REVIEW OF THE EFFECTIVENESS OF OPERATIONAL PROCEDURES FOR THE IDENTIFICATION, PLACEMENT AND SAFEGUARDING OF VULNERABLE YOUNG PEOPLE IN CUSTODY

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OPERATIONAL REVIEW

PREFACE

This Operational Review of the effectiveness of procedures and practices that facilitate the identification, placement and safeguarding of vulnerable young people in custody was commissioned by the Minister for Correctional services, Mr Paul Goggins MP following the verdict of a Coroner's Inquest into the death of Joseph Scholes at HM Young Offenders Institution Stoke Heath in March 2002.

The Operational Review first summarises the findings of investigations, including the Coroner's Inquest, into the circumstances of Joseph's death. From the range of conclusions and recommendations of those investigations, the Operational Review identifies key areas of concern that need to attract attention if services are to meet their safeguarding responsibilities and hold public confidence. In later chapters, the Operational Review examines how improvements in specific areas of policy and practice can be developed and implemented.

As author I would like to place on record my thanks for the full support and assistance that has been offered during the preparation of this Operational Review. Special thanks go the Professor Rod Morgan, Chairman of the Youth Justice Board and to the managers and staff at YJB headquarters. Similar thanks are extended to Mr Nigel Hancock, Head of the Safer Custody Group (now part of the National Offender Management Service) and to Mr Ron Le Marechal, Head of the Prison Service Juvenile Group and their respective team colleagues.

I would also wish to thank Mr Stuart Robinson, Governor of Warren Hill YOI and Mr Peter Smallwood, Governor of Stoke Heath YOI for their generous assistance during my visit to their establishments. Finally I would like to thank Chris Holmes and Kathryn Coleman of the Safer Custody Group and Karen Jewiss of the YJB for their support and assistance with the excellent briefing that I received to inform the Review.

David Lambert CBE

Chair of Norfolk ACPC

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EXECUTIVE SUMMARY

Joseph Scholes

John Joseph Peter Scholes, known as Joseph or Joe, died by hanging at Stoke Heath Young Offender Institution on 24 March 2002. He was a little over 16 years old and was in the second week of a 24 month Detention and Training Order (DTO) for attempted robbery.

Joseph's life had not been easy. His parents separated in 1995 and he had had an unsettled existence, with frequent changes of house and school. From about the age of 12, Joseph became of concern to Trafford Social Services Department. He alleged that he had suffered physical and sexual abuse. He began to harm himself and became involved in substance misuse. A psychological assessment diagnosed Depressive Conduct Disorder and found that Joseph was a risk both to himself and to others. In November 2001, he jumped from a first floor window (possibly in an attempt to commit suicide) and was involved in a violent altercation with the ambulance crew who came to assist him. This incident resulted in a conviction for affray.

In December 2001, after the police had found him living in a car park in a caravan, he was placed in a children's home in Manchester. On the night of 6 December, he went out with three other children from the home. They committed a number of robberies, were arrested and subsequently tried and convicted. The judge, who accepted that Joseph's involvement had been peripheral and that there were concerns about his ability to cope with a custodial sentence, sentenced him on 15 March 2002 to a 24-month Detention and Training Order (of which up to half would have been spent in custody). He was placed in Stoke Heath Young Offender Institution. Because of his vulnerability he was accommodated in the Health Care Centre. Ten days into his sentence, in spite of a high level of care and a number of measures that had been taken to safeguard him, Joseph was found hanging from the bars of his cell.

There have been a number of investigations and inquiries into aspects of Joseph's death. The Prison Service conducted its own investigation; the Youth Justice Board (YJB) undertook a Serious Incident Review; and Trafford Area Child Protection Committee held a review under Chapter 8 of the Department of Health guidance, *Working Together to Safeguard Children*. An inquest was held over 10 days in April 2004. The jury returned a verdict of accidental death and pointed to systems failures that had contributed to it.

