Youth Justice Board
Bwrdd Cyfiawnder Ieuenctid

Recommendations to the Youth Justice Board for England and Wales, following investigations into deaths of children in custody between 2000 and 2010

Contents

Introduction

The tables in this document contain recommendations made to the Youth Justice Board (YJB) following the deaths of children in custody between 2000 and 2010. These recommendations are taken from available records and the document therefore may not, therefore, provide an exhaustive record of recommendations received prior to 2004.

Liam McManus, died 29 November 2007, aged 15

Source	Date of recommendation	Recommendation
Coroner (Non-Rule 43 Report)	2009	Since Liam McManus' death the YJB have moved to 'e' Asset, which as I understand it, is an electronic document that all wing officers are able to access. My concern in relation to this document is two fold. The first is that in Liam McManus' case the caseworker failed to read the Asset document, post court report and vulnerability alert which were available to him. The consequence of this was that the YOTs expectation that the prison officers would be aware of the risks that Liam posed was completely circumvented. This may be due to pressure of time occasioned by reception targets, late arrivals and number of prisoner arrivals at one time, all of which have concerns raised by the prison officers at this inquest. My concern is that whilst the 'e' asset document may be available it does not mean that it will be looked at. The second point is that Liam's Asset documentation extended to some 32 pages. Whilst it may be hoped that prison officers read this document, the reality of the situation from all of the inquests I have done in both the adult and juvenile estate is that prison officers are extremely pressed for time. A 32 page document may prove a hindrance to a prison officer obtaining information when he is short of time and dealing with a prisoner in fraught circumstances. My concerns were whether or not the YJB had offered training or guidance to YOTs as to including the necessary information in a briefer form which can be more easily absorbed by prison officers. Whilst I appreciate the Asset documentation is primarily a tool to minimise re-offending and sentence planning it appears that its use is now being widened to an audience that may be less familiar with the complexities of such an instrument.

Source	Date of recommendation	Recommendation
Coroner (Non-Rule 43 Report)	2009	The new documentation produced for the Youth Justice Board is a substantial improvement over the pre-existing documentation. I also welcome the change in terminology from “vulnerable” in non COSR to “significant risk factors”. However, two points do occur. The first is, as raised by Mr Pickett, Head of St Helens Youth Offending Service, that there is no indication as to what “significant” means. Whilst I appreciate that it is not possible to define “significant” some indication may be beneficial. “Significant” is, in judicial parlance usually taken to mean something that contributes more than minimally, negligibly or trivially to an event. My concern is that YOTs are sufficiently clear as to what the term means so that they can discharge their functions and “significant” does not replace “vulnerable” as a term of debate at deaths of juveniles in custody. The second point relates to paragraph 6.9 of the Operations Manual for the Allocation, Placement and Transfer of Young People within Young Offenders Institutions. It appears to me that the test employed in this paragraph differs from whether or not a person suffers from significant risk factors and in their paragraph requires that a person has to be expressly at risk from themselves or others to be placed in an STC or SCH.
Prisons and Probation Ombudsman	2009	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.

Source	Date of recommendation	Recommendation
Prisons and Probation Ombudsman	2009	Urgent steps should be taken to ensure that placement decisions are made in accordance with the criteria explained on the YJB website. Placement recommendations and decisions must 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 125 staff in the establishments in which young people may already have been held.
		(Joint YJB and NOMS). A protocol should be agreed for the prompt and efficient transfer of young people's custodial records when they move between Secure Children's Homes, Secure Training Centres and Prison Service establishments. The protocol should make it clear that YOT workers are responsible for arranging the transfer of such documents.
		(Joint YJB and NOMS). Consideration should be given to the implementation of a system for the effective transfer of information when a young person serves his sentence in more than one location, whether that be a Secure Children's Home, a Secure Training Centre or a YOI.
Serious Case Review (St Helen's Local Safeguarding Children Board)	2009	The Chair of the Local Safeguarding Children Board to write to HM Prison Service and the Chief Executive of the Youth Justice board to request them to review and report on the effectiveness of mental health services at the YOI, especially mental health assessment, in the light of this Review.

Source	Date of recommendation	Recommendation
Serious Case Review (St Helen's Local Safeguarding Children Board)	2009	The Chair of the Local Safeguarding Children Board to write to the Chief Executive of the Youth Justice Board proposing introduction of an arrangement whereby, exceptionally, community based Youth Offender Services may signal to secure establishments a requirement for a priority sentence planning meeting.
		The Chair of the Local Safeguarding Children Board to write to the Chief Executive of the Youth Justice Board proposing that its Post-Court Report protocols and forms are amended so as to require an explicit examination of the subject's response to previous episodes of secure care (YOI, STC, LASCH) to inform recommendations to Court.
		The Chair of the Local Safeguarding Children Board to write to the Chief Executive of the Youth Justice Board and HM Prison Service proposing an arrangement which ensures that case records from previous periods of detention are, in the case of a breach of licence and recall, automatically transferred to the new establishment as they are already in the case of direct transfers.
		The Chair of the Local Safeguarding Children Board to write to the Chief Executive of the Youth Justice Board and the Secretary of State for Children, Schools and Families drawing attention to the concerns that have been raised in this Review about the potential for miscommunications and misunderstandings caused by the different ways in which terminology is used risk and its implications for working together.

Source	Date of recommendation	Recommendation
Serious Case Review (St Helen's Local Safeguarding Children Board)	2009	The Chair of the Local Safeguarding Children Board to write to HM Prison Service, and the Chief Executive of the Youth Justice Board proposing a review of and, if necessary, amendments to protocols, procedures and management roles so that assessment, induction and planning processes are expedited in cases of potential risk to the child.

Sam Elphick, died 15 September 2005, aged 17

Source	Date of recommendation	Recommendation
Prisons and Probation Ombudsman	2008	The YJB should consider the level of their monitoring of the Service Level Agreement at Hindley with a view to increasing its frequency and intensity.
		As part of the planned audit of National Standards, the YJB should consider clarifying the procedures in relation to when a young person arrives at a unit without all of the relevant paperwork, taking into account the NoDocs system that was introduced in 2004.
		The YJB should review the 'NoDocs' system to ensure that it makes an effective contribution to procedures for transferring assessment information between the community and the secure estate.
		The YJB should clarify the procedures in relation to a young person arriving at a unit without all relevant paperwork.
		The YJB should consider how to ensure that continuity and accountability are established and maintained between all the community agencies that have an interest in young people in custody.
Serious Case Review (Manchester Local Safeguarding Children Board)	2006	The Chief Executive of the Youth Justice Board should look into arrangements to coordinate the activity of YOTs working with the same child or young person.

Gareth Price, died 20 January 2005, aged 16

Source	Date of recommendation	Recommendation
Coroner Rule 43 Report	2008	My first concern regards the secure facilities placement booking form. It was quite clear from the evidence heard that what the YJB read into the completion of this document was entirely different from the views of the social worker completing it.
		Having read the general documentation dealing with the functioning of remand services and the role of YOTs neither I nor the family's Barrister understood how the system operated. Whilst the YJB documentation may be intelligible to those who are already familiar with the workings of the system, the documentation is arcane and unintelligible to those who wish to understand the operation of the system. In view of the confusion of at least one of the social workers before me in Court it would seem that clear and easily understood explanations of the social workers' role would be helpful.
		My concern relates to the post-court report section dealing with "vulnerability" ... The various witnesses in court gave widely differing descriptions of "vulnerability". Some described vulnerability in terms of depressive type symptoms and likely self-harm, others described it in terms of adverse treatment by other prisons and some described it in terms of factors that made it more likely that they may have a difficult time in prison or self-harm. In addition to these various descriptions there is also the legal description of vulnerability in respect of 15 year old boys set out in the Criminal Justice Act dealing with remand to various secure establishments. It appears that there are a range of uses of this term which are not consistently understood by those involved with its application or defined in the documentation.

Source	Date of recommendation	Recommendation
Prisons and Probation Ombudsman	2006	The Youth Justice Board should consider the possibility that any derogation from National Standards should be authorised by the relevant YOT Management Board with a clear record of the decision, justification for the decision and an action plan to reinstate the National Standard.
		YJB National Standard 2.56 is the shared responsibility of the home YOT and the establishment. The YJB should consider revision of this National Standard as part of its response to the findings from the National Standards Audit 2005.
		The health screening tool for juveniles, currently being developed by the Youth Justice Board, should be prioritised for completion. The First Reception Health Screen was designed for adults and it relies heavily on self reporting, which may be inappropriate for juveniles.
		The Youth Justice Board should publish the criteria by which decisions are made to transfer young people in order to increase confidence in the placement transfer process.
		The YJB should consider the collation and publication of data regarding the number of transfer requests received and the number actioned on a regular basis.
Serious Case Review (Durham Local Safeguarding Children Board)	2008	It is essential that the Youth Justice Board puts in place a mechanism to ensure that the recommendations outlined in the Prison & Probation Ombudsman report are monitored through the SLA with the Prison Service. The Youth Justice Board should also consider whether any of the recommendations proposed have application with individual Local Authority Secure Children's Homes and Secure Training Centres.

Source	Date of recommendation	Recommendation
Serious Case Review (Durham Local Safeguarding Children Board)	2008	The Youth Justice Board should ensure that remand management arrangements in secure establishments are monitored through its Effective Regimes framework to demonstrate YOTs/secure establishments are complying with the relevant National Standards.
		The Youth Justice Board should undertake a feasibility study to examine the costs and implications of removing all ligature points in all secure accommodation facilities for young people.
		The Youth Justice Board, in the light of the Children Act 2004, should identify with the DfES the roles and responsibilities of the lead professional as they affect the YOT practitioner.
		The Youth Justice Board should set out guidance requiring Local Management Boards of YOTs to be accountable for the implementation and monitoring of National Standards: the Board should be responsible for informing the Regional Managers of any departure from National Standards.
		The Youth Justice Board should review the implementation of National Standards 2.56 and 2.57.
		The Youth Justice Board, the Prison Service, the Department of Health and the DfES should draw up guidance to ensure that any child or young person in the secure estate thought to be experiencing or at risk if significant harm should be subject to the normal child protection procedures.

Source	Date of recommendation	Recommendation
Serious Case Review (Durham Local Safeguarding Children Board)	2008	The Youth Justice Board should draw up guidance in relation to recording policy, procedures and practice, and in particular in relation to timescales of the completion of records.
		The Youth Justice Board should undertake an audit of National Standards on an annual basis to monitor the extent to which YOTs are compliant with National Standards. The Youth Justice Board should explore the possibility of a thematic approach to areas of practice to provide YOTs with guidance on how to improve performance, possibly along the lines of the outcomes of the Children Act.
		Where a YOT is considering any derogation from National Standards through its local management structures, the Local Management Board should inform the Youth Justice Board Regional Manager of the local decision with a rationale and audit trail of discussion. Whilst the Regional Manager is unable to authorise any derogation of National Standards it is important that they are aware of any implications for service delivery at a local level.
		The Youth Justice Board should in conjunction with the DfES, Department of Health and Prison & Probation Ombudsman identify the status of Serious Case Reviews in relation to any review of a young person in the secure estate so that relevant reports are properly co-ordinated.
		In the light of its recent National Standard Audit findings on remand planning arrangements, the Youth Justice Board should consider further guidance for YOTs on remand planning

Source	Date of recommendation	Recommendation
Serious Case Review (Durham Local Safeguarding Children Board)	2008	The Youth Justice Board in conjunction with the DfES should seek to harmonise the various assessment systems including Asset and Common Assessment Framework, through a modular approach with core information being contained in one document with specialist modules being attached.
		The Youth Justice Board should publish criteria by which decisions are made to both place young people in secure establishments and to transfer young people between secure establishments.
		The Youth Justice Board should issue guidance on the process for requesting a transfer of responsibility for a young person in custody from the home YOT to the local YOT.
		The Youth Justice Board should seek to find extra resources to boost mental health services for YOTs and the secure estate.
		The Youth Justice Board should ensure that Regional Managers complete their own Local Management Reviews as part of the Youth Justice Board Serious Incident Procedure where a child dies in custody. The Youth Justice Board should also ensure that each Regional Manager is clear about their role in relation to Local Management Reviews as outlined in the revised Serious Incident guidance.

Source	Date of recommendation	Recommendation
Serious Case Review (Durham Local Safeguarding Children Board)	2008	Information on the role of the Prison & Probation Ombudsman, the new Local Safeguarding Children Board, the lead professional, the updating of Working Together and a general update of the safeguarding of children and young people in secure settings must be made available to YOTs and the juvenile secure estate through a briefing sheet. This should be undertaken by the Youth Justice Board immediately.
		The Youth Justice Board has no guidance or information on work with young people from Traveller families. Guidance should be provided for YOTs taking advice from NOMS and DfES who will already have some knowledge of work with Travellers.
		The Youth Justice Board should monitor the effectiveness of risk assessment guidance and take up of the training by YOTs during 2005.
		The Youth Justice Board should issue guidance on the roles and responsibilities of YOT staff seconded to YOIs with particular reference to how they relate to roles and responsibilities of Prison staff and other YOTs.
		The Youth Justice Board should ensure that the new social worker posts being created in YOIs are integrated into all safeguarding policy within a YOI. Where applicable, the Youth Justice Board should consider merging these posts into teams with other seconded specialist staff such as the seconded YOT remand workers to assist with co-ordinated case management.

Source	Date of recommendation	Recommendation
Serious Case Review (Durham Local Safeguarding Children Board)	2008	The Youth Justice Board should take the opportunity to reiterate to YOTs the importance of the case management role that each supervising officer has. The Youth Justice Board is advised to emphasis this as part of guidance on electronic case management systems and could integrate this into current feasibility work linked to plans for a new national case management system. YOT staff must also be made aware that once a child is received into secure accommodation the responsibility for that young person rests with the YOT through the case management arrangements.
		The Youth Justice Board should consider how to ensure that seconded YOT staff in any individual YOI are kept informed of any safeguarding matters concerning young people on remand or in custody. It is recommended that the new social worker posts within YOIs assist in implementing procedures to ensure that relevant information on any behaviour that places a young person at risk is passed immediately to seconded YOT staff and also on to the supervising officer in the home YOT.

Adam Rickwood, died 8 August 2004, aged 14

Source	Date of recommendation	Recommendation
Coroner Rule 43 Report (first inquest[1])	2007	The YJB monitor should be fully aware of all documents and statistics produced from an establishment with the detailed reporting procedures in place to ensure that all relevant information from all STCs is centrally monitored and assessed so the whole STC system and similar institutions may benefit.
		The evidence at the hearing showed deficiencies in the CCTV system, the morse watchman system and the handheld videos of restraints and therefore there should be clear management responsibility for ensuring the correct use of such technology, that it is funded adequately thus providing a significant benefit from protection for trainees and staff alike.
		I would encourage a regular audit of information sent by Youth Offending Teams to the YJB to ensure that sufficient and adequate information is being provided to ensure that young people are allocated to the most suitable institution.
		There needs to be clear training to ensure adherence to procedures and protocols affecting young people who may be subject to a Court Ordered Secure Remand (COSR)

[1] There was a second inquest into Adam Rickwood's death, which took place in 2011, but did not make any recommendations to the YJB

Source	Date of recommendation	Recommendation
Coroner Rule 43 Report (first inquest)	2007	With regard to trainees transfer request forms from one establishment to another there needs to be a clearly defined protocol to identify whose responsibility it is to send what information and when to the transfer team at the Youth Justice Board.
		I would hope that a review could be undertaken to enable consideration to be given as to whether there should be more than one level of response – perhaps a two tier response- to what is presently known as first response as there has been evidence provided at the inquest that a first response can be seen as an aLiam McManusost inevitable step towards PCC which may hamper the proper deployment of de-escalation techniques with the young person in question.
		The evidence clearly indicated that there was confusion between PCC instructors, PCC trainers and Care Officers with regard to PCC its application and the reasons therefore and when if ever guidance in the appropriate manuals could be disregarded.
		An urgent review should be undertaken to clarify the interrelationship 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.

Source	Date of recommendation	Recommendation
Coroner Rule 43 Report (first inquest)	2007	Some staff members could not remember being trained in matters of self harm/suicide awareness and if they could not remember being trained it is doubtful that they could remember what their training did or ought to have included. Accordingly, it may well be of benefit to all staff employed in STCs for a review to be carried out of training within centres particularly in matters of suicide prevention/self harm.
		The evidence indicated certain system deficiencies with regard to handover procedures and therefore I believe that it would be of benefit for there to be clearly defined handover procedures to ensure that important and relevant information about trainees was handed over from one shift to another.
Prisons and Probation Ombudsman	2006	I recommend that the centre Director and the YJB review the systems and procedures governing all aspects of operations in the centre to ensure nothing is left to chance and introduce robust audit procedures to monitor their effective implementation.
		I recommend that, in commissioning future STCs, the YJB follows the model for designing and constructing SCHs, particularly as it relates to obtaining professional advice from experts in child care in secure settings.
		I recommend that the YJB apologises for the lack of meaningful and timely engagement with Mrs Pounder following Adam's death.
		I also recommend that the YJB be required to respond to Transfer Requests with a likely timescale for transfer, so that the responsible local authority can be asked to find appropriate alternative accommodation (at least in the case of COSRs) instead.

Source	Date of recommendation	Recommendation
Prisons and Probation Ombudsman	2006	I recommend that the YJB revises the Placement Alert form to give much greater prominence to vulnerability.
		I recommend that the guidance document be amended to direct YOTs to consider specific areas of the young person's history, behaviour and current demeanour as well as their likely response to custody when assessing vulnerability.
		I recommend that the YJB conducts a review of the nose distraction technique and of the way it is taught.
		I recommend that the use of PCC (including the reason for it and any resulting injuries) be rigorously monitored by both centre managers and contract monitors and that investigations be carried out where: - the number of incidents in a particular month is high; or - where one member of staff is involved in a high number of PCCs as compared with his/her colleagues; or - where an injury has resulted.
Serious Case Review (Lancashire Local Safeguarding Children Board)	2006	The YJB and Ofsted review Hassockfield STC and ensure that all identified system failures have been addressed.
		The YJB reconsiders and redefines the role of the Monitor within STCs, given that the Monitor was not able to identify the system failures.

Gareth Myatt, died 19 April 2004, aged 15

Source	Date of recommendation	Recommendation
Coroner Rule 43 Report	2007	All matters raised by the death of Gareth Myatt should be brought immediately to the attention of OFSTED. OFSTED will, of course, need to examine and review the actual use of PCC by STCs. They will also need to examine the effectiveness of the system for referrals to outside agencies.
		Procedures to ensure speedy access for emergency vehicles to STCs should be reviewed.
		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.
		Those responsible for PCC must clearly state publicly the range of circumstances in which PCC can be used, whether there are immediate amendments to the STC rules or not. Those responsible must also constantly consider whether or not PCC is being used too frequently, or is being used inappropriately, for example as a “default” system in the way I have already outlined.

Source	Date of recommendation	Recommendation
Coroner Rule 43 Report	2007	Whatever decision is made by Parliament as to the circumstances in which PCC can be used, there must be full and careful teaching given to staff as to the meaning and full implications of the STC Rules. Staff and trainees need very clear guidelines as to the day-to-day interpretation of the STC rules and the circumstances in which physical restraint is and is not allowed.
		The resources at the Prison Service Training Centre at Kidlington (and elsewhere if relevant) should be reviewed, along with the system of training the National Instructors themselves, so as to ensure that all those at the highest level are familiar with developments in techniques and in medical knowledge of Positional Asphyxia at the relevant time.
		In the event that teaching continues to be "cascaded down", so that teaching continues to be carried out by STC staff at STC level, then as a bare minimum there needs to be nationally based supervision and inspection of such teaching, by the Ministry of Justice.
		Particular attention should be paid, during training, to the theory and practice as to "medical aspects" arising from the use of PCC, with full discussion of those aspects. There should be distinct "lesson plans" within the teaching to minimise any tendency for the teaching to be diluted by the "cascading down" process.
		The present PCC manual should be reviewed immediately and regularly thereafter, so as to ensure that it contains the most up to date medical information.

Source	Date of recommendation	Recommendation
Coroner Rule 43 Report	2007	The PCC manual (or a simplified but adequate version of it, particularly with regard to medical safety) should be provided to all those staff in STCs who are empowered to use PCC. Such a document should also be provided to all those with monitoring responsibilities.
		A system should be established to inform the staff coming on duty as fully as possible about the newly arrived trainees whom they will be dealing with. It is unsatisfactory that staff pick up the information piecemeal, for example by what they might be told by other staff handing over to them, or by using such information as might be available in their unit within files.

Ian Powell, died 6 October 2002, aged 17

Source	Date of recommendation	Recommendation
Serious Case Review (Bridgend Area Child Protection Committee)	2003	The Chief Officer of the Youth Justice Board should ensure the arrangements for commissioning and establishing additional capacity in the secure estate take fully into account the issues that have arisen concerning the fitness of HM Parc to provide care for vulnerable young people that were evident some months after it opened. This should include adequacy of staffing and management arrangements, supervision, monitoring, training and clarity of the policy and procedural framework.

Joseph Scholes, died 24 March 2002, aged 16

Source	Date of recommendation	Recommendation
Lambert Report[2]	2005	PSO 4950 sets out requirements in cases where it is considered that a young person should be referred for in-patient psychiatric treatment in an NHS hospital under the Mental Health Act 1983. The young person must receive a psychiatric assessment and an application for transfer must be made to the Home Office. It is understood that although this process may be satisfactorily undertaken, the problem remains one of availability and accessibility of suitable secure in-patient psychiatric beds. This is a major problem that is currently being addressed in discussions between the YJB and the NHS. This Operational Review strongly supports those initiatives. Until this serious and constrained resource issue attracts some relief, it will continue to act as a major inhibitor to the realisation of the safeguarding objectives set for Health Care Centres.
		This situation makes it vitally important that the YJB and the Prison Service use every means to closely monitor and quality assure policies and practice in this area. Key aspects of the reception arrangements can be subject to regular monitoring and review, and these should complement the monitoring remit of the regional YJB Performance Monitor.

[2] Lambert, D. (2005) *Review of the Effectiveness of Operational Procedures for the Identification, Placement and Safeguarding of Vulnerable Young People in Custody.*

Source	Date of recommendation	Recommendation
Lambert Report	2005	The use by the Prison Service of protective clothing as an aid to the management of young people who threaten self-harm and suicide will remain a contentious issue. The aim must be to reduce recourse to this practice to an absolute minimum. It will therefore be important for the Prison Service and the YJB to closely monitor its incidence and level of use. It is recommended that this should be achieved through the institution of regular sampling exercises by the YJB Performance Monitor.
		The YJB accepts that to achieve a secure juvenile estate that is based upon, and is able to fully embrace in practice, the above vision will not be achieved easily and may indeed take some time. They accept that the current range of provision is less than ideal; that there is a geographical imbalance in provision, many YOI units being still housed in large, traditional cell block buildings on sites shared with young adult prisoners and that much more needs to be done to train and develop staff in all establishments in positive, child-centred care and control methods. There is also a need for additional high quality educational and vocational training that prepares the young people for their return to, and resettlement, in the community.
		Importantly, the YJB has agreed that an initiative should be launched that will explore the development of smaller scale 'intermediate' units within selected YOIs. The units will be designed and appropriately managed and more intensively staffed so as to meet the needs of a minority of older young people identified as 'particularly needy'. There is general agreement that some older boys cannot, for a variety of reasons, cope with the mainstream YOI population and also cannot be placed with much younger, smaller or less mature children in an STC or LASCH. Should such developments take place this would be a welcome addition to the range of provision currently available to young people with such special and demanding needs.

Source	Date of recommendation	Recommendation
Lambert Report	2005	The YJB is also exploring alternatives to full security, including the possibility of extending the quantity of open YOI accommodation (currently 60 open beds are provided in one YOI) and the provision of units with a secure perimeter only. Another alternative may be the development of closely supervised accommodation within a community location.
		It is important that YOT staff are provided with good quality and contemporary information about positive developments within the YOI estate.
		It is noted that the YJB has, for some time now, sought to develop separate arrangements for the escorting of juvenile offenders to YOI from court; escorting young people with adult offenders is not safe or satisfactory. Separate arrangements already exist for the children and younger detainees up to 16 years of age and the YJB plans during 2004/5 to extend the service to other juveniles. This move is welcome and everything must be done to abolish the conditions reported above.
		The question of a possible re-design of the plan to accommodate more information and planning has been raised with the YJB. The YJB report that feedback from YOTs who have seen and tested the new Plan [The Vulnerability Management Plan form (Version 2-August 2004)] have been very positive and the YOT-specific format is seen as a useful addition to Asset. The current preference is for the retention of the shorter format that practitioners can complete thoroughly rather than have a longer, more detailed document that does not get completed. If a young person becomes involved with other agencies then additional planning and review documentation will be required. This Operational Review therefore recommends that the new format be thoroughly reviewed after a suitable period of use.

Source	Date of recommendation	Recommendation
Lambert Report	2005	The material and concerns examined in this Operational Review, which relate to the management of risk and to the understanding and clarification of the concept of vulnerability, reinforce the importance of supporting this initiative. The lessons from the investigations into the death of Joseph Scholes and similar Serious Incident Reviews demonstrate how key the Asset framework is to the entire process and how important it is that YOT staff and other colleagues in the juvenile justice system use it fully and with confidence. The new guidance on the management of risk will need to be appropriately incorporated into the INSET training once the new assessment materials have been produced.
		This Operational Review would wish to support the aim of achieving a higher and more confident level of decision making, but this will only be attained by the development of features of the placement process already in place. The Placements Team is a learning organization and would appear to have the capacity to provide first class service. Greater confidence in this area will be achieved by: - improved completion of the Asset documentation and supportive evidence. - closer dialogue between YOT officers and Placements Team caseworkers about the judgement of degrees of vulnerability - shared knowledge and assessment of placement options - shared decision making about preferred placement options and contingency planning - moderation, through supervision, of placement decisions by the head of the Placements Team - establishment of a placements decisions audit trail.

Source	Date of recommendation	Recommendation
Lambert Report	2005	It is important that the YJB has a clear placement policy that articulates how the places within the secure estate are to be utilised and how access to these places is managed through the effective working of the YJB Placements Team
		This Operational Review strongly supports the aim of reaching and maintaining a higher and more confident level of decision making, but this will only be attained by the consistent development of features of the placement process already in place
		The most crucial element in this framework is the development of mutually confident dialogue and shared working between the staff of the YOT and the YJB Placements Team
		The YJB have selected performance in this important area of practice as one of its eight secure estate Performance Indicators for 2004/5. At May 2005, provisional Prison Service performance figures for 2004/5 appear to show that over a quarter of young people (26.1%) continue to arrive at YOIs without the relevant paper work. This is a matter of ongoing concern. The YJB and Prison Service should maintain pressure across the youth justice system to improve performance in this area of practice.
		If the proposal to require YOTs to support their completion of the Asset with contributing evidence is followed then it makes sense that this material should also travel with the young person
		Decisions to facilitate a transfer would appear to be appropriately based on a consideration of the young person's needs and behaviour, and the suitability of their current placement to meet those needs. This Operational Review supports the further development of transfer policy and practice where based on these principles.

Source	Date of recommendation	Recommendation
Lambert Report	2005	This Operational Review strongly supports the conclusion of the joint Child Protection and Safeguards Review, 2003, that the practice of moving young people around the YOI estate through Prison Overcrowding Drafts has a destabilizing impact both on the effectiveness of regimes and on the best interests of the young people transferred.
		Although it has been noted that a protocol for the selection of young people, and the procedures to be followed in such circumstances, has been agreed between the YJB and the Prison Service, it is recommended that this practice be kept under close review and all means of amelioration explored.
		The current internal YJB Placements Team framework for rating vulnerability and risk, the 'Key indicators of Risk' should be re-developed so as to align with the proposed 4-tiered categorization of vulnerability articulated by 'Managing Risk in the Community'.
Serious Case Review (Trafford Area Child Protection Committee)	2003	[For Trafford YOT and YJB] Especially in cases of vulnerability, secure placement booking forms should be sent to the YJB Team well ahead of trial accompanied by a full explanation of the risk factors at work and a clear recommendation for placement. The need to get permission to share medical reports should be anticipated. If necessary, the YOT Office should speak directly to the YJB case officer to ensure that there is full understanding and awareness. Procedures in the event of absence of key personnel or changes of personnel need to be considered.
		Secure placement booking forms should promote specificity, perhaps by offering a list of options and then asking for the reason for the choice.

Source	Date of recommendation	Recommendation
Serious Case Review (Trafford Area Child Protection Committee)	2003	The criteria for eligibility for placement in a secure children's home need to be explicit; referrers should be asked to provide facts to support the case using the criteria. Reasons for low priority ratings should be stated and the YJB Placement Team should check all marginal cases by speaking to the YOT.
		[YJB, Prison Service and Stoke Heath YOI] Arrangements for ensuring that the YOI gets all the relevant information quickly needs to be reviewed with respective responsibilities clearly established. In cases where a risk of self-harm is identified, YOIs should be provided with details of a child's psychiatric history when they arrive. if it is missing it should be pursued urgently. Furthermore, steps should be taken to ensure that anyone who needs to has access to all the information within Stoke Heath.
		[Trafford YOT and YJB] In cases where placement in a YOI carries unacceptable risk, the YOT should (1) communicate with the YOI within 24 hours to ensure everyone there is fully briefed and contribute to a protection plan; (2) the YOT initiate a transfer request as soon as the disposal is made; the process could be facilitated by identifying a place in a secure children's home at the same time. I acknowledge that the YOT management review recommends visiting in 3 days; my view is that this case required something quicker.

Kevin Jacobs, died 29 September 2001, aged 16

Source	Recommendation
Serious Case Review (Lambeth ACPC)	Consideration should be given to an effective method of collating psychiatric/ psychological information concerning young people in care/ custody and to the creation of coordinated Mental Health Plans.
	The information in the different agencies' databases should be collated, and those young people identified as particularly vulnerable who are young offenders and fall into one or more of the following categories: (a) in care; (b) have learning difficulties; (c) are prone to self harm; (d) have been sexually abused.
	The respective roles of the YOT officer and the social worker in relation to a young person who is both in custody and in care should be clarified. We consider the YOT officer should have the coordinating role but that the social worker should retain responsibility for all aspects of the young person's continuing care. We consider the development of a written protocol to be desirable.
	Consideration should be given to the commissioning of a review of the literature concerning suicide among adolescent boys generally, and adolescent boys in custody in particular. We think that such a review would inform training of relevant personnel, and the development of training materially usefully.