Youth Justice Board
Bwrdd Cyfiawnder Ieuenctid

Deaths of Children in Custody: Action Taken, Lessons Learnt

Contents

Foreword 3

Executive summary 4

1. Background 10

2. The children 11

3. Placements, assessments and terminology 14

4. Restraint 19

5. The custodial environment: the YJB's role in commissioning, monitoring and improving the secure estate 24

6. Learning from young adult deaths 31

7. What we still need to do 33

Appendix A: Case studies 36

Appendix B: Investigations 45

Bibliography 48

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Foreword

The death of any child is a tragedy. When that child is in custody, the death also raises important questions for the state in respect of its duty to keep the child safe.

In 2000, the Youth Justice Board for England and Wales (YJB) took responsibility for commissioning places in the secure estate for children and young people in England and Wales, and for placing children in secure units after they had been sentenced by the courts. Since then, 16 children have, tragically, died in custody.

Following each death, we have worked hard to respond to the findings and the recommendations of the agencies charged with investigating the deaths, including those of coroners, the Prisons and Probation Ombudsman (PPO) and local safeguarding children's boards.

Although this work has gone on for over a decade, this document is the first public account of how the YJB has discharged its leadership role by ensuring that we not only act on the recommendations following a child's death, but that we learn and disseminate across the youth justice system the wider lessons in each case. So this report is about action and about change. The publication of this report has come about in no small part as a result of the leadership of Frances Done, who was until last month Chair of the YJB. Frances championed this issue and I would like to recognise here her significant contribution to the report and the actions that it describes.

The children whose deaths are at the heart of this publication are still mourned and missed by their families, their friends and those who worked to support them. Our response to their deaths and our continuing focus on improving the secure estate for children and young people is intended to ensure that children's experience in custody enables them to be supported, rehabilitated and, above all, kept safe.

Angela Sarkis

Acting YJB Chair

Executive summary

Sixteen boys have died in custody since the YJB took responsibility for placements and commissioning in the secure estate in April 2000. With the exception of Gareth Myatt, all of the boys' deaths are thought[1] to have been self-inflicted.

Analysis of the available records from inquests, Prisons and Probation Ombudsman (PPO) investigation reports, Serious Case Reviews and one government-commissioned inquiry (Lambert, 2005) suggests that the YJB has been the direct recipient of about 120 recommendations.[2] This report describes how these recommendations have been implemented.

Placements, assessments and terminology

Recommendations

The greatest concentration of recommendations made to the YJB related to our function of placing young people into different types of secure establishment. Investigators raised concerns of one kind or another about the placement process. They identified a lack of shared understanding between youth offending teams (YOTs) and the YJB about what information is required to make a placement decision, and an unacceptable degree of missing documentation for young people being placed in custody.

Linked to our placement function is the YJB's role in approving and facilitating transfers between establishments. Our role in the transfer process attracted several recommendations, identifying the need for a clear, published protocol explaining responsibilities, timescales and, most importantly, the criteria for transfers.

Asset, the YJB's assessment tool for children and young people, was criticised in some investigation reports. Linked to this were recommendations relating to confusion about the way that a young person's 'vulnerability' was assessed or described.

Some reviews recommended improvements to mental health screening and assessment, specifying that bespoke tools were required for young people, and that there needed to be better co-ordination of mental health services and plans when young people were in custody.

Reports called for change in remand legislation to remove the anomaly that meant that some children could only be remanded into an under-18 young offender institution (under-18 YOI), rather than a secure training centre (STC) or secure children's home (SCH).

[1] Inquests have not yet concluded into the circumstances surrounding some of the more recent deaths of children in custody and so are yet to formally determine how the boys died.

[2] The full list is available at: www.justice.gov.uk/youth-justice/monitoring-performance/serious-incidents

Actions

The actions taken are as follows.

- In November 2012, a single remand order, the remand to youth detention accommodation, was introduced by the Legal Aid, Sentencing and Punishment of Offenders Act 2012. Children remanded to youth detention accommodation can now be placed in either an SCH, STC or an under-18 YOI, with placement decisions informed by the YOT and YJB Placement Service assessments of the young person's individual risks and needs. The Act also provides that all young people remanded to custody are now granted looked-after child status.
- *AssetPlus* has been developed, and roll-out will begin in late 2014 or early 2015. This new assessment framework will replace *Asset*, and has been directly informed by the findings from deaths in custody and the subsequent recommendations.
- In 2009, we commissioned the National Children's Bureau to review our YJB Placement Service. The resulting report (Hart, 2009) echoed many of the findings from deaths in custody and made recommendations for structural change, which we implemented.
- In 2010, we introduced Connectivity in order to improve information-sharing and transfer between YOTs, the YJB and custodial establishments when children go into custody.
- In 2012, we introduced the Placement Information Form which replaced the less comprehensive Placement Alert Form and was supported by improved guidance for YOTs, particularly in relation to identifying areas of risk to a child's safety or well-being.
- eAsset is an electronic sentence planning tool which is now used by all custodial establishments holding children and young people, and enables up-to-date information about all aspects of a child's needs, risks, plans and progress in custody to be recorded and shared by establishments if a transfer takes place.
- In 2012, the YJB and the Department of Health introduced the Comprehensive Health Assessment Tool (CHAT), a tool specifically developed for use in the youth justice system, and designed to enable consistent and comprehensive identification and assessment of the health and health-related needs of children by the right professionals at the right time.
- We commissioned *Healthcare Standards for Children and Young People in Secure Settings* (Royal College of Paediatrics and Child Health, 2013), which were introduced in 2013.
- We have taken steps to improve awareness among YOTs, secure estate staff and families of young people in custody about how to make a transfer request if they have concerns about a child's current placement.

Restraint

Recommendations

Restraint was a specific concern in two cases, and attracted 12 recommendations.[3] Investigators urged the YJB to seek clarity on the legislation governing the use of restraint in STCs, and to ensure that all involved in its use understood what the law allowed. Reviews of specific techniques were requested, alongside a more general recommendation to improve guidance and the monitoring and use of data, taking into account medical evidence and expert opinions.

Actions

The actions taken are as follows.

- The YJB's sponsors[4] commissioned the *Independent Review of Restraint in Juvenile Secure Settings* (Smallridge and Williamson, 2008), as a direct result of recommendations arising from deaths in custody.
- Following on from this review, the Ministry of Justice (MoJ), the National Offender Management Service (NOMS) and the YJB developed, and in 2012 began to introduce, a new system, the Minimising and Managing Physical Restraint (MMPR) programme,[5] for managing behaviour and physical interactions with children in custody.

The custodial environment: the YJB's role in commissioning, monitoring and improving the secure estate

Recommendations

The physical custodial environment was commented upon in four cases. We were challenged to employ better use of technology to ensure the safety of young people, and to consider whether specialist units and safer cells would help young people most at risk of self-harm in custody.

The YJB was asked to reinforce the role of monitors within the secure estate, particularly in STCs, where monitors have a statutory function.

Actions

The actions taken are as follows.

- We have invested more than £10m in projects to make the physical custodial environment safer.

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[3] Excluding those made in the 2008 *Independent Review of Restraint*, which had a broader scope than the two restraint-related deaths.

[4] At this time, the YJB's sponsors were the Ministry of Justice and the Department for Children, Schools and Families (now the Department for Education).

[5] For more information about MMPR, see www.justice.gov.uk/youth-justice/custody/behaviour-management/minimising-and-managing-physical-restraint

- We have invested in a number of schemes to enhance CCTV coverage in areas of potential conflict.
- We are working to improve the YJB's monitoring role in the secure estate, most recently introducing the Performance Monitoring Framework, which provides clearer information about establishments' performance and any areas of risk.
- We commission independent advocacy services to work with children in custody. The specification for the current contract was developed with direct reference to the lessons we have learnt from deaths in custody.

National Standards

Recommendations

Reports recognised the important role of the *National Standards for Youth Justice Services* in guiding practice, but identified some weaknesses in content and implementation. Calls were made for a formal process to authorise deviations from *National Standards*. There was also a need for better monitoring (perhaps by way of an annual review) of the relevance and implementation of the standards, and a set of *National Standards* which gave greater prominence to child protection.

Actions

The actions taken are as follows.

The YJB has issued a number of revisions to the *National Standards for Youth Justice Services*, with the most recent in early 2013. The revised standards have incorporated learning from deaths in custody and reinforced messages about the safeguarding of young people. An example of this is the inclusion of a standard that specifies that, where instances of self-harm or suicide attempts occur, secure estate staff must ensure that healthcare is provided in accordance with section 1.7 of NICE clinical guideline 16 (self-harm) (National Collaborating Centre for Mental Health, 2004).

Workforce development

Recommendations

A number of recommendations highlighted the need for better training and development of staff performing a range of roles. In custody, recommendations focused on better staff training on suicide awareness, information-sharing, completion of assessments and case management. Investigators recommended a role for dedicated social workers to support looked-after children, alongside the need for those working with a young person in custody to have a clear understanding of their roles and responsibilities.

Actions

The actions taken are as follows.

- The YJB has funded dedicated social workers in all under-18 YOIs.

- The Juvenile Awareness Staff Programme (JASP) was introduced in under-18 YOIs in 2003 to improve the resilience and skills of those working with children in the youth justice system.
- In 2013, JASP was replaced by a tiered training programme developed with NOMS – Working with Young People in Custody; this programme is designed to help improve staff understanding of the needs of this cohort of children and young people, and consists of four modules:
  - Child Protection and Safeguarding
  - Adolescent Development
  - Speech, Language and Communication Needs
  - Emotional and Mental Well-being.

Recommendations specific to individual cases

The remaining recommendations were specific to individual cases and included:

- a separate escort service for young people
- improved communications between staff and young people who have made a complaint about their treatment while in custody
- clarity about the roles and responsibilities of the different bodies and agencies involved in investigating deaths in custody
- meaningful and timely engagement with families, following deaths in custody
- better co-ordination between community services when there is more than one local authority or YOT involved in the management of a young person's case.

Actions

The actions taken are as follows.