Following the inquest, the coroner wrote to the Home Secretary identifying a number of areas of concern and recommending a public inquiry. On 16 September 2004, in a Written Statement to Parliament, the Parliamentary Under Secretary of State for Correctional Services announced three measures he was taking in response to the coroner's concerns: the

Sentencing Guidelines Council was asked to consider the sentence Joseph had received; the Youth Justice Board was asked to take account of the coroner's concerns in drawing up its plans for the future of the secure estate; and I was appointed to review the operational issues arising from Joseph's case – those relating to the roles of the Youth Offending Team (Yot), the YJB and its placement team and the young offender institution itself.

Earlier reviews and investigations into Joseph's death

The investigations and reviews referred to in the previous paragraph, including the inquest, identified a number of areas of concern. These were: whether Joseph's sentence was appropriate; whether placing him in a young offender institution was in his best interests; and whether an adequate assessment was carried out pre-sentence. More generally, they questioned the suitability of the arrangements for placing children who are at high risk; the efficiency of arrangements for transmitting information to and within young offender institutions; and the adequacy of care and supervision arrangements in young offender institutions - and particularly of safeguarding measures. Apart from the two issues the Sentencing Guidelines Council and the Youth Justice Board have been asked to consider, these issues form the content of the current Operational Review (OR). The OR looks at the particular questions raised by Joseph's case within the context of the broader operational questions that have been identified.

Assessment of young people

Information on young people in the youth justice system is collected and transmitted by Youth Offending Teams (Yots) using the *Asset* form. This system was introduced by the YJB in 2000. It provides for an assessment of "dynamic risk factors" and includes an opportunity for the young person to give his or her own views. The consensus of the investigations into Joseph's death was that the *Asset* relating to him was less than satisfactory. It lacked important information. Best practice requires that *Asset* should be a "living document" and should be updated to include post-sentence information. Judgements need to be informed by evidence. Since Joseph's death, the YJB has taken a number of steps to improve practice relating to assessment. It has commissioned guidance for Yot staff. This OR strongly supports the principles underlying that guidance and the advice it gives. The four-tier categorisation of risk it employs is a useful basis for prioritisation. The YJB has developed the template for a Vulnerability Management Plan, to be used in the case of higher-risk young people. Practitioners have commented favourably, but it may need to be made more comprehensive. This OR therefore recommends that it be reviewed within a reasonable time of its introduction. The YJB has also issued guidance on the sharing of information between agencies.

Placement of young people in custody

Offenders under 18 who are sentenced to custody are placed in one of three types of establishment: a young offender institution; a secure training centre or a secure children's home. The YJB's placement team decides which type of establishment each young person should go to. A review in 2003 of the placement function noted the team's strengths and achievements, but also various limitations, such as the lack of information of acceptable quality that was being provided to the team. It recommended a number of improvements. This OR can report that these have now been put in place. They are detailed in a policy statement issued in July 2004 and a revised protocol (September 2004), which requires all placements of at-risk young people to be reviewed within three working days.

The placement team bases its decisions on indicators of risk. This OR considers that these need to be redeveloped in line with the four-tier categorisation referred to above. Further enhancement of the placement operation can be achieved by: improved completion of the *Asset* documentation and supporting evidence; closer dialogue between Yots and the placement team about assessments of vulnerability; more information sharing (which should be facilitated by the forthcoming introduction of a secure e-mail network) and shared decision-making; the establishment of an audit trail; and quality assurance of placement decisions by the head of the placement team. This OR commends the very responsive approach the team has demonstrated.

Child Protection and Safeguarding

Child protection and the safeguarding of young people in young offender institutions have received considerable attention in recent years. The approach to safeguarding set out in Prison Service Order (PSO) 4950, which was originally issued in 1999, went wider than the consideration of child protection as defined by the Children Act 1989 and subsequent guidance. The child protection protocol attached to PSO 4950 prescribed detailed safeguarding arrangements to be put in place at each young offender institution, including a Child Protection Committee and Child Protection Co-ordinator and deputy. It also encouraged the development of links with the local Area Child Protection Committee. A revised version of PSO 4950, with a much stronger emphasis on safeguarding and child protection, was issued in September 2004. This OR strongly supports the advice in the revised Order that the Co-ordinator posts should be at senior level, preferably as full-time Safeguards Managers; it also supports the recommendation that a Safeguards Committee should be set up in each establishment.

Safeguarding in young offender institutions was the subject of an important judgement of the Administrative Court in November 2002. This established that the Children Act 1989 applied to children in young offender institutions,

with the consequence that local authorities continued to owe duties to those children (though subject to the requirements of imprisonment). The judgement prompted a joint review by the YJB and the Prison Service of safeguarding in young offender institutions, which made a wide range of recommendations for improved services and practice. These are in the process of being implemented. The most notable recommendation was the appointment of social workers in young offender institutions to improve safeguarding and ensure that local authority obligations to children are properly fulfilled. This OR welcomes the YJB's decision to fund the appointment of 25 social worker posts.

Liaison with Area Child Protection Committees is a key element of safeguarding practice, but, to date, it been rather patchy. The new arrangements under the Children Act 2004 should make for a more consistent approach. It is important that young offender institutions should be involved in developing the new Local Child Safeguarding Boards to be established under the 2004 Act.

Reception of young people into young offender institutions

The circumstances of a young person's arrival at, and first impressions of, a young offender institution are bound to have a strong influence on his or her adaptation to custody. PSO 4950 sets out in detail the arrangements to be put in place for receiving young offenders into young offender institutions. The establishment needs immediate information about the young person, including any risk he or she might pose to himself or to others. However, it appears that over a quarter of trainees continue to arrive without the relevant papers. That is a matter of concern. The creation of a secure e-mail system should assist transmission of information, but quality improvements depend upon improved skills and awareness on the part of Yots.

PSO 4950 requires the provision of 24-hour health care facilities at establishments that take young people direct from court. The young person is to be medically examined within 24 hours, and assessed for risk of suicide or self-harm. The YJB's National Standards require that these assessments must be begun within one hour of arrival. Following the assessment, a health care plan must be prepared. Recent figures suggest that over 99 per cent of young people admitted to YOIs are assessed as required within 24 hours.

Concern has been expressed about the practice of searching young people on arrival. This OR accepts that body searches are necessary to prevent drugs or potential weapons from being brought into an establishment. However, as PSO 4950 makes clear, such searches must be conducted with proper sensitivity.

There are several areas where current practice in young offender institutions can be improved. Some split-site establishments, which house under-18s and 18-20 year olds in adjacent accommodation, have combined reception

facilities for both age groups. This OR recommends that the YJB should continue its drive to establish separate facilities. If there are large batches of new arrivals, it is important that adequate staffing and organisational arrangements are in place. Reception facilities need to be kept in good condition, as badly-maintained facilities can give the impression that the establishment is not a safe place. Transport arrangements from court are not always adequate, particularly where long journeys are involved. This OR welcomes the YJB's move to provide separate escorting arrangements to and from court for all juveniles. It is essential that the YJB and the Prison Service should monitor policy and practice relating to escorting and reception.

Regimes for under-18s in young offender institutions

PSO 4950, which specifies the regime for under-18 year olds, states that the regime should promote their well-being and healthy growth. Like Joseph, many trainees are from unstable backgrounds, have mental heath problems and at some time in their lives have been in local authority care. A significant number also have learning difficulties. The emphasis on safeguarding is therefore crucial.

The induction process, which lasts one week, should provide the trainee with the information he or she needs, in a form that is easily understood. This OR commends the induction booklet prepared for trainees on Stoke Heath's "A" Wing.

The PSO requires the drawing up of a sentence plan, including an individual learning plan, within 10 working days of arrival. Investigations into Joseph's case have made recommendations about the timing of the initial planning meeting. This OR considers that in high-risk cases it should take place within 3-5 days. Other issues examined include the quality of record-keeping, the policy of storing information in several locations, and the arrangements for access to records, particularly medical records. The YJB and the Prison Service need to develop an efficient record storage, access and retrieval system for the juvenile secure estate.

For each trainee, a personal officer is appointed to provide support and to promote contact with the trainee's family and Yot supervising officer. The personal officer should also act as a role model. This OR recognises the practical difficulties in providing one-to-one personal officer support 24 hours a day. The team approach recommended in PSO 4950 has been criticised, but this OR considers that it may offer a workable model, provided it is modified to ensure that a single officer is in the lead.

One of Joseph's greatest anxieties was that he would be bullied if he moved from the Health Care Centre to a residential wing. It is essential that establishments have an effective anti-bullying policy. PSO 4950 requires that establishments operate a policy approved by the Area Manager and appoint an Anti-Bullying Co-ordinator. The Child Protection and Safeguards Review in

2003 found that existing policies were too reactive, training was inadequate and there were only limited support services and intervention programmes. It recommended a robust programme of improvements. This OR can report that there have been some positive developments - most young offender institutions now have an anti-bullying committee, for example – but there is much more that can be done.

Protection against suicide and self-harm

Young offenders as a group face greater risks to their health than other young people of the same age. In the population at large, increasing numbers of young people face mental health problems and a substantial proportion of these are sent to young offender institutions. Responsibility for health care provision in young offender institutions is transferring to Primary Care Trusts and discussions are taking place between the YJB and Department of Health on increasing the number of secure psychiatric hospital beds.

The Prison Service has taken a range of measures since 2001 to help prevent suicide and self-harm. This OR notes the progress that has been made to date and the serious approach of staff and managers in young offender institutions. However, the measures are not juvenile-specific and young offender institutions need to adapt them to the needs of under-18s.

This OR looked at the use of “safer cells” and constant observation as methods of seeking to prevent suicide. Both can be necessary in very high-risk situations, but they are not solutions to the problem and more positive interventions are needed to assist a young person who feels suicidal.

On 23 March 2002, the day before he died, Joseph had a telephone conversation with his mother in which he spoke about self-harm. It has been suggested that monitoring the telephone conversations of at-risk young people could assist in preventing self-harm. That would have very large resource implications. A more manageable option, which this Operational Review recommends, is that the telephone conversations of those at-risk young people who are accommodated in Health Care Centres should be monitored in this way.

During his first four days in the Health Care Centre at Stoke Heath, Joseph was dressed in “safer clothing”, a single garment designed to minimise the risk of its being used for purposes of self-harm. The inquest jury expressed concern that removing a young person’s ordinary clothing and requiring him or her to wear safer clothing could be dehumanising. This OR has looked at the use of safer clothing as a safety measure and at the alternatives to the removal of ordinary clothing. Safer clothing can have a role to play, but the aim should be to keep its use to a minimum. There is a risk that young people may conceal suicidal feelings in order to avoid having their own clothes taken away. Staff will require good practice guidance and support to enable them to assess situations and consider alternative strategies for preventing self-harm.

This OR recommends that the YJB Performance Monitor should conduct regular sampling exercises to monitor the extent to which safer clothing is used.

Training

Staff training has an essential part to play in ensuring effective implementation of measures to prevent young people in custody from harming themselves. There have been significant developments in this area, notably the new Professional Certificate in Effective Practice (Youth Justice). The YJB's target is that 80 per cent of practitioners should have qualified to receive this by 2006. Other training initiatives include work on how to complete the *Asset* documentation. This OR welcomes the initiatives the YJB has planned. It strongly supports the commissioning of a training needs analysis and the development, as proposed, of a safeguarding package. The Juvenile Awareness Staff Programme (JASP) for all staff in young offender institutions is another welcome development. The module on vulnerability assessment might bring further benefits if more time were allocated to its delivery. This OR commends the training package "Understanding Self-harm" which forms part of the "Self-harm Toolkit" which the Prison Service Safer Custody Group made available in September 2004.

Quality assurance in the secure estate

An active programme of quality assurance within the secure estate is essential if improvements recommended above are to be realised. YJB's establishment of the *Effective Regimes* monitoring framework is an encouraging development. It is important that this should not become over-bureaucratic.

Serious incidents in the youth justice system, such as a death in custody, are the subject of investigation and review by various agencies. This OR welcomes the YJB's decision to revise its Serious Incident Review process and align it with other review frameworks. There is scope for closer alignment of Serious Incident Review practice with the procedure for ACPC Chapter 8 reviews.

Conclusion

Since Joseph's tragic death, a wide range of measures have been taken to improve safeguarding of young people in young offender institutions. This OR has examined them and made recommendations for improvement. The YJB and the Prison Service have shown a commitment to change. More can be

and needs to be done to ensure the safety of the often very vulnerable young people who are remanded or sentenced to custody.

Since Joseph's tragic death, a wide range of measures have been taken to improve safeguarding of young people in young offender institutions. This OR has carefully examined them and made recommendations for improvement. The YJB and the Prison Service have shown a commitment to change and have developed a set of policies and procedures that focus directly on safeguarding issues and have the potential capacity to deliver a more effective and safer service. But much more can be and needs to be done.

It remains important to recognise the key part that both quality control, through compliance and active management, and quality assurance - through inspection, monitoring and active learning - need to play in ensuring that the safeguarding framework is fully implemented and embedded. It is also important to develop a workforce that is dedicated to the underlying philosophy of care in custody and committed to the task of ensuring that the welfare of the young person is paramount.

OPERATIONAL REVIEW

CHAPTER 1

INTRODUCTION

A Death in Custody

1.1 Joseph Scholes sadly died at Stoke Heath Young Offenders Institution (YOI) on 24 March 2002. He was 16 years and one month old at the time and was only nine days into a two-year Detention and Training Order imposed by the Manchester Crown Court on the 15 March 2002. Because Joseph had a known history of vulnerability and self-harm he had been placed in safer accommodation in the Stoke Heath Health Care Centre. However, during the afternoon of 24 March 2002 an industrial craftsman at the YOI while checking for a maintenance problem found Joseph hanging from strips of linen attached to the window bars of his cell. Staff tried to revive Joseph and a prompt response was reported from the emergency services, but Joseph was pronounced dead at North Staffordshire Hospital later that afternoon.

Joseph Scholes – the history of a very vulnerable young man

1.2 John Joseph Peter Scholes, known as Joe or Joseph, was born on 20 February 1986. Joseph's parents married in1988, but separated in 1995. Mrs Scholes reported that the family had led an unsettled life with financial problems, frequently moving house and changing the children's schools. There is little coordinated information about Joseph's early childhood, but some indications that all might not be well for him.

1.3 In October 1998 Trafford Social Services Department dealt with allegations that [X], with whom he was living at the time, was hitting him. The matter was investigated, but it appears to have been concluded that there was not enough evidence for criminal proceedings. Both the Police and Social services appear to have been satisfied with verbal assurances from [X].

1.4 Later that year, in December 1998, Manchester Social Services Department were presented with a range of worrying issues about the family. [Details of further allegations omitted.] Manchester investigated these matters, in consultation with Trafford Social Services Department, but eventually concluded that no action would be taken on the grounds that there was insufficient evidence and that [the children] were now safe living with their mother.

1.5 Two years later, in December 2000, Joseph repeated [some of these] allegations. There was a joint police/social services investigation but again no action taken on child protection grounds, although Mrs Scholes was provided with advice about various support options. However, Joseph was by then nearly 14 years old and concerns were being raised about his behaviour and

mental health. By January 2001 Joseph was being treated for depression by his General Practitioner who also advised that he should receive psychological help. From this time on the Family and Child Treatment Service (FACTS) reported that Joseph's behaviour was becoming increasingly unpredictable and aggressive from this time on. There were several instances of exclusion from school.

1.6 During 2001 Joseph's behaviour continued to generate growing concern to his doctors and school, including concerns about the degree of his substance misuse and increasing threats of violence to his mother. His medication was increased and the Child and Adolescent psychiatrist requested an urgent assessment from the Prestwich FACTS Team. The psychiatrist continued to press for an assessment through July into August amidst growing concern about an escalation of Joseph's violent behaviour, particularly towards his mother. At the beginning of August after having been reported missing by his mother and damaging her car, Joseph was accommodated overnight at a family unit and then went to live with his half-sister, Claire. During the following weeks the situation remained difficult, but by 11 October both Joseph and Claire had moved to live back in Trafford with Mr Scholes.

1.7 On 10 November 2001 police attended Mr Scholes's home to assist an ambulance crew. It was reported that Joseph was in a violent state and had jumped from a first floor window, then run off. He was found nearby, but was violent to the ambulance men, punching and kicking and making verbally abusive threats. Joseph was restrained and arrested for affray. On 13 November the Child and Adolescent psychiatrist saw Joseph and she arranged continuing treatment and follow up pending transfer to Trafford NHS and Social Services.

1.8 Later that month a psychiatric assessment was completed by the FACTS team. This assessment concluded with a diagnosis of Depressive Conduct Disorder, with abuse of alcohol and other substances. The assessment linked Joseph's offending behaviour with self-preservation. Joseph was considered a risk, both to himself and others, and a view was offered that if he should end up in custody then the risk of self-harm could well increase. The FACTS assessment report recommended a detailed risk-reduction strategy.

1.9 At the end of November 2001 Trafford Youth Offending Team (Yot) eventually referred Joseph to Trafford Social Services Department and sought information from Manchester. Both Mr and Mrs Scholes were in the process of moving away from the area and Joseph experienced a rootless few days after Mr Scholes is alleged to have ejected him for unacceptable behaviour. When Joseph was found by the police living in a caravan in a car park, he was made the subject of a Police Protection Order. By 1 December 2001 Trafford SSD agreed to place Joseph at their Northenden Road Children's Home. This was considered a good placement option as the home had a stable resident group of children without a significant history of offending.

1.10 On 6 December 2001 it is reported that Joseph told a social worker that he was settled and getting on well with staff and other residents at the home. That night, however, he went out with a group of three other children and, after taking alcohol, took part in three street robberies involving mobile telephones, he was arrested and the following day, charged and bailed.

1.11 On 11 December 2001 Joseph appeared in court to face the affray charge. He was convicted and sentenced to a one year Supervision Order: he would continue to live at the children's home and engage in a range of interventions aimed at anger management, victim empathy, offending behaviour and substance misuse issues. Over the next few weeks Joseph continued to demonstrate his vulnerability and there were many instances where he was a serious management problem or threatened self-harm. In February Joseph saw a second Child and Adolescent psychiatrist who expressed extreme concern about Joseph's 'fragile emotional state' and recommended containment and constant vigilance.

1.12 On 26 February 2002 Joseph appeared at Manchester Crown Court and pleaded guilty to the robbery charges. He was convicted and remanded on bail for reports. The next day there was a serious incident at the children's home. Joseph was seen to be under a great deal of pressure and very 'unwell', had cut himself several times, including his face and had damaged his bedroom with graffiti. Joseph also went missing from the home between 7 and 9 March 2002. He returned of his own volition, but on 12 March 2002 was charged with breach of bail.

1.13 On 15 March 2002 Joseph appeared for sentence at Manchester Crown Court. He received a two year Detention and Training Order. Later that day he was transferred to HM YOI Stoke Heath at Market Drayton.

Investigations into the Circumstances of Joseph's death

Prison Service Investigation

1.14 Following Joseph's death at HM YOI Stoke Heath on 24 March 2002, an investigation was immediately initiated by the Prison Service. On the day following the death the West Midlands Area Manager for Prisons instigated an investigation to be conducted in accordance with Prison Service Order 1300 - Investigations. The investigation was completed on 17 May 2002.

YJB Serious Incident Review

1.15 All deaths in custody are subject to a Serious Incident Review that is conducted by a senior YJB manager or an independent consultant. Such a review was initiated into Joseph's death. (The Chief Executive of the Youth Justice Board (YJB) may also commission a Serious Incident Review of any other incident that they considers requires one.) A Local Management Report into the circumstances of Joseph's death was prepared by the Operations Manager of the Trafford Youth Offending Team immediately after

the event. This report was completed on 17 April 2002. This report was then forwarded to YJB in June 2002 and contributed to the Serious Incident Review. An interim report was presented to the YJB on 18 September 2002. A final report was prepared and presented to the YJB Audