth Offending Team Officer.

From the psychiatric report, we learn that the trainee was a healthy, placid baby and that he did not suffer any major childhood illnesses. He was not hyperactive. The trainee was referred to a clinical psychologist by his general practitioner in early 2003. He met with the psychologist together with his parents. The trainee was referred because, following the death of a friend in a car accident when he was driving, he developed traumatic symptoms, namely poor sleep patterns, flashbacks, nightmares and withdrawal. The severity of the symptoms did not reach the threshold for a diagnosis of post traumatic stress disorder. The trainee received serious injuries to his hand in the car accident requiring surgery and physiotherapy. A psychiatrist's summary opinion was that the trainee had not had any mental health difficulties prior to the car accident and the symptoms experienced subsequently were now resolved. He recommended that therapeutic interventions should now target educational, social and family based dynamics.

On admission to Lancaster Farms, the trainee was subject to a first reception health screen. This screen relies on the self reporting of the individual. The trainee gave the name of his general practitioner but reported he had not seen him in recent months. He was on no medication and had no recent injuries or outstanding hospital

appointments. The trainee reported no illnesses or allergies. With regard to substance use, he said he drank a couple of cans of alcohol a day but did not use drugs. The nurse signed that he was fit for normal location and that there was no immediate action needed.

In the trainee's notes was an undated 'Health Care Questionnaire for Parents' completed by his mother. She confirmed the information about his hand injury. She also completed the section on drugs, alcohol and smoking. She said he drank 'whatever he gets his hands on' and smoked 'whatever he gets'. With regard to using drugs, her response was 'I know he has but what?' There is no other positive identification of drug use in the records seen. Regarding mental health, the trainee told the nurse he had been treated by a psychiatrist in Darlington following a car accident. He said he had never tried to harm himself nor did he feel as though he would want to.

Documents sent to Lancaster Farms from the Youth Justice Board conflict somewhat with the reception screen report. The placement booking form dated 6 September was positive for vulnerability although no reason was given. However a vulnerability alert form from the YJB faxed on 6 September defines the trainee's vulnerability. It highlights that it was his first time in custody and indicates the risk factors as age, emotional upset, nature of offence: rape of female. It also described him as a 'looked after child' which was not correct. From a handwritten annotation, it seems the health care department at Lancaster Farms was informed of the vulnerability alert on 10 September. A bail assessment for the trainee which is undated (faxed to the prison by the home YOT on 21 January 2005) shows a positive indicator for self harm. The evidence was that 'Durham YOT informed me that the trainee discussed self harm and was referred to CAMHS Service in 2003'. There was no evidence of this in the psychiatrist's report. The trainee's Asset profile contains a positive response for mental illness and self harm. However, both responses are negated by entries saying that the psychiatrist found the trainee was not mentally ill and that there was no evidence for the self harm indication.

The trainee did not have any recorded interaction with the health services until 23 September when he was seen by a doctor after a self harm attempt. This self harm attempt was on the evening of 12 September and the trainee should have been seen by a doctor in order to complete the F2052SH medical assessment within 24 hours. An F213SH should also have been completed in relation to his self harm attempt, but none was done. The Senior Nurse Manager, who did not come into post until November, confirmed that, according to Prison Service Standard 22, Health Services for Trainees, the trainee should have had a post reception health screening within one week of reception. This was not done in the trainee's case.

### **Background information**

The trainee's background is well documented elsewhere in this report. However, comments from the psychiatrist may be relevant here. He reported that there were risk factors in the trainee's history which had contributed to his delinquency. For example, large family size – four or more children doubles the delinquency rate – low parental income, poor and unsettled housing arrangements, low level of parental monitoring – parents busy with large family – lower level of parental attachment – older siblings taking on parental tasks. He also highlighted parental style of discipline – higher level of punishment, lower level of reward for positive behaviour, poor educational attainment and peer group pressure. The last two were, in the psychiatrist's view, continuing to play an important role in the trainee's offending.

The chronology of clinical events during the trainee's time in Lancaster Farms has been woven into the preceding overall chronology of events in the report.

### **Emerging issues**

There were system failures with regard to the vulnerability alert not being available to the nurse in reception and a post reception health screen not being done.

Mental Health in-reach records are not filed in the main record. This is not relevant to the trainee, but initially left the investigation team wondering whether he had or had not been seen by the mental health-in reach team. Good practice is for colour coded notes in the main record.

It is not clear what arrangements there are for information sharing generally. There should be an entry in the main clinical record to alert others to the young person's engagement with another discipline/service. In the trainee's case there were disconnections between, for example, the Chapel group, the counsellor, the psychologist and F2052SH support plan targets.

**YJB recommendation 4:** *The health screening tool for juveniles, currently being developed by the Youth Justice Board, should be prioritised for completion. The First Reception Health Screen was designed for adults and it relies heavily on self reporting, which may be inappropriate for juveniles.*

**Lancaster Farms recommendation 13:** *The decision not to implement a system of codes for calls for medical assistance as recommended in the Death in Custody report of February 2004 should be reconsidered. Examples of codes used effectively in other establishments could be usefully examined for potential application at Lancaster Farms.*

**Lancaster Farms recommendation 14:** *Although the use of the defibrillator was not appropriate in the trainee's case, medical staff should be trained in the use of defibrillator machines so that they can be taken to the scene of a serious incident and used when their use is appropriate.*

**Lancaster Farms recommendation 15:** *- Medical staff should be reminded of the importance of completing the Segregation Safety Algorithm accurately. Medical records should be reviewed, and the young person spoken to prior to the Algorithm's completion.*

**Lancaster Farms recommendation 16:** *The Governor should ensure that a F213SH is completed as a matter of course after any act of self-harm attempt has been made, irrespective of whether any injury has been sustained.*

**Lancaster Farms housekeeping point b:** *Management checks should be in place to track whether post reception health screening has been completed within the standard time frame.*

**Lancaster Farms housekeeping point c:** *It would be in keeping with the modernisation of trainees' health services for more appropriate terminology to be used in practice and in documentation. Examples of out-dated terminology are 'prison hospital' instead of health centre, 'medical officer' instead of doctor and 'inmate' instead of trainee, young person or offender.*

### **Good practice – Healthcare in Lancaster Farms**

- *The Health Questionnaire for Parents as completed by the trainee's mother, is a useful additional assessment tool.*
- *On 7 December, staff in healthcare showed a caring and understanding attitude to the trainee. They explained that they were trying to give him some 'concessions' (from his earlier adjudication punishment) and that as soon as his behaviour improved, they could do so. Within a few hours, they had given the trainee some art work to do and a newspaper to read.*
- *On 10 December, staff in healthcare organised for the trainee to have his television back early because they were aware that he was anxious and worried about his planned court appearance due in a few days time. Having his television back helped the trainee to remain calm. Healthcare staff showed understanding and compassion in that they responded appropriately to the trainee's individual circumstances.*

## **12. The questions and concerns of the trainee's parents**

### ***- Why weren't the trainee's parents told of the self harm concerns about their son?***

The parents were aggrieved, and rightly so, that they were not notified of their son's self harm during his time in Lancaster Farms. Nor had they been advised of his violent and anti-social outbursts. As a result, they were deprived of the opportunity to make a contribution towards helping him to get on a more even keel. It has been made clear earlier in this report that there is a requirement under both YJB National Standards and Prison Service Order 4950 for the family to be made aware of incidents such as self harm.

### ***- Given previous attempts at self harm in Lancaster Farms, why wasn't a more robust preventative system in place?***

My investigation has shown the dates when the trainee was subject to the suicide and self harm monitoring procedures (F2052SH) used at Lancaster Farms.

I have concluded that the system complies with national guidance in certain respects, but that a lack of communication about support targets across different departments in the prison and outside of the prison (with families and YOT supervising officers) is making the system less effective than it should be.

### ***- Why was there a delay in informing the parents about their son being found hanging on 19 January?***

I have explored in my report the actions of the prison. The parents were distressed at the manner in which they were told of what had happened to their son on 19 January. Given the difficulty the prison staff had in tracing them, and having regard to the trainee providing details of his brother's telephone number (which was not available when prison staff tried to phone him), I think the staff did what they could in the circumstances. It was nevertheless upsetting for the parents to find out in the way they did. Contacting the YOT supervisor was a sensible way of obtaining the home telephone number. However, the prison should then have contacted the parents without any further delay, instead of waiting for an update from the hospital or further information about the family situation.

As I have also noted earlier, the prison could also have chosen to contact the police in the trainee's home area and asked them to break the news to the parents by way of a home visit.

### ***- Was the prison aware that the trainee had lost his brother through suicide in the past?***

Lancaster Farms was aware of the death of the trainee's brother.

### ***- Is extra vigilance taken by prisons when someone is due for sentencing?***

Prisons are generally aware, through guidance and publications from the Safer Custody Group at National Offender Management Service Headquarters (the group that issues national policy on the prevention of suicide and self harm), that the time just before and just after sentence may be a more difficult period for a trainee.

The assessment written by the psychologist at Lancaster Farms certainly highlighted the trainee's anxiousness about his sentencing date. The report was not appropriately actioned by Lancaster Farms. However, it is worth noting that the trainee was not actually due to be sentenced on 20 January and would not have travelled to court on that day. His case was listed for 'mention'.

***-Why are bed sheets not removed during the day and returned at night as this was what the trainee had used to try suicide in the past?***

The trainee was not on the suicide and self harm monitoring procedures on 19 January. He would not therefore have had any restriction on normal cell contents. Sheets and blankets are not generally removed from young people at Lancaster Farms during the day.

Prison Service national level policy strongly discourages the removal of items that may be used to self harm (such as bed sheets, razors, shoelaces) in all but the most extreme cases. The policy then only permits removal for a short period of time whilst the person is managed through the immediate crisis period. I think this policy is right.

***-What record does Lancaster Farms have in relation to deaths in custody?***

Lancaster Farms opened in 1993. There were no deaths in custody until 2004 when a 20 years old died at the prison. His death was apparently self-inflicted.

***-Will it be determined how long the trainee was hanging?***

The post mortem report may be able to determine this.

***- Was the trainee going to be moved closer to their home as the distance made it hard to visit him?***

A section of my report explores in detail why the trainee was placed at Lancaster Farms. It is likely he would have been transferred after sentencing to a prison closer to County Durham.

### 13. List of Recommendations

**YJB Recommendation 1 - The Youth Justice Board should publish the criteria by which decisions are made to transfer young people in order to increase confidence in the placement transfer process.**

**YJB Recommendation 2 - The YJB should consider the collation and publication of data regarding the number of transfer requests received and the number actioned on a regular basis.**

**YJB recommendation 3: The Youth Justice Board should consider the possibility that any derogation from National Standards should be authorised by the relevant YOT Management Board with a clear record of the decision, justification for the decision and an action plan to reinstate the National Standard.**

**YJB recommendation 4 - The health screening tool for juveniles, currently being developed by the Youth Justice Board, should be prioritised for completion. The First Reception Health Screen was designed for adults and it relies heavily on self reporting, which may be inappropriate for juveniles.**

*No comments have been received from the YJB about the above recommendations.*

**YOT Recommendation 1 - Bail Asset should be expressly linked to the Core Asset of a young person in order that all relevant information is captured in this document, especially where a young person is in a court away from their home area. In this way, a comprehensive picture of a young person can be communicated to a judge to enable them to make an informed decision about the remand status of a young person.**

**County Durham Youth Engagement Services recommendation 1 - CDYES should consider developing and revising the risk management policies they have, taking into account the YJB recently published guidance on the management of risk in the community (March 2005).**

*The CDYES response to this recommendation was:*

*“This recommendation is accepted. CDYES risk management policy has been revised and procedures have been amended. All Operations Managers and practitioner staff have been trained in the YJB risk management guidance. CDYES deploys a senior practitioner to the County Durham and Darlington Public Protection Unit (PPU) whose role is to act as liaison/guidance for CDYES and PPU in risk management of young people.”*

**County Durham Youth Engagement Services recommendation 2 - CDYES should consider planning appropriate training in risk management and assessment, planning and review, to take account of the supervision of young people on remand or in custody.**

*The CDYES response to this recommendation was:*

*“This recommendation is accepted. See above regarding delivery of appropriate YJB risk training. Specific training to be developed, alongside this training, in working with young people in the secure estate, as part of a resettlement strategy. The training will encompass risk of harm to self (vulnerability) as well as risk of harm to others.”*

**County Durham Youth Engagement Services recommendation 3 - CDYES should ensure that appropriate information about young people they have worked with is provided to prisons. If the YOT supervisor cannot visit and meet with staff at the prison or attend a remand planning meeting, they should ensure key information is passed by telephone, e-mail or letter.**

*The CDYES response to this recommendation was:*

*“This recommendation is accepted. CDYES will develop written guidance for staff in the management of young people in custody. This will include up-to-date information sharing and attending planning and review meetings. Also, the training will encompass case recording of information sharing (particularly verbal communication) to ensure an audit trail. This will be disseminated as part of the resettlement training detailed above.”*

**County Durham Youth Engagement Services recommendation 4 - Staff from CDYES should be reminded of the importance of communicating with each other and of sharing relevant information from their work with young people.**

*The CDYES response to this recommendation was:*

*“This recommendation is accepted. In the absence of YJB guidance, CDYES has developed and implemented a Recording Policy and Procedures for staff. This states what information should be recorded, how information should be recorded and when information should be recorded. Management oversight of performance and audit of practice is integral to the policy. The procedures also stress the importance of staff communicating with each other and the reasons why this is important.”*

**County Durham Youth Engagement Services recommendation 5 - CDYES should remind all supervisors writing pre-sentence reports on those held in custody to talk to or meet with appropriate staff (for example, the personal officer or unit manager) in the prison or secure training centre who look after the young person.**

*The CDYES response to this recommendation was:*

*“This recommendation is accepted. CDYES has produced written procedures for staff in the writing of pre-sentence reports, including the requirements for gathering information on young people who are remanded in custody, particularly the importance of speaking with the Personal Officer/Unit Manager on a frequent basis.”*

**YJB, CDYES and Lancaster Farms Recommendation 1: YJB National Standard 2.56 is the shared responsibility of the home YOT and the establishment.**

*Lancaster Farms accepted this recommendation.*

**- CDYES should ensure any decision by a supervisor not to attend a remand management meeting is documented and has line management approval.**

*CDYES accepted this recommendation and confirmed that it has been implemented by issuing a written instruction to staff.*

**- Lancaster Farms should ensure that remand planning meetings go ahead without the involvement of the home YOT supervisor if they decline to visit or contribute.**

*Lancaster Farms accepted this recommendation and said it was implemented immediately.*

**-In the absence of attendance from the home YOT, the host YOT should secure all relevant information from the home YOT.**

*CDYES accepted this recommendation.*

**- The YJB should consider revision of this National Standard as part of its response to the findings from the National Standards Audit 2005.**

**Prison Service recommendation 1 - The Prison Service should provide clear guidance on the use of 'Removal from unit', detailing what this punishment entails. The guidance should ensure that the punishment does not amount to cellular confinement by another name.**

*The Prison Service accepted this recommendation and said, "Guidance will appear in the new Discipline Manual which has an implementation date of 3 January 2006".*

**Prison Service recommendation 2 - The Prison Service should consider requiring Governors to ask trainees and young people on reception for a 'back up' name, address and telephone number, in the event that the preferred person is uncontactable. Governors should also be asked to check periodically that next of kin details given at first reception are still correct.**

*The Prison Service accepted this recommendation and said, "This will be considered by the Women's team and Juvenile Group, in consultation with the YJB, when revising PSO 4950".*

**Lancaster Farms Recommendation 1 -Where a young person is assessed as vulnerable on a Secure Facilities Booking form, action should be taken immediately by the secure establishment to ensure that Asset is obtained. This will enable the secure establishment to fully assess the risk that the young person presents.**

*The response from Lancaster Farms to this recommendation was*

*"Accepted. The no-docs system applies and is in place currently. Specific consideration is given to those noted to be vulnerable. However, if out of normal hours, YOT staff may not be available and it will not be possible to obtain the Asset immediately."*

**Lancaster Farms Recommendation 2: The Governor should remind all staff involved in arranging visits, either legal or medical, of the need to book an appropriate location and allocate enough time for that visit to take place.**

*The response from Lancaster Farms to this recommendation was :*

*"Accepted. This is already in place but a Governor's order will be issued to reinforce this."*

**Lancaster Farms recommendation 3 - The Governor should encourage unit staff, and personal officers in particular, to complete frequent entries about each young person.**

*Lancaster Farms accepted this recommendation and said, "All staff will be provided with clear guidance about personal officer work and encouraged to make quality entries on wing files".*

**Lancaster Farms recommendation 4 - The Governor should remind managers that decisions in relation to Child Protection issues are to be made after as full a risk assessment as possible. The impact of not permitting visits to take place must be factored carefully into this assessment. Decisions to reject an application should be explained to the trainee verbally and in writing.**

*Lancaster Farms accepted this recommendation and said, "A letter has been written to all governors involved in the decision making process reminding them of factors which must be taken into account and that the decision must be given both verbally and in writing".*

**Lancaster Farms recommendation 5 – The Governor should oversee a review into the suicide and self harm prevention procedures at Lancaster Farms.**

*Lancaster Farms accepted this recommendation and said, "ACCT has been implemented, which amounts to a full review and change of procedures".*

**The review should include:**

- **measures to ensure that those people with parental responsibility and the YOT supervisor are informed of significant events such as a young person going onto the ACCT system and acts of self harm.**

*Lancaster Farms response - The ACCT policy document has a section which covers this requirement, but will need to be expanded to include YOT Supervisors.*

- **measures to ensure that support plans are communicated to relevant staff in the prison and that commitments in support plans are followed through.**

*Lancaster Farms response - The ACCT procedures now require CARE MAPs and nominates a Case Manager with reviews held that ensure Support Plans are delivered.*

- **measures to ensure that specialist assessments and reports regarding young people deemed to be at risk of suicide or self harm are communicated to an appropriate manager in order that the learning and recommendations from such reviews are acted upon and monitored.**

*Lancaster Farms response - The Safeguards Manager will develop a protocol.*

- **measures to ensure that prior to a case review, each young person feels that they have had sufficient notice of the meeting.**

*Lancaster Farms response - Case managers to ensure reviews and dates are discussed with the trainee.*

- **consideration of whether to re-introduce a peer support scheme and to include trainee representation on the Suicide Prevention Team (repeat of recommendation in an earlier report)**

*Lancaster Farms response - A review is underway. Lancaster Farms will start an 'Insider' provision on the juvenile side of the establishment in November 2005.*

**Lancaster Farms recommendation 6 - The Governor should oversee a further review of the Personal Officer Scheme. This review should clearly state the role of a personal officer. It should also identify a system to ensure that YOT supervisors and families of young people are appropriately informed about incidents and events that occur whilst the person is in custody in line with YJB National Standards and PSO 4950. The new scheme should promote general dialogue between the prison and the family of the young person so that their particular circumstances and culture can be better understood.**

*Lancaster Farms accepted this recommendation and said, "All staff will be provided with clear guidance about personal officer work and encouraged to make quality entries on wing files. The ACCT procedures include letters to the families re self-harm, but YOT Supervisors need to be included in the review".*

**Lancaster Farms recommendation 7 – Procedures, record keeping and management oversight of Ullswater Unit should be improved:**

- **emphasis should be given to correct completion of Segregation Safety Algorithms**
- **statutory functions such as exercise must be discharged**
- **activity levels should be improved to at least the minimum standards laid down in PSO 4950 and especially in relation to the amount of time young people are allowed out of their cells.**
- **managers should check records and note any regulatory action they have taken**
- **Ullswater Unit care programme should be reinstated and the gymnasium brought back into use**
- **the Independent Monitoring Board must be notified of the use of Special Accommodation**

*Lancaster Farms accepted this recommendation and said, "Robust and revised management checks will be introduced – and are included in SPDR's and Business Plans and the SMARG (Segregation Monitoring and Review Group) meetings".*

**Lancaster Farms recommendation 8 – The Governor should remind managers to ensure that young people are not over-charged with offences against prison discipline and that in determining punishments, governors take into account the individual circumstances of the young person including mental health issues and their level of vulnerability.**

*Lancaster Farms accepted this recommendation and said, "A Notice to Staff has been issued and will be included when the Adjudication Tariff meetings take place. This also includes principal officers when conducting Minor Reports".*

**Lancaster Farms recommendation 9 – The Governor should remind healthcare staff to attend all incidents where Control & Restraint techniques are used, both planned and spontaneous incidents.**

*Lancaster Farms accepted this recommendation and said, "A letter has been sent by the Governor to the Head of Healthcare".*

**Lancaster Farms recommendation 10 - The Governor should consider issuing vent aids and cut down equipment to be worn on staff belts.**

*Lancaster Farms accepted this recommendation and said, "This has been accepted locally but is not a national mandatory policy".*

**Lancaster Farms recommendation 11 – The Governor should review post incident procedures for a death in custody. Consideration should be given to appointing a scene area controller and having a key group de-brief separate from the main de-brief.**

*Lancaster Farms accepted this recommendation and said, “The local Contingency Plans have only recently been adopted – they include an ‘Incident Scene Bronze’ (Scene Area Controller). The ‘Key Staff’ debrief is covered in the Critical Incident Debrief held by the Area Office who send a Facilitator”.*

**Lancaster Farms recommendation 12 - The Governor should review arrangements to ensure that the family or next of kin of a person who has made a serious self harm attempt or who has died in custody, are contacted by the prison or police as quickly as possible.**

*Lancaster Farms accepted this recommendation and said, “The ACCT procedures cover this requirement in part but do need to be revisited to be very clear, especially concerning death in custody”.*

**Lancaster Farms recommendation 13 - The decision not to implement a system of codes for calls for medical assistance as recommended in the Death in Custody report of February 2004 should be reconsidered. Examples of codes used effectively in other establishments could be usefully examined for potential application at Lancaster Farms.**

*Lancaster Farms accepted this recommendation and said, “This has been reconsidered. It has been agreed to implement appropriate coding systems”.*

**Lancaster Farms recommendation 14 - Although the use of the defibrillator was not appropriate in the trainee’s case, medical staff should be trained in the use of defibrillator machines so that they can be taken to the scene of a serious incident and used when their use is appropriate.**

*Lancaster Farms accepted this recommendation and said, “Initial training was delivered in February 2005, updates are planned. The equipment has been put in a rucksack for easy transportation along with emergency drugs. We have two packs – one in the Primary Care Unit, the other in the In-patient facility. Policy and Protocol are to be updated”.*

**Lancaster Farms recommendation 15 - Medical staff should be reminded of the importance of completing the Segregation Safety Algorithm accurately. Medical records should be reviewed, and the young person spoken to prior to the Algorithm’s completion.**

*Lancaster Farms accepted this recommendation and said, “All staff have been issued with the guidance on the use of the Segregation Safety Algorithm for Registered Nurses. This guidance will be discussed at Staff Meetings, and staff will be reminded of the importance of reviewing Clinical History/ IMR as part of the decision making process”.*

**Lancaster Farms recommendation 16: The Governor should ensure that a F213SH is completed as a matter of course after any act of self-harm attempt has been made, irrespective of whether an injury has been sustained.**

The response from Lancaster Farms to this recommendation was:

“Accepted. Already in place but a Governor's Order will be issued to reinforce this.”

**Lancaster Farms housekeeping point a - The Governor should ensure that video recordings of significant events or incidents are kept until after any investigation has been concluded.**

*Lancaster Farms accepted this housekeeping point and said, “Systems implemented to ensure that all video / CCTV evidence is saved until seen by the Investigation Team”.*

**Lancaster Farms housekeeping point b - Management checks should be in place to track whether post reception health screening has been completed within the standard time frame.**

*Lancaster Farms accepted this housekeeping point and said, “Will be implemented immediately and we will ensure compliance”.*

**Lancaster Farms housekeeping point c - It would be in keeping with the modernisation of trainees' health services for more appropriate terminology to be used in practice and in documentation. Examples of out-dated terminology are 'prison hospital' instead of health centre, 'medical officer' instead of doctor and 'inmate' instead of trainee, young person or offender.**

*Lancaster Farms accepted this housekeeping point and said, “Notice to Staff has been issued – all managers and staff have been instructed to use this terminology and all Notices and Policies will be reviewed”.*