- We have always commissioned a separate escort service for all young people being transported to or from STCs or SCHs. For children being transported to or from under-18 YOIs, we have always specified that they may only be carried by the prison escort and custody service in separate vehicles from adults (or since 2011, those which have been modified to provide separate entry and exit points for each individual being escorted). We have also worked closely with NOMS to ensure that the prison escort and custody service is suitable for children.
- In 2011, we undertook a review of the complaints process in SCHs, STCs and under-18 YOIs. The review made a number of recommendations for the YJB and custody providers and has helped to drive change in the complaints process in STCs and under-18 YOIs.

- We have developed a protocol for working with the organisations and bodies involved in investigating and reviewing the circumstances surrounding a death in custody. Following the deaths in custody of Ryan Clark, Jake Hardy and Alex Kelly in 2011 and 2012, we convened meetings between the PPO, the police, local authorities and NOMS in order to establish roles and responsibilities early in the investigatory process. The YJB's Safeguarding Governance Panel oversees and provides governance to all the work we have undertaken in response to recommendations and findings from deaths in custody.
- We recognise that the period of time immediately after a death is confusing and painful for families and loved ones. Our approach to engagement with families during this time will always be informed by an understanding of what they require and request at the time, and suitable intermediaries will be used as appropriate. The YJB contributed to the development of the Independent Advisory Panel on Deaths in Custody's[6] family liaison standards and has worked with STCs and SCHs[7] to promote the standards.
- In 2010, the YJB published the *Case Responsibility Protocol* (YJB, 2010) to clarify the roles of YOTs in cases where more than one local authority is involved in a case. We will update this advice in 2014.

Next steps

Learning and action to make custody safer must be continuous. We have already begun to make changes in response to the lessons and draft recommendations from investigations into the deaths of Ryan Clark, Jake Hardy and Alex Kelly. We have identified that further work needs to take place in the following areas:

- the care and support of looked-after children
- reducing bullying and its impact in the secure estate
- listening to children and acting upon what they say
- continuing to improve information-sharing
- understanding better how to support children at risk of self-harm or suicide.

We are also working closely with the MoJ as they seek to transform youth custody, to ensure that what we know and have learnt about keeping children safe in the secure estate is embedded in plans for a Secure College and under-18 YOI reforms.

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[6] More information on the Independent Advisory Panel on Deaths in Custody and its work can be found here: iapdeathsincustody.independent.gov.uk/.

[7] Responsibility for taking this action in YOIs rests with NOMS.

1. Background

This report explains the changes we have made to respond to the comments and recommendations made by reviewers and investigators[8] following deaths in custody. It ends with an explanation of what we still need to do.

The YJB is the public body with the responsibility in law for:

- commissioning and purchasing secure places for young people under the age of 18
- placing young people sentenced or remanded to custody by the courts
- assessing future demand for secure accommodation and planning to meet this demand.

Since being given these responsibilities in 2000, we have sought to better understand the circumstances of each death in custody, and then to make changes to make custody safer for children. We have worked with and supported those responsible for conducting reviews and investigations following deaths in custody, such as coroners, the police, the PPO and Serious Case Review panels.[9] We have also found valuable the reports of other interested bodies, which rightly provide challenge to us in relation to this high-profile and sensitive issue. Most recently, we have been giving careful thought to how we can act on the learning identified in the INQUEST and Prison Reform Trust publication *Fatally Flawed: Has the State Learned Lessons From the Deaths of Children and Young People in Prison?* (2012) and the PPO's recent report, *Learning from PPO Investigations into Three Recent Deaths of Children in Custody* (2013).

In making changes, we work closely with our partners and stakeholders in the wider youth justice system – especially (but not only) government departments, providers of custody[10] and YOTs.

In 2011 and 2012, Ryan Clark, Jake Hardy and Alex Kelly died while in youth custody. Investigations into the circumstances surrounding their deaths have not yet concluded, and it is not possible or appropriate for this report to comment on their findings in detail. But we have taken steps to address the issues raised in the draft reports and have identified lessons of our own. This learning, and the action we are taking as a result, is summarised in the final chapter.

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[8] The YJB does not hold records of the inquests, area child protection committee or YJB serious incident reports for Mark Dade, Philip Griffin or David Dennis. For Anthony Redding and Kevin Henson, the YJB only has copies of its own review of practice.

[9] For further information about investigations, see Appendix B.

[10] The National Offender Management Service, private providers and local authorities.

2. The children

The boys whose deaths were found to be self-inflicted (or are thought to be, where inquests have not concluded), all used ligatures.

Alex Kelly, aged 15

Died 25 January 2012, Cookham Wood YOI

Alex was placed at Cookham Wood YOI on 10 October 2011. He was remanded overnight and then sentenced on 11 October to a 10-month Detention and Training Order (DTO). This was Alex's second time in custody (and in Cookham Wood). On 24 January, Alex was found in his cell and taken to hospital, where he died the following day.

Jake Hardy, aged 17

Died 24 January 2012, Hindley YOI

Jake was placed at Hindley YOI on 6 December 2011. This was his first time in custody and he was serving a DTO. He was found on 20 January and taken to hospital, where he died on 24 January.

Ryan Clark, aged 17

Died 18 April 2011, Wetherby YOI

Ryan was remanded into custody on 30 March 2011 and placed at Wetherby YOI. He died on 18 April 2011, when he was found in his cell by staff. Ryan had spent 19 days in Wetherby YOI during his first period in custody.

Liam McManus, aged 15

Died 29 November 2007, Lancaster Farms YOI

Liam was found to have died in his cell on the morning of 29 November 2007. On 8 November, he had been sent to Lancaster Farms YOI to serve the 44 days remaining of his DTO sentence after he had breached his licence conditions in the community.

Sam Elphick, aged 17

Died 15 September 2005, Hindley YOI

Sam was discovered in his cell on the evening of 15 September 2005. He had been at Hindley YOI since 7 March 2005, where he was initially remanded and later sentenced to custody. This was Sam's first time in custody.

Gareth Price, aged 16

Died 20 January 2005, Lancaster Farms YOI

Gareth died at the Royal Infirmary Preston on 20 January 2005 after he had been found in his cell at Lancaster Farms YOI. On 6 September 2004, he had been remanded in custody for the first time, and was placed at Lancaster Farms YOI.

Adam Rickwood, aged 14

Died 8 August 2004, Hassockfield STC

Adam Rickwood died in his cell on 8 August 2004 while he was detained on remand at Hassockfield STC. He was aged 14. Earlier that evening, he had been restrained using Physical Control in Care (PCC)[11] techniques.

Gareth Myatt, aged 15

Died 19 April 2004, Rainsbrook STC

Gareth died at Rainsbrook STC on 19 April 2004 after being restrained. At the time of his death, Gareth had been at Rainsbrook for four days and was serving a DTO.

Ian Powell, aged 17

Died 6 October 2002, Parc YOI

Ian was 17 years old when he died in his cell at Parc YOI on 6 October 2002. Ian had been on remand at Parc YOI for one month, but had previously been in custody in another YOI.

Joseph Scholes, aged 16

Died 24 March 2002, Stoke Heath YOI

Joseph died at Stoke Heath YOI on 24 March 2002. He was 16 years old and was nine days into a two-year DTO during his first period in custody. Joseph had a known history of self-harm, and had been placed in safer accommodation in the Stoke Heath Health Care Centre, where he died.

Kevin Jacobs, aged 16

Died 29 September 2001, Feltham YOI

Kevin died in the early hours of 29 September 2001. He had been serving a six-month DTO from which he was due to be released on 19 October 2001. Numerous incidents of self-harm preceded Kevin's death, and seven checks were made on him on the night he died.

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[11] The approved method of restraint in STCs at the time.

Mark Dade, aged 16

Died 27 July 2001, Wetherby YOI

At the time of his death, Mark was 14 days into a four-month DTO sentence. He was dependent on drugs and, although he had received support from his local Drug and Alcohol Team before going to custody, it appeared that no arrangements had been made to manage his withdrawal when he arrived in custody.

Anthony Redding, aged 16

Died 15 February 2001, Brinsford YOI

Anthony was found in his cell during the early evening of 14 February 2001. He was pronounced dead at hospital the following day. Anthony had been at Brinsford since 25 January 2001 where he was serving a four-month DTO from which he was due to be released on 23 March. There were significant concerns raised about Anthony's risk to himself when he arrived at Brinsford and, as a result, he was held on the healthcare wing from his reception until 9 February.

Kevin Henson, aged 17

Died 6 September 2000, Feltham YOI

Kevin was found in his cell on the morning of 6 September 2000. At this time he was remanded in custody.

Philip Griffin, aged 17

Died 1 August 2000, Wetherby YOI

Philip died at Wetherby YOI on 1 August 2000, and, at that time, had been on remand for 55 days.

David Dennis, aged 17

Died 30 May 2000, Brinsford YOI

David was found in his cell on 30 May 2000, an hour after he failed to attend the gym as usual. At the time of his death, David was on remand and had been in custody for eight days.

3. Placements, assessments and terminology

The process for preparing for and placing young people in custody has been criticised in the majority of inquests and investigations. Our role in making decisions about where children are placed in custody has an instant and direct impact on young people, setting this function apart from many of the YJB's other responsibilities. Accordingly, we have focused efforts on improving the systems, processes and skills that support us in making thorough assessments and appropriate placement decisions.

Role of the YJB Placement Service

The YJB Placement Service is responsible for placing young people remanded or sentenced to custody in appropriate secure accommodation. To do this, placements officers rely on information provided by youth offending teams (YOTs) to understand the needs of young people and any risks to their safety or well-being.

The YJB needs to carry out three key functions when it places young people in custody:

1. advising YOT staff about the types of establishments which might be available for young people in different circumstances
2. taking receipt of a set of documents and using them alongside recommendations from YOT caseworkers to make a decision about the most appropriate placement for a young person
3. passing documents about young people to secure establishments so that they can use them to assess young people.

Recommendations

Investigations have commented about the quality and flow of information from YOTs to the YJB Placement Service and onwards to custodial establishments. Issues are related to infrastructure, the quality of information provided, and the systems for ensuring that the information meets a minimum standard.

Confusion about the placement options available to young people who are made subject to a remand to custody as opposed to a court-ordered secure remand has been a feature in a number of investigations. The appropriate placement of children who face or pose particular risks has been seen to be hampered by these restrictions and the failure of YOTs to understand them when they are (a) advising the court and (b) making placement recommendations to the YJB Placement Service.

The YJB can facilitate transfers between custodial establishments if there are concerns about the safety of the young person or those around them. Investigators have questioned the clarity of this process and sought improvements in the way the YJB communicates information about transfers to

YOTs and families. The process for sharing information when young people transfer between establishments has also been raised as a concern.

Concerns have also been raised about a lack of consistency and potential for misunderstanding in the use of the term 'vulnerable' within the youth justice system. The term has been used frequently to define and describe young people in a range of circumstances. It is strongly argued that all children in the youth justice system are intrinsically more vulnerable than most other young people, although the distinct characteristics or risks, the identification of which might enable us to support individuals, are harder to specify.

Some of these systemic problems are exemplified in the individual experiences of Liam McManus, Adam Rickwood, Joseph Scholes and Sam Elphick, and are described in Appendix A.

Actions

We have improved the quality and flow of information

Significant work has gone into improving the infrastructure of information-sharing between YOTs, the YJB and the secure estate when a young person goes into custody. The key developments here include:

- introducing Connectivity in 2010 – this is an IT platform which enables information to be shared and securely transferred between case management systems. This has reduced the number of placement documents being sent to the YJB via secure fax and email, and allows them to be uploaded to eAsset – a case management and sentence planning system used by the YJB Placement Service and the secure estate
- extending and improving eAsset, which is now used by all custodial establishments holding children and young people and enables up-to-date information about all aspects of a young person's needs, risks, plans and progress in custody, to be recorded and shared by establishments if a transfer takes place
- introducing the Placement Information Form as a replacement for the Placement Alert Form and as the key document for providing the YJB Placement Service with information about young people's needs when they are likely to enter custody. The Placement Information Form is supported by detailed guidance which explains placement options (including the specialist units available and how to access them) and asks YOT workers to provide detailed information about the risks posed to and by the young person so that their needs can be appropriately assessed when a custodial placement is required
- Improving the way we check and quality assure the information we receive at the point of placement, and working with YOTs where targeted support is required to improve performance and quality.

It is also envisaged that the full roll-out of the Youth to Adult Transitions (Y2A) portal, which is explained in more detail in Chapter 5, will enable better sharing of information between both custodial establishments (in the youth and adult justice systems) and other agencies which may be involved in young people's care.

We have changed guidance to improve decision making and support our staff to make appropriate challenges to placement recommendations

The YJB relies on YOT caseworkers to make informed placement recommendations based on their assessments of the needs and risks of the young people under their supervision. A number of changes have been made to the placements guidance and process, which are intended to improve the quality of placement decisions and, while the YJB still relies heavily on the information and recommendations from the relevant YOT caseworker, YJB Placement Service staff are trained and supported in challenging the YOT's recommendations when appropriate. This ensures that the placement decision is balanced to take into account the YOT's assessment of the young person and the YJB's understanding of the establishment best suited to meet their needs. The safety and wellbeing of the child is at the forefront of this decision-making process.

In a five-month period in 2012, 1,008 placements were made by the YJB. In 87% (876) of cases, the YJB followed the YOT's recommendation. However, in 43 cases where YOTs had recommended placement in an under-18 young offender institution (under-18 YOI), the YJB decided to place the young person in either a secure training centre (STC) or, more often, a secure children's home (SCH). In 18% (31) of cases where YOTs recommended that a young person should be placed in an STC, the YJB ultimately decided that an SCH was the more appropriate placement.

Table 1: Placements in a five-month period in 2012

		YOT recommended placement in:		
		Under-18 YOI	**STC**	**SCH**
Actual placement was made in:	**Under-18 YOI**	**731**	38	2
	STC	8	**104**	18
	SCH	35	31	**41**

We considered the issue of distance from home in light of a shrinking custodial estate, and introduced better support for families who have to travel

In 2004, the YJB had a stated aim to place 90% of young people within 50 miles of home. However this target was removed in 2007. Distance from home is now one of a range of important factors that will be considered by placement officers when deciding where young people should be held, but the structure and geography of the secure estate for children and young people is such that a placement close to home will not always be possible or preferable. For example, a young person may need to be placed into a specialist unit which is further away than the closest custodial establishment.

On 1 March 2013, the mean average distance from home for young people in custody was 45.6 miles (as the crow flies). However, this average figure masks many variations, and it is unsurprising that girls and those who need specialist units are normally further from home because they can only be placed into a

smaller number of establishments. We are actively supporting families to visit relatives in custody, and the YJB provides financial assistance to meet families' travel costs. Much of this is co-ordinated by YOTs and we remind them regularly of the support that is available.

We continue to work to reduce the number of missing placement documents for children entering custody

The introduction of the Placement Information Form and Connectivity have both been supported by a programme of work to improve YOT performance in the timely provision of documents to the YJB Placement Service, and by significant revisions to the YJB's 'NoDocs' (now called 'Missing Documents') process and guidance. This has included general communications about this issue, alongside targeted support work with those YOTs who regularly fail to supply the required information within the right timescales. There have been some improvements in the provision of documents since this project began in early 2012, but we want to see further improvements in performance.

The project to improve the provision of placements documents and to increase use of Connectivity will continue until we are satisfied that information is being provided in a timely and appropriate manner by all YOTs, and that the information provided is of a consistently high quality. Further work will also be required to ensure that YOTs have access to the technology they need to use Connectivity at court buildings.

We have made the transfer process more accessible

In relation to concerns about the transparency of the transfer process, the transfer process has now changed. We have improved awareness among YOTs, secure estate staff and families of young people in custody about how to request a transfer if they have concerns about a child's current placement. The YJB's web pages now contain information about who can request a transfer and how to do it.[12]

We have worked to support the government in introducing a single remand order for all children

The placement anomalies for young people on remand that arose in Gareth Price's case (see Appendix A) have featured in a number of cases. In November 2012, the single remand order, the Remand to Youth Detention Accommodation, was introduced by the Legal Aid, Sentencing and Punishment of Offenders Act 2012. Children remanded to youth detention accommodation can now be placed in either an STC, SCH or under-18 YOI, with placement decisions informed by the YOT and YJB Placement Service assessments of the young person's individual risks and needs. The Act also provides that all young people remanded to custody are now granted looked-after child status, with the designated local authority responsible for ensuring that young people are offered the support they are entitled to under this provision.

The YJB is working with local authorities, secure accommodation providers and courts to implement the legislation and to support effective practice in relation to the new provisions, and has provided guidance on the implications of LASPOA

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[12] See www.justice.gov.uk/youth-justice/custody/placing-young-people-in-custody/placement-decisions-and-reviews

to those working in youth justice[13]. This includes working with YOTs to reduce potentially unnecessary secure remands, developing robust alternatives to custody, working with the Judicial College to improve sentencers' confidence in alternatives to secure remand, and improving the quality of the YJB's data on young people remanded to custody.

These significant developments in policy and practice have removed discrepancies in placement options for older children, and seek to ensure that the use of custody is appropriate. When custody must be used, the most appropriate placement is identified based on the individual needs of the young person, regardless of age.

We have reviewed the way the word vulnerable is used in guidance, and will make the assessment of risk more specific and detailed in our new assessment framework

Recommendations relating to the use of terminology, particularly in relation to assessments and descriptions of vulnerability, are exemplified in the recommendation from the PPO's report into the circumstances surrounding Liam McManus's death:

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

PPO, 2009: p125

As a word that permeates the language of youth justice, the term vulnerability cannot be eradicated. The complexities of this issue are described thoroughly in a recent report by INQUEST and the Prison Reform Trust: *Fatally Flawed: Has the State Learned Lessons From the Deaths of Children and Young People in Prison?* (2012). The report says that:

> *although vulnerability is meant to be a key consideration in decisions by the courts and the YJB about whether and where to place children in prison, it is subject to differing definitions by different agencies.*

The YJB's new assessment framework, *AssetPlus*, which will begin to replace *Asset* in late 2014 or early 2015, reflects changes in thinking and research to better define and describe the risks to a young person's safety or well-being. This phrase is defined as meaning 'the risk that a young person's safety and well-being is now, or may be, compromised either through his or her own behaviour, personal circumstances or because of the acts or omissions of others.' We have already introduced this term into the Placements Information Form alongside guidance for practitioners on identifying risks.

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[13] See www.justice.gov.uk/youth-justice/courts-and-orders/legal-aid-sentencing-and-punishment-of-offenders-act-2012

4. Restraint

The YJB accepts that there are sometimes occasions where the safest way to protect children and staff in the secure estate is to use physical restraint. Its use is rightly subject to strict legal requirements, monitoring and scrutiny. In 2004, one boy in custody died as a direct result of restraint, and another boy took his own life a few hours after being restrained. Both cases highlighted shortcomings in some of the techniques used to restrain children in custody. They also raised concerns about the way that the legislation governing physical interventions was interpreted across the youth justice system, including how the legislation translated into the roles and responsibilities of the government, the YJB, secure estate providers, and individual members of staff.

Recommendations

The YJB, as commissioner of the secure estate, holds responsibility for data collection and monitoring the use of restraint in STCs and under-18 YOIs. However, in the investigations into the deaths of Gareth Myatt and Adam Rickwood, clarity about the role of the YJB in relation to restraint ownership, policy, training and use was a key area of concern. The lack of clarity, alongside concerns about practice, reviews and learning has now been resolved, addressing some of the key recommendations highlighted below:

> *There should be an immediate, urgent and complete review by both the Ministry of Justice and the YJB of all the techniques of physical restraint and control within PCC, such a review to include a review of the medical safety of each and every one of those techniques.*
>
> *The YJB and the forum of STC directors should develop a clear system of 'best practices' as to behaviour management. These best practices should relate particularly to the need for, and the avoidance of, the need for the use of PCC.*
>
> *All those involved in the STC system need to consider very carefully and very regularly how they can learn lessons from what happened to Gareth Myatt, and how they can build on good practice, and how they can prevent another trainee dying as a result of physical restraint.*
>
> Coroner's Rule 43 letter to the YJB (unpublished) (2007), inquest into the death of Gareth Myatt at Rainsbrook STC
>
> *PCC is used too frequently and in many cases too soon. There is an urgent need for improved methods of behaviour management, ideally supported by better staff training at all levels, primarily in dealing with adolescents and their challenging behaviour.*
>
> PPO, 2006a: p108
>
> *An urgent review should be undertaken to clarify the inter-relationship between the Criminal Justice and Public Order Act 1994 (s9), the STC Rules issued thereunder and the Directors Rules to avoid any confusion*

whatsoever. It must be seen as essential that there must be no ambiguity in anyone's mind, young person, staff, management or those in the YJB or indeed government as to when the use of restraint or force to maintain good order and discipline or for compliance reasons is authorised.

Coroner's Rule 43 letter (unpublished) (2007), first inquest into the death of Adam Rickwood at Hassockfield STC

Adam Rickwood died after he had hanged himself in his bedroom, a few hours after he had been restrained by staff at Hassockfield STC, who had used the approved 'nose distraction technique'. He had been restrained because he had refused, when asked, to move from a communal area to his room. When Adam died in 2004, there was confusion at every level within the youth justice system about whether or not restraint for this purpose (maintaining the good order and discipline of the establishment) was lawful. This confusion led to a systemic failure to identify unlawful practice – an issue which was resolved in 2008 when the Court of Appeal ruled that the use of restraint for the purpose of maintaining good order and discipline in STCs was, and always had been, unlawful.

There have been two inquests into Adam's death and, at the second, the jury found that the use of the nose distraction technique on Adam "more than minimally" contributed towards his decision to take his own life.

Action

In 2008, the government and the YJB published a response to the coroners' recommendations following the inquest into Gareth Myatt's death and the first inquest into Adam Rickwood's death (there were no recommendations made under Rule 43 following the second inquest, which took place in 2011).[14]

Since 2008, there have been several key developments, which are outlined below.

The government banned two restraint techniques and commissioned the 'Independent Review of Restraint in Juvenile Secure Settings'

After Gareth Myatt and Adam Rickwood died, the techniques used in their restraints were banned. Later, and in response to scrutiny and criticism of both the content and governance of Physical Control in Care (PCC) – the approved system for restraint in STCs – the government commissioned the *Independent Review of Restraint in Juvenile Secure Settings*. This review was published in 2008. It was undertaken by Peter Smallridge and Andrew Williamson,[15] who explored policy and practice in all three types of secure accommodation for children and young people. They were asked to make recommendations to the government on:

- the operational efficacy, safety (including medical safety), and ethical validity of restraint methods in secure settings for children and young people, and the circumstances in which they may be used

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[14] The report can be found at www.justice.gov.uk/downloads/publications/moj/2010/response-inquest-myatt-rickwood.pdf

[15] Smallridge and Williamson are social workers who have been directors of social services, social service managers and chairs of NHS trusts.

- the system of training provided to staff using restraint in secure settings for children and young people
- the arrangements for cross-departmental knowledge-sharing on the use of restraint and behaviour management across a range of secure settings for children and young people
- the respective responsibilities of the Ministry of Justice (MoJ), the Department for Children, Schools and Families, the YJB, HM Prison Service and individual providers of SCHs, and other relevant institutions, in relation to the safety and effectiveness of restraint, including clarification of the approval methods for restraint techniques
- the responsibilities of local safeguarding children boards in relation to the safety of restraint in their area
- whether the arrangements in place to record and monitor the use of restraint and the arrangements for sharing and analysis of information relating to deaths, injuries and warning signs exhibited following restraints, are adequate in all secure settings for children and young people.

The authors of the *Independent Review of Restraint* called for more consistency in the policies and practices for restraining children in all parts of the secure estate for children and young people. They recommended developing a new system of restraint, concluding that "a degree of pain compliance may be necessary in exceptional circumstances", but, emphasising that restraints involving pain should be subject to "rigorous monitoring". Overall, the report concluded that:

> *while good policies, procedures, the training and preparation of staff, their supervision and management and the culture of the organisations in which they work are crucial factors in determining the frequency and propensity for restraining young people, in the end it is the judgement of the member of staff when an incident occurs which is the single most significant factor in how it is dealt with in practice.*
>
> Smallridge and Williamson, 2008

We worked with others to respond to the recommendations made in the 'Independent Review of Restraint'

The YJB worked with colleagues across government to agree and implement an action plan to address the review's 58 recommendations. This included developing and introducing a new system of restraint for STCs and under-18 YOIs.

The National Offender Management Service (NOMS) was tasked with developing the new restraint system and placing it within a wider behaviour management framework, to enable the safer management of young people in custody. The *Independent Review of Restraint* proposed six principles for the use of restraint:

1. Force should be used only as a last resort.
2. Force should be used only to prevent the risk of harm.
3. The criteria for using force should be consistent across settings.

4. The minimum force necessary should be used, and this should be proportionate to the identified risk.
5. Only approved restraint techniques should be used.
6. Force should only be used in the context of an overall approach to behaviour management, including de-escalation and debriefing, in which children and young people are actively involved.

These principles have been reflected in the government's *Use of Restraint Policy Framework for the Under-18 Secure Estate* (MoJ, 2012b) and in the YJB's revised code of practice, *Managing the Behaviour of Children and Young People in the Secure Estate: Code of Practice* (2012a).

The government also established the Restraint Advisory Board, an independent expert panel, to oversee the development and assessment of the new restraint system, called Minimising and Managing Physical Restraint (MMPR). The Restraint Advisory Board was chaired by Professor Susan Bailey, President of the Royal College of Psychiatrists, and included experts drawn from paediatrics, forensic psychiatry, physiotherapy, behaviour management and operational backgrounds.

The YJB has commissioned research to review head-hold restraint techniques and non-pain compliance restraint methods, as we committed to do in our 2013/14 Business Plan (YJB, 2013a). This action addresses recommendations made by the Restraint Advisory Board in their 2011 report, *Assessment of Minimising and Managing Physical Restraint (MMPR) For Children in the Secure Estate*.

We supported the development and roll-out of MMPR

In 2012, ministers approved MMPR for use in STCs and under-18 YOIs, and accepted all the Restraint Advisory Board's recommendations. The YJB is working with NOMS and the Ministry of Justice to manage the roll-out of MMPR for use in STCs and under-18 YOIs. The Independent Restraint Advisory Panel has replaced the Restraint Advisory Board. It has oversight of all the Restraint Advisory Board recommendations and responsibility for monitoring progress against them.

The syllabus for MMPR training focuses on recognising and managing the difficult and challenging behaviour that can occur within the secure estate for children and young people. It provides staff with the knowledge and skills to recognise the stages of conflict development, to assess the actual level of threat, and to implement appropriate resolution strategies. Staff must be able to initiate actions that accord with the ethical and legal issues surrounding the physical restraint of young people. Young people must have access to a complaints procedure, which allows them to register any concerns, complaints or allegations.

We ensured that the new restraint system had clearly defined roles and responsibilities

Clearly defined roles and responsibilities for individuals and organisations have been central in the development of MMPR. At a strategic level, the MoJ now has responsibility for the policy framework for restraint in STCs and under-18 YOIs, NOMS holds responsibility for the MMPR syllabus and the training of instructors and staff, and the YJB, as commissioners of the secure estate, holds

responsibility for data collection and monitoring the use of restraint in STCs and under-18 YOIs.

MMPR training emphasises a number of key roles that staff members need to take during a restraint incident. For example, two such roles are the use of force supervisor (who monitors the well-being of the child being restrained) and the incident manager (who manages the overall incident). Neither takes part in the restraint itself.

Additionally, we have ensured that establishments maintain a continual focus on restraint minimisation, and we monitor establishments against their restraint minimisation strategies. We have also supported establishments to improve debriefing after restraint incidents (for both young people and staff), including developing a protocol that sets out the respective roles and responsibilities of establishments and advocates.

5. The custodial environment: the YJB’s role in commissioning, monitoring and improving the secure estate

The YJB’s main functions (as set out in statute) include:

- monitoring the operation of the youth justice system
- placing young people in custody
- advising the Secretary of State on the operation of the youth justice system
- identifying and promoting effective practice across youth justice services
- making grants to local authorities to support development and delivery of good practice
- commissioning a distinct secure estate for young people.

In order to deliver our responsibilities in terms of custody provision, we work in partnership with secure accommodation providers and wider partners to deliver regimes that both protect the public and keep young people safe, addressing the causes of their offending behaviour.

Although the majority of recommendations to the YJB arising from deaths in custody have related to placements into custody and the use of restraint, more specific concerns have been raised about a number of other issues, which we have been asked to address through our commissioning and monitoring functions.

Action to invest in the secure estate

In 2005, we agreed a three-year capital works project worth £6.25m to improve the safeguarding of young people in public sector secure establishments. The project focused on three key areas: safer cells, cubicular showers, and improved use of closed circuit television (CCTV).

Since 2008/09, we have invested a further £5m. Of this, £2m was spent on substantially expanding CCTV coverage and quality in secure training centres (STCs) and under-18 young offender institutions (under-18 YOIs), and improving real-time and colour specification. During this time, the Department for Education provided funding for the same improvements in secure children’s homes (SCHs). We have invested a further £2.2m on increasing the number of safer cells, and over £600,000 on providing cubicular showers.

In January 2014 the Government set out plans to put education at the heart of detention, including investment in a secure college pathfinder to open in the East Midlands in 2017. This investment offers the opportunity to commission

distinct provision, designed specifically around the needs of children and young people, in terms of the physical design of facilities and through services that allow a multi-agency approach to addressing young people's education, health and resettlement needs.

Monitoring the secure estate

Secure estate monitoring evolved following the introduction of STCs in 1998. The Criminal Justice and Public Order Act 1994 requires each STC to have a monitor to:

- review and report to the Secretary of State on the running of the STC
- investigate and report on allegations made against custody officers
- certificate, approve, and, where necessary, suspend and revoke, custody officers' certificates
- perform functions conferred upon the monitor by the STC Rules 1998, including hearing appeals from trainees on clothing, requests and complaints.

Initially, Home Office monitors were specifically recruited for STCs and based permanently in each centre. Since 2000, the YJB's monitors (having moved from the Home Office when responsibilities for youth justice changed) have had the additional responsibility of monitoring all secure estate sites and for ensuring contract compliance for advocacy services, escort providers and the Lucy Faithfull Foundation, which have all been directly commissioned by the YJB to deliver services for children and young people in custody. However, the YJB is not an inspection body and does not have an explicit statutory role in the monitoring of any custodial sector except for STCs, where monitoring is undertaken in accordance with the Criminal Justice and Public Order Act 1994.

Recommendations

The Prisons and Probation Ombudsman (PPO) made recommendations (see Appendix A) about the monitor's role in ensuring compliance with the service level agreement in place at Hindley YOI. The confusion surrounding the use of force in STCs, which was identified following Adam Rickwood's death, also required us to address the role of monitors.

Actions

We changed our monitoring regime and clarified roles and responsibilities

In 2007, the YJB restructured the monitoring team and the monitors began working to a new quality management system, with clearer roles and responsibilities. We are continuing to improve the monitor's function to make it more meaningful and transparent. Within the context of a smaller number of monitors covering a small but diverse secure estate, we primarily seek to focus monitoring activity on the areas of greatest risk, as identified through performance reporting and from the reports of regulators and inspectors. This approach has led us to conduct a range of focused reviews across the estate on subjects including restraint minimisation strategies, the transfer of health information and adjudication.

We worked with providers to develop and introduce a new performance monitoring framework

Since 2012, the YJB has been developing and piloting a performance management framework for under-18 YOIs that will focus monitoring on high-risk processes such as complaints, and the use of separation and restraint so that serious concerns can be more readily spotted and escalated. Monitors are now working more closely with inspectorate bodies, including HM Inspectorate of Prisons and Ofsted.

Commissioning: Specialist units

Recommendations

Reviews recommended that the YJB and HM Prison Service should develop specialist units to support the complex needs of some young people in custody, particularly older boys.

Actions

We funded and helped to develop a range of specialist provisions in custody

The Keppel Unit, based at Wetherby YOI, opened in October 2008. This specialist unit provides enhanced support to young people deemed unable to cope in mainstream under-18 YOIs due to their complex needs. The goal of the unit is to provide a supportive environment that enables the boys to participate in the education provision, programmes, interventions and activities offered within an under-18 YOI to address their individual needs. The process evaluation we commissioned in 2011 concluded that "the Keppel Unit is performing well in terms of its goal and the assumptions surrounding it," and that:

- *the majority of young people are being accurately placed on the unit*
- *the physical building appears to be contributing to outcomes*
- *the multi-disciplinary team is forming good relationships with the young people*
- *the young people are engaging more on the unit than they had in previous placements.*

Cordis Bright, 2011: p18

More recently, in 2013, HM Inspector of Prisons conducted an unannounced inspection at the Keppel Unit and described it as providing "…a model of how a specialist unit should be run" and finding that "…young people were provided with a high standard of care within a well run facility' (HM Inspector of Prisons, 2014: pp5-6).

In addition to the Keppel Unit, we commission the specialist Willow Unit at Hindley YOI for children who have complex needs and a unit at Wetherby YOI for young people serving indeterminate or long-term sentences. We commission specialist services in three under-18 YOIs to work with young people who have

committed sexual offences[16] and also have established a mother and baby unit at Rainsbrook STC. We are using the learning from these units to inform our plans for the future of the secure estate for children and young people.

We funded dedicated social workers in under-18 YOIs

In addition to our work to improve specialist provision in the secure estate, since 2011[17] the YJB has provided funding to ensure that there are dedicated social workers in all under-18 YOIs. These social workers were introduced to support the needs of the large number of looked-after children in custody and advise the workforce on their child protection responsibilities. This provision is helping to ensure that children who have some of the most complex needs in custody are better supported.

Commissioning: complaints

A key safeguard for young people in custody is an effective and responsive complaints system that acknowledges concerns young people may have, and provides suitable redress and protection when failings are identified. For a number of reasons, it may be difficult for children in custody to express or articulate their worries, and it is for that reason that we constantly seek to find different ways of engaging young people. Recommendations from coroners and others have highlighted this issue and its importance.

Recommendations

Following the inquest into Gareth Myatt's death (see Appendix A), the coroner made the following recommendations in relation to complaints:

> *Where any complaint by a trainee is being investigated, it is essential to talk to the trainee. It is not adequate simply to proceed only on the basis of what the trainee has put in writing and then interview only the staff. The practice should be adopted, whoever is investigating the complaint, that the trainee is spoken to, not only in the initial stages, but during the course of the investigation and after the investigation as well.*
>
> *In addition, there must be a clear protocol as to what action should be taken and by whom when a complaint is made by a trainee, or after a decision has been taken to refer injuries or any other matter to an outside body. In particular there should be a clear protocol as to the circumstances, if any, in which it might be appropriate to ask the STC itself to investigate any matter. The reasons for a withdrawal of a complaint need careful investigation by outside bodies.*

Coroner's Rule 43 letter to the YJB (2007) (unpublished), inquest into the death of Gareth Myatt at Rainsbrook STC

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[16] From April 2014, commissioning responsibility for this service will sit with NHS England, and we are working with them to ensure that it continues to meet the needs of this group.

[17] There have been social workers in under-18 YOIs since 2005, but the provision had been inconsistent across the estate. Since the YJB provided funding in 2011, there have been social workers in all under-18 YOIs, with a clear service specification and support from the National Offender Management Service (NOMS).

Actions

We conducted a review of complaints and commissioned a report to better understand what children in custody thought of the complaints system

In 2011, the YJB published a report, *Review of the Complaints System in the Secure Estate for Children and Young People*,[18] which made a number of recommendations for improvements in the complaints process against six key principles:

1. The complaints system should be easy to use and accessible to all.
2. Written responses should be timely, of high quality and appropriate.
3. Responses to complaints should be discussed with the young person, and they should always have the right to give feedback.
4. All complaints should be considered from a safeguarding perspective.
5. Young people should be able to express their grievances in a variety of ways.
6. Young people must be able to complain easily to independent, outside agencies.

Our own work in this area was complemented by two reports produced by User Voice and the Office of the Children's Commissioner: *Young People's Views on Safeguarding in the Secure Estate* (User Voice, 2011) and *Why are They Going to Listen to Me? Young People's Perspectives on the Complaints System in the Youth Justice System and Secure Estate* (User Voice and the Office of the Children's Commissioner, 2012).

We improved the complaints process for children in STCs

A key recommendation relating to the complaints system in STCs was that the PPO should have his role expanded to cover complaints in STCs. This change came into force in September 2013 as a result of joint work between the YJB, the Ministry of Justice (MoJ) and the PPO.

We improved advocacy services for children in custody

In addition to the work we have done to improve accessibility and complaints handling for children and young people in custody, we have also sought to improve advocacy services for them. Young people in the secure estate have had access to independent advocates since 2004. We see this service as a cornerstone of children's rights, and sought to improve the service using direct lessons from deaths in custody when we re-commissioned the service in early 2013.

[18] yjbpublications.justice.gov.uk/en-gb/Resources/Downloads/Review%20of%20the%20Complaints%20System%20in%20the%20Secure%20Estate.pdf

Effective practice development: health in custody

Recommendations

Investigations into the deaths of Liam McManus, Joseph Scholes, Gareth Price and Kevin Jacobs all made recommendations for the YJB to improve the tools available to help identify and support mental health issues and self-harm risks. The need for better integrated and consistent healthcare has arisen in a number of reviews.

Actions

We worked with government partners to develop and introduce the Comprehensive Health Assessment Tool (CHAT)

In 2012, the YJB and the Department of Health began to roll out CHAT. CHAT is a tool specifically developed for use in the youth justice system, and is designed to enable consistent and comprehensive identification and assessment of the health and health-related needs of children by the right professionals, at the right time.

CHAT is a five-part tool which begins with a screening tool completed on entry to a custodial establishment to identify immediate and urgent health needs, including mental health and substance misuse concerns, risk of harm to self and others, and medication requirements. Best practice dictates that this is completed within two hours of arrival and certainly before the first night. Following the initial screening, there are more in-depth assessments on physical health, mental health, substance misuse and neuro-disability (for example, learning disabilities and difficulties, and speech, language and communication needs).

We commissioned 'Healthcare Standards for Children and Young People in Secure Settings'

In June 2013, the Royal College of Paediatrics and Child Health published *Healthcare Standards for Children and Young People in Secure Settings,* which had been commissioned and funded by the YJB. The YJB worked collaboratively with a group of royal medical colleges – led by the Royal College of Paediatrics and Child Health, and backed by all four UK children's commissioners – to develop these standards. The 69 standards are designed to help plan, deliver and quality assure the provision of children and young people's health services in secure settings. The standards adopt a pathway approach, following a young person's 'journey' through custody, and include sections on entry and assessment, information-sharing, transfer and continuity of care, and multi-agency working. In addition, there is a section relating to the need for sharing information and the role of healthcare staff before, during and after restraint procedures.

The standards represent a significant step forward in providing consistent and high-quality care in the distinct custodial environment, and we will undertake further work to understand the impact they have, particularly within the changing landscape of healthcare commissioning.

Effective practice development: Restorative Justice

Recommendations

A number of investigations have identified bullying or victimisation as a feature in the experiences in custody of boys who have died in custody.

Actions

Our *Behaviour Management Code of Practice* (YJB, 2012a) sets out our expectations to custody providers about how poor behaviour should be managed, and sets out the use of Restorative Justice as a key tool in tackling harmful behaviour.

In 2012, we published a *Restorative Justice Framework*[19] which includes a section on the use of Restorative Justice in custody, with examples of where it has been used effectively to resolve conflicts within the secure estate. We are now exploring ways to further promote its use.

[19] See www.justice.gov.uk/youth-justice/working-with-victims/restorative-justice/restorative-justice-framework/restorative-justice-practice-custody

6. Learning from young adult deaths

Since 2008, the YJB has sought to engage with investigations into the deaths of young adults in prison where there is likely to be direct or indirect learning for the youth justice sector. Many young adults in custody were previously known to the youth justice system and a large proportion of those young adults who have recently died in prison had also been in youth justice custody. While our focus rightly remains on ensuring that the under-18 custodial estate is distinct, and as safe as it can be for children, we recognise the contribution we can make to producing better outcomes for young adults and have undertaken significant work to bring about improvements in interactions and information-sharing when young people move between youth and adult justice services. Billy Coulson's case demonstrated the need for effective transitions very clearly (see Appendix A).

Recommendations

Key issues identified by the Prisons and Probation Ombudsman (PPO) and coroner in Billy's case, which the YJB has learnt from, focused on:

- information-sharing – youth offending teams (YOTs) and Probation Services need better information-sharing systems and protocols, to ensure that knowledge about risk factors can be shared to inform risk assessments and support plans
- formality – a formal case transfer process creates opportunities for information-sharing and increased protection for individual young people.

Actions

Improving transitions between youth and adult justice services

Since 2011, the YJB has been leading a programme of work to improve the processes by which young people move between youth and adult justice services, whether in the community or custody. We want to improve the safety and outcomes for those within the criminal justice system and reduce the likelihood of reoffending, find efficiencies and better protect the public.

We established and co-chair the Youth to Adult Transitions Forum

In early 2012, the YJB established a cross-government Youth to Adult Transitions Forum, which is jointly chaired by the YJB, the National Offender Management Service (NOMS) and the Ministry of Justice (MoJ). The forum seeks to ensure that the relevant transition leads from government departments work in partnership to improve transitions from youth to adult justice services. Membership comprises colleagues from the YJB, the MoJ, NOMS, the Welsh Government, the Department of Health, the Department for Education, the Department for Work and Pensions, the Department for Business Innovation and Skills, HM Courts and Tribunals Service, the Home Office, and the Department for Communities and Local Government.

A programme has been agreed by all partners which includes:

- work to ensure continuity of services across health when a young person transitions from the youth to adult justice systems
- work to increase the confidence of practitioners in considering a young person's maturity as part of the transitions process
- workforce development for relevant staff in young adult secure establishments[20] that will provide them with the necessary knowledge and skills to manage and support the individual needs of young people in transition
- information for young people to highlight the differences between appearing in the youth court and in the adult court.

We developed and published the Youth to Adult Transitions Framework

In September 2012, the YJB published the *Youth to Adult Transitions Framework*. The framework provides advice to YOT and probation managers writing local protocols for managing transitions in their community. We are reviewing how well the framework has been received by youth and adult justice services and whether changes to local protocols are leading to improvements in outcomes for young people.

We are working with NOMS to improve transitions to the adult custodial estate

In September 2012, NOMS published a protocol for transitions from youth to adult custody, *Guidance on Transfers from Under 18 Young Offender Institutions to Young Adult Young Offender Institutions* (MoJ, 2012c). This offers advice to staff involved in the process within both the under-18 and over-18 secure estates by setting out how the process should work and what the expected roles and responsibilities are. Additionally, it contains transfer matrices to assist staff in the under-18 estate to identify suitable placements in the over-18 estate. NOMS has described the protocol as a first step and intends to develop it further by making it mandatory in the form of an HM Prison Service Instruction (PSI), which we hope will come into force in 2014. We are also working with NOMS to develop a pilot to further test and develop the instruction. A tracking and monitoring exercise of some young people through the transition is being conducted, which will inform the content of the PSI.

We worked with NOMS to develop and pilot the Youth to Adult (Y2A) Portal

The Y2A Portal is a web-based system which aims to improve information-sharing from YOTs to probation trusts and young adult YOIs. In the past, some of the information that had been shared between youth and adult justice services was incomplete or late, which meant that there were shortcomings in assessments and plans. The Y2A Portal provides practitioners with a secure mechanism to transfer up-to-date information in a timely manner. In addition, the portal provides summary views, allowing practitioners to review key pieces of information more rapidly and easily, including safeguarding concerns. The Y2A Portal has been successfully piloted and is now being implemented across England and Wales.

[20] Young adult YOIs normally hold those aged between 18 and 20 years.

7. What we still need to do

We are still learning from deaths in custody. Our action must take place within the wider context of research and findings in children's services and the broader youth justice sector. The YJB's learning must also not rely solely on the investigations of others but on our own assessments and understanding of the system we lead. That means that while the investigations into the deaths of Ryan Clark, Jake Hardy and Alex Kelly are still under way, we have sought where possible (using draft reports and our own information) to learn and act. We have also taken account of the Prisons and Probation Ombudsman's (PPO's) recent publication *Learning Lessons Bulletin: Child Deaths* (PPO, 2013).

During our audit of previous recommendations and the detailed work we have undertaken since Ryan Clark, Jake Hardy and Alex Kelly died, we have identified a number of areas where further improvement is required.

We must improve support and outcomes for looked-after children

Of the 16 boys who have died, we know that at least 11 had at some time been subject to care orders. Many of them had spent time in care. Children who have looked-after status before they enter custody are over-represented in the youth justice system and in the secure estate (Schofield et al, 2012). It seems possible that they are even more disproportionately represented in death in custody statistics. We know that looked-after children need better support in custody, and that is why we funded the appointment of dedicated social workers in under-18 young offender institutions (under-18 YOIs), whose job it is to ensure that looked-after children are assisted, represented and that their needs are met. We have developed the service specification for these social workers to ensure that their responsibilities in this area are clear. We have also required under-18 YOIs, for the first time, to collect data about the looked-after children in their care so that we can develop a better understanding of the issues they face to inform future service provision. In 2014, we will review the provision to see whether further changes to the specification are required.

We must work with custody providers to help them to address bullying

Bullying presents a major challenge in the secure estate (Gyteng et al, 2013). We are working alongside secure estate providers to develop and share effective practice (such as the use of Restorative Justice) to tackle bullying and violence within the secure estate, and to invest in the physical environment of the establishments we commission. We want staff in secure establishments to better understand the causes and impact of bullying and to better address the needs of both victims and perpetrators.

We must continue to listen to children about what they need to keep safe and to understand how custody affects them

In Chapter 5 we described some of the steps we have taken to ensure that children in custody have their voices heard. We are committed to doing more to understand what children in custody feel that they need, and to ensuring that they have independent support to make this clear. The PPO now has a role in investigating complaints from children in secure training centres (STCs), and we continue to work with HM Inspector of Prisons and the Managing the Quality of Prison Life team to make sure that we get regular feedback from children in custody.

We must continue to improve information-sharing

The information we share with professionals and families about the systems and processes for children going into custody needs to be better. We are improving the information available on our web pages and we are committed to raising awareness of what professionals and families should do if they have concerns about a young person in custody.

We will also continue to find ways to improve the quality of information shared with the YJB Placement Service and the secure estate when a child enters custody, to ensure that all those involved understand fully the young person's risks, and concerns that have been identified by the workers and professionals who know them best. We will do this through:

- renewed efforts to work with YOTs to reduce the number of missing documents at the point of entry to custody
- work to better quality assure Placement Information Forms
- the implementation of *AssetPlus*
- the roll-out of the Y2A Portal
- our contribution to the NOMS-led work to revise the Person Escort Record, which plays a key role in communicating risks during a time when there are frequent handovers of responsibility.

We will also support the research, commissioned by the Independent Advisory Panel on Deaths in Custody,[21] to assess the efficacy of information-sharing between YOTs and the secure estate for assessing and managing the risk of self-harm and suicide by children and young people.

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[21] This research is being carried out by the University of Greenwich and the Runnymede Trust.

We must work with providers to better understand how to best support children identified as being at risk of suicide or self-harm

When children and young people in custody are at risk of harm, self-harm or suicide, they need extra support and supervision that recognises their needs. We recognise the concerns raised by the PPO about whether the Assessment, Care in Custody and Teamwork (ACCT) system is sufficiently child-focused. In the year ahead we will be working with NOMS to consider this issue, including whether changes need to be made to ACCT in the short-term and, in the longer term, to think about whether ACCT is the appropriate framework for supporting at-risk children in under-18 YOIs.

We must ensure that children's safety is the key consideration when we are planning the future of the secure estate

Our thoughts now turn to the long-term future of the secure estate, and our work with the Ministry of Justice (MoJ) to shape custody for children in a way that keeps them safe, and focuses on ensuring children return to their home communities with a positive and purposeful future ahead of them.

The YJB is working alongside the MoJ as it seeks to transform youth custody. We are committed to the belief that the secure estate for children and young people should be recognised as specialist provision, and commissioned services should recognise the distinctive approach required. We recognise that the future commissioning programme needs to take account of the need to ensure that change is carefully managed across the secure estate to minimise any risks to the safety of young people and the stability of the estate. We are keen to ensure that evidence-gathering and a lessons-learnt process are built into the implementation plan for the new Secure College model for youth custody recently announced by government. In order for young people to engage effectively in custody, it is a prerequisite that they feel safe there, so ensuring safety, stability and security will be particularly critical during the development of the model.

Appendix A: Case studies

Each death that has occurred in youth custody is very significant. Yet the total number is small in statistical terms and this makes it difficult to identify trends and make generalisations in relation to the boys' characteristics or those of their detention. With this in mind, in this section, and though it would not be possible to compress their lives and circumstances into a single report or case study, we have tried to include further information about some of the boys. In the many reports about them, they are frequently defined by their deaths or by the behaviour that drew them into the youth justice system. We do, however, at the same time recognise that the crimes committed by these boys could also have had a significant impact on the lives of victims.

Though they had offended, we have sought to go beyond this descriptor because it is important that each boy who died is remembered primarily as a child with interests, hopes, wishes and feelings. It is, however, perhaps a sad indictment of their circumstances that, despite the many lengthy investigation reports into the boys' deaths, we know very little about their personalities or aspirations. As Stephen Shaw says in his report on the death of Adam Rickwood:

> *I have found this a uniquely troubling story. At its centre is an intelligent but damaged and vulnerable 14-year-old boy who took his life while in the care of the state, having planned the details of his own funeral. If this does not constitute a tragedy, the word has lost all meaning.*

PPO, 2006a: p105

The case studies that follow are compiled from Prisons and Probation Ombudsman (PPO) reports, local authority Serious Case Review reports (where published) and other publications. Rather than trying to give a full overview of each child's situation, they seek to illustrate some of the key themes that have arisen in a number of cases. At the end of each case study we have outlined some of the key actions taken which have addressed the recommendations made.

Placement decisions
Liam McManus

Liam was from Liverpool and from the age of seven was raised by his aunt and uncle. He found it difficult to settle at school and as he got older, his behaviour became increasingly troubled. He received help from mental health services and others. He engaged in what was described as 'persistent low-level offending over a short period of time' and was sentenced to serve a four-month Detention and Training Order (DTO).

By the time he died, Liam had been held in three different custodial establishments. First, in June 2007, he was placed in Thorn Cross YOI, but after ten days, he was moved to Red Bank Secure Children's Home (SCH). Although Liam had been identified as at risk of self harm and bullying, this

was not the reason for his move to Red Bank. In fact, it was considered that because he was awaiting a trial for further charges, the open conditions available for him at Thorn Cross were not appropriate for him.

Liam was released from Red Bank in August, but within a couple of weeks had returned, having breached the conditions of his order and been given a new four-month DTO. Upon release from Red Bank, Liam again breached the terms of his order and on 8 November 2007 was recalled and placed into Lancaster Farms YOI. Liam was found in his cell on the morning of 29 November 2007.

Liam had been identified as at risk of harming himself and others. This was well-documented and shared with the YJB and subsequently with the YOI. The YJB had followed the recommendation of Liam's youth offending team (YOT) worker – who knew Liam and his circumstances best – that he be placed in a YOI rather than an SCH, feeling that a more controlled environment would be better for him. Under the circumstances, and with no apparent reason to question the recommendation, Liam's *Asset* was not examined by the YJB Placement Service and another placement was not considered.

The PPO accepted that an SCH placement would not have been appropriate for Liam and acknowledged that to send him to an STC would have meant him being far from home and would potentially have impacted on his contact with family. However, in his final assessment, the PPO concluded that "…the YJB are ultimately responsible for making placement decisions, I do not think they should rely solely on the recommendations of the YOT worker."

Additionally, the PPO felt that the placement contradicted the YJB's own guidance on the placement of 15 to 16 year-old boys who shared the sort of risk factors Liam was known to have. He recommended that:

> *Urgent steps should be taken by the YJB to ensure that placement decisions are made in accordance with the criteria explained on its website. Placement recommendations and decisions should be informed by an assessment of young people's ability to cope with the physical and cultural environment of the establishments under consideration. Placement recommendations and decisions should also take account of all available information about the young people under consideration, including home circumstances, Asset details, vulnerabilities and risks, as well as any relevant suggestions made by staff in the establishments in which young people have previously been held.*
>
> Prison and Probation Ombudsman, 2009

Action taken

- We have introduced improved quality assurance of placement decisions to make sure that staff are supported to make safe and appropriate placements (see page 15)
- We promote a culture where YOT placement recommendations are challenged where we think that a child's needs can be better met elsewhere (see page 16)
- We introduced the Placement Information Form (PIF) to enable YOTs to

provide key information about a child's needs and risks for the specific purpose of making placement decisions (see page 15).

Distance from home and transfer requests
Adam Rickwood

Adam was from Burnley in Lancashire, where he lived for most of his life with his mum and three sisters. He was described by an educational psychologist as "an intelligent boy who has the potential to succeed academically and follow a worthwhile career path". He was close to his grandparents, and had hoped to work in a friend's car-valeting company after he left Hassockfield STC.

Adam died at Hassockfield STC in August 2004 when he was 14 years old. He had been placed at Hassockfield STC on 10 July 2004, which was around 100 miles from his home. He was held under a court-ordered secure remand, which had been in place since 29 June. However, before that date, and although the court had required it, secure accommodation had not been available, and Adam had been placed in two children's homes. He absconded from the first, but had settled well in the second by the time a secure placement became available. The jury in the second inquest into Adam's death found that his placement so far from his family home "more than minimally" contributed to Adam taking his own life.

Adam's mum was concerned about his placement at Hassockfield and raised this with his YOT worker soon after his arrival. However, a transfer request was not submitted until he had been at the STC for 10 days. The PPO found that the transfer request was inadequate, as it failed to provide supporting evidence of Adam's risk factors and his distance from home. The PPO was unable to find evidence of the YJB having done anything with the transfer request, and it appears that, because it was not marked as urgent, it was not prioritised by the YJB Placement Service at a time when there were a number of young people waiting for beds in SCHs (the type of placement that had been requested for Adam).

During his review of Adam's case, the PPO found that, regardless of whether Hassockfield was the right establishment for Adam, decisions about his placement were hampered in two key ways. First, the Placement Alert Form used by YOTs was in need of improvement, as it did not provide sufficient opportunity for YOT workers to highlight concerns about risks to young people's safety and well-being and offered no guidance on how to escalate self-harm concerns. Second, the transfer process was unclear and did not enable those involved to know what to expect of the different people involved in the process, including families.

Action taken

- We commission sufficient capacity within the youth custody to ensure that there are spaces in secure accommodation for all children who need it, and have the option of spot purchasing additional beds in secure children's homes if and when we need to
- The criteria and process for requesting a transfer are now on our website

and we have promoted this among YOTs (see page 17)

- We use a range of communication tools to publicise the financial support available to families visiting children in custody (see page 16).

Risk assessments
Joseph Scholes

Joseph was from Manchester, where he lived for most of his life with his mother and his sisters and brother. He liked climbing trees and building dens. It is thought that he was sexually abused as a child (Lambert, 2005) and this is likely to have at least contributed to his very disturbed behaviour, which eventually led to him being looked after in a children's home.

Joseph was given a Supervision Order following an incident with his father and then, while staying at the children's home, he was with a group of other young people who committed a violent street robbery in Sale. Although it was accepted at court that Joseph had not been physically involved in the robbery, he received a two-year DTO. He was sent to Stoke Heath YOI where he remained for nine days, before he died on 24 March 2002.

Though much has changed in the process for placing young people in custody since Joseph died in 2002, the lessons from his case are still very valid. There were a number of reviews into the circumstances surrounding Joseph's death. Perhaps most notable of these was the Lambert Review, commissioned by government and published later in 2005. The Lambert Review considered in great detail both the circumstances of Joseph's placement in custody and the changes to the systems for placing young people in custody that had occurred afterwards.

Joseph was 16 when he was placed in Stoke Heath YOI. It was his first time in custody and he was recognised as being at risk of self-harm. There were no places available in SCHs or STCs at the time Joseph was sentenced and, as such, he was instead sent to a YOI. Though the YOI was made aware of Joseph's risks, his YOT continued to be concerned about whether Stoke Heath was the right environment for him and, on 21 March, three days before Joseph died, his YOT worker submitted a transfer request to the YJB asking for him to be moved to an SCH. A staff absence meant that the transfer request was not dealt with by the YJB. The reviews into Joseph's death all found that he should have been placed into an SCH and that, while much of the paperwork which accompanied him to custody was well completed, the format of the documents did not allow for the risks he posed to be sufficiently assessed or described.

Action taken

- The format of the Placement Information Form now highlights key areas of risk to young people's safety and well-being
- Our internal processes for responding to transfer requests are more robust and include a minimum requirement for the YJB to respond to non-urgent, unplanned transfer requests within three days

- The work undertaken by the YJB and many others to reduce the use of custody for children means that custody is used as a last resort and that there are now robust and more appropriate community interventions for children who can be rehabilitated more effectively in the community (see page 17).

Bullying
Sam Elphick

Sam was born and lived in Manchester. He had three siblings and was described by his mother as fearless. He enjoyed some gardening work he did as part of a reparation order. Sam's mum sought help for him on a number of occasions while he was growing up because of his destructive behaviour and difficulties engaging with school, and he eventually became a looked-after child. He became involved in crime and was remanded in custody at Hindley YOI.

Sam had a very difficult time in custody and frequently self-harmed. He also reported a number of incidents of bullying. In his report, the PPO recognised the difficulties a large establishment like Hindley has in managing bullying and recommended that:

> *Consideration should be given to sub-dividing the juvenile accommodation at Hindley, in order to facilitate better care and supervision of young people, particularly in the furtherance of minimising the opportunity for bullying.*
>
> PPO, 2008

Action taken

- We have commissioned specialist units to better support those children who are identified as having particular needs and/or where there are identified risks to their safety or well-being (see page 26)
- In 2012 we revised and reissued our *Behaviour Management Code of Practice* (YJB, 2012a). This document explains to custody providers what the YJB expects them to do to ensure that establishments provide a culture of safety and positive behaviour where bullying is addressed (see pages 22 and 30)
- We are working with secure estate providers to ensure that restorative justice is used as a key and proven method of repairing harm and resolving the issues that have led to it (see page 30).

Special support for children at risk of self-harm
Ian Powell

Ian was from Skewen, near Neath in Wales. He had a difficult childhood and entered the care system when he was eight or nine years old. He was unsettled and spent time in a variety of care placements. He first became known to the police when he was 10 years old and, by the age of 15, he was

in custody serving a 10-month DTO at Ashfield YOI. Ian had the support of the Neath Port Talbot Leaving Care Team, but struggled to live independently when he returned to the community after a second period in Ashfield. He relied heavily on alcohol and drugs, which frequently affected his behaviour. He sometimes slept rough and was described by staff who worked with him as reverting to a fantasy world when things were difficult.

On 9 September 2002, Ian was detained overnight by police – there was a warrant for his arrest because he had failed to attend court in relation to offences he had been arrested for in August. When he was detained, Ian lost his accommodation and so the court considered that he could not be bailed. He was remanded to Parc YOI and died there by hanging less than a month later on 6 October 2002.

Before he went to Parc, it was known that Ian was both at risk of harming himself and susceptible to bullying – a concern which had left him afraid to return to Ashfield YOI where he had previously been held. One of the reviews into Ian's death found that, after arriving at Parc, he was not assessed as requiring additional monitoring but as benefiting from sharing a cell. Despite this, he had no contact with his personal officer and spent long periods of time on his own in his cell, when he developed a pattern of being awake until the early hours and asleep during the day. This enabled him, on the night of his death, to burn holes in his light fitting in order to secure a ligature.

Action taken

- Purposeful activity a vital element of rehabilitation. Secure estate monitors see regular data on this from secure establishments and are able to challenge poor performance
- We have introduced advocacy services in all establishments to ensure that children's voices are heard and that they have independent support when they need it (see page 28).

Restraint
Gareth Myatt

Gareth was from Stoke-on-Trent and received his first conviction in 2000, aged 11. His family life was chaotic and he had difficulties with his behaviour from an early age. He spent a number of periods of time in various care settings. He was first remanded in custody in October 2002, when he was 13 years old.

Gareth died at Rainsbrook STC, Northamptonshire on 19 April 2004, having been restrained by members of staff. While being restrained, Gareth vomited. He died from positional asphyxia. At the time of his death, Gareth had been at Rainsbrook STC for four days and was serving a DTO after pleading guilty to breaching his community sentence under the Intensive Supervision and Surveillance Progamme (ISSP), and two further offences.

The reviews into Gareth's death recorded the circumstances immediately preceding his death as follows. Gareth was asked to go to his room, after he had become abusive when asked to clean a sandwich maker by staff. Later

that evening, staff went to Gareth's room to speak to him and he became more verbally aggressive. Staff then took the decision to remove items from his room, which they felt was necessary to reduce risk. As this was happening, Gareth tried to assault staff, and was restrained. Gareth stopped speaking or struggling, appeared to have difficulty breathing and was released from restraint.

Although a verdict of accidental death was recorded by the inquest jury, the coroner wrote to the Secretary of State for Justice and suggested 34 actions under his Rule 43 powers.[22] Eleven of the recommendations related directly to the governance, policy, use and monitoring of restraint and the key issues highlighted by the inquest are detailed on page 19. The jury expressed concern that no-one at the YJB had management responsibility for Physical Control in Care (PCC), the restraint policy that was in place at Rainsbrook when Gareth died.

Action taken (see Chapter 4)

- The government banned the use of the technique used to restrain Gareth
- We supported the development and roll-out of a new restraint system: *Minimising and Managing Physical Restraint*
- We worked with others to clarify the roles and responsibilities in relation to the use of restraint in secure settings.

Remand arrangements and transfers
Gareth Price

Gareth was the ninth of 13 siblings and lived near Durham. He was active and enjoyed cycling, boxing and horse riding. When Gareth was 12, he discovered the body of his older brother after he had killed himself. This had a profound effect on Gareth, who was described by his family as changing 'overnight'. Within 18 months, he was involved with the youth justice system. In 2003, Gareth was driving a stolen car in which one of his friends died. He received a Referral Order for the offence of death by dangerous driving, but again his behaviour deteriorated and, despite support from family and professionals, on 6 September 2004, Gareth was eventually remanded in custody charged with two very serious offences.

While on remand, Gareth repeatedly self-harmed and threatened to self-harm, including two incidents when he placed a noose around his neck. Gareth died at the Royal Infirmary Preston on 20 January 2005, after he had been found hanging in his cell at Lancaster Farms YOI.

Gareth had offended in Merseyside while on holiday, which meant that, after arrest, he had been taken to Sefton Magistrates' Court, where he was given a court-ordered secure remand. The conditions of the remand meant that he had to be held nearby in HM Prison Service accommodation. The YJB was therefore not involved in the decision to place Gareth at Lancaster Farms.

[22] www.justice.gov.uk/downloads/burials-and-coroners/guide-charter-coroner.pdf

However, the inquest into Gareth's death found that the YOT in this case was unclear as to its responsibilities in influencing the placement decision and did not understand the differences between a remand to custody and a court-ordered secure remand.

Gareth had pleaded guilty to the offence he had been charged with at the hearing in October 2004, but he remained on remand at Lancaster Farms and had not been sentenced by the time he died. Evidence given to the PPO and the coroner suggested that he could have been transferred to a more suitable establishment closer to his home shortly after sentencing. While this is conjecture, because Gareth was never sentenced, the PPO and the coroner raised concerns about the clarity of the YJB's process for the request of transfers,[23] as such a request could have meant Gareth being placed more appropriately during the time he was remanded.

Action taken

- In 2012 the government introduced the Legal Aid Sentencing and Punishment of Offenders Act (LASPOA), which created a single remand order and removed confusion about who could be placed in different types of youth secure accommodation following remand (see page 17)
- We issued guidance to YOTs to ensure clarity about what the changes introduced by the LASPOA meant (see page 17)
- All children remanded now become 'looked-after children' and are therefore entitled to additional support from their home local authority when remanded (see page 17).

Transitions between youth and adult justice services
Billy Coulson

Billy was from London. He had become involved in crime and was supervised by a YOT from the age of 14. In November 2007, Billy was sentenced to an 18-month DTO, which he served at Huntercombe YOI. During his time there, Billy attended education and church services. When he was released on licence in June 2008, Billy had turned 18 but, because he was serving a DTO, he continued to be supervised by his YOT during the community element of his sentence.

On 15 September 2008, Billy was arrested for a further offence. He appeared before magistrates at Stratford Court – an adult court with no YOT practitioner in attendance – on 16 September. He was taken to Chelmsford Prison, an adult establishment. Billy was 18 years and five months old when he was found hanging in his cell on 20 September 2008.

The Probation Service at court on 16September had no information about Billy (and would not normally have assessed him prior to his court hearing anyway), but both the police and his sister had contacted the YOT and asked someone

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[23] The YJB would have been responsible for responding to a transfer request despite not being involved in Gareth's initial placement.

to attend. His resettlement worker went to court but unfortunately did not arrive until after Billy had appeared in court, where he was remanded to custody. She saw Billy and was concerned by his behaviour. She brought this to the attention of the court custody officers, and later his YOT case manager and one of the YOT team managers. Billy was not placed on self-harm or suicide monitoring at court, or when he arrived at prison, where he was assessed as having no risks of self-harm or suicide.

The following day, once Billy had been transferred to Chelmsford Prison, the three YOT officers met to discuss their concerns about the risks to his safety. They telephoned the duty governor at Chelmsford and explained that Billy had mental health issues, alcohol problems and that he had previously self-harmed and attempted suicide, with his last attempt having been only two days before he was arrested. The duty governor took note of this information and passed it to the Safer Custody Team within the prison. However, all of the concerns raised by the YOT were not communicated within the prison. Billy shared a cell for his first three nights in custody. He was then moved to a different wing and placed alone in a double cell the night before he died.

Action taken (see Chapter 6)

- We jointly funded (with MoJ) a project to develop the *Y2A Portal* which enables practitioners to share information about needs and risks in a timely way when young people move between the youth and adult justice systems
- We commissioned NOMS to improve transitions between youth and adult custody
- We established and jointly chair a cross-government Transitions Forum which seeks to improve safety and reoffending outcomes for young people in transition in the criminal justice system.

Appendix B: Investigations

Since the YJB was established by the Crime and Disorder Act 1998, the investigation frameworks that enable independent learning following a death in custody have changed. Each death has been subject to a coroner's inquest with a jury and, since the death of Adam Rickwood in August 2004, all deaths have also been investigated by the Prisons and Probation Ombudsman (PPO). In almost all cases, the local authority in the area the young person normally lived in has conducted its own review of the way agencies worked together to support and protect them. These reviews have been in different formats. The remit and key objectives of the three main investigation types are summarised below.

Coroner's inquest with jury

Coroners inquire into violent or unnatural deaths, sudden deaths of unknown cause, and deaths that have occurred in custody. An inquest is a limited, fact-finding inquiry, the purpose of which is to:

- establish the identity of the person who has died, and how, when, and where the person died
- assist in the prevention of future deaths
- provide public reassurance.

An inquest does not establish liability or blame. Although it receives evidence from witnesses, an inquest does not have prosecution and defence teams, like a criminal trial. The coroner and all those with proper interests simply seek the answers to the above questions.

In every jury inquest, the coroner decides matters of law and procedure, and the jury decides the facts of the case and reaches a verdict. The jury cannot blame someone for the death. If there is any blame, this can only be established by other legal proceedings in the civil or criminal courts, although the jury can state facts which make it clear that the death was caused by a specific failure of some sort or by neglect.

PPO fatal incident investigation

The PPO's office exists to carry out independent investigations into deaths and complaints concerning:

- those in custody, including young people in secure training centres (STCs) and under-18 young offender institutions (under-18 YOIs)
- those supervised by probation
- immigration detainees.

The ombudsman decides on the extent of the investigation, depending on the circumstances of the death. The ombudsman's remit includes all relevant

matters for which the National Offender Management Service (NOMS), the UK Border Agency and the YJB are responsible (except for SCHs in the case of the YJB), or would be responsible if not contracted elsewhere. It therefore includes services commissioned from outside the public sector.

The aims of the ombudsman's investigations are to:

- establish the circumstances and events surrounding the death, especially regarding the management of the individual by the relevant authority or authorities within remit, but including relevant outside factors
- examine whether any change in operational methods, policy, practice or management arrangements would help prevent a recurrence
- in conjunction with the NHS where appropriate, examine relevant health issues and assess clinical care
- provide explanations and insight for the bereaved relatives
- assist the coroner's inquest to fulfil the investigative obligation arising under Article 2 of the European Convention on Human Rights,[24] by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable action or practice is identified, and any lessons from the death are learnt.

Local safeguarding children board Serious Case Reviews

The scope of the local safeguarding children board includes safeguarding and promoting the welfare of children in three broad areas of activity:

- work to protect all children from maltreatment, or impairment of their health or development, and to ensure that they grow up experiencing safe and effective care
- proactive work that aims to target particular groups – for example, children identified as "in need" under the Children Act 1989 and groups of children who potentially face greater risks to their safety and wellbeing than the general population, for example children in the youth justice system, including custody
- responsive work to protect children who are suffering, or are likely to suffer significant harm.

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[24] Article 2 states:

> *1. Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.*
>
> *2. Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than absolutely necessary:*
>
> *a. in defence of any person from unlawful violence;*
> *b. in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;*
> *c. in action lawfully taken for the purpose of quelling a riot or insurrection.*

The main purposes of a Serious Case Review are:

- for agencies and individuals to learn lessons from the case to improve the way in which they work, both individually and collectively, to safeguard and promote the welfare of children
- to identify clearly what those lessons are, both within and between agencies, and how, and within what timescales, they will be acted on, and what is expected to change as a result
- to improve intra- and inter-agency working and better safeguard and promote the welfare of children.

Serious Case Reviews are not inquiries into how a child died or was seriously harmed, or into who is culpable. These are matters to be determined by coroners and criminal courts, respectively.

The YJB's approach to learning

Our approach to learning, and translating that learning into change, has evolved over the years. We have always seen the learning from deaths in custody as a high priority for the organisation. The YJB's Safeguarding Team supports all investigations and inquests, and reports regularly to the chief executive and the Audit and Risk Committee to embed the lessons from deaths in custody in the policies and strategies developed by both the YJB and the bodies with whom we work.

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Publication reference number: B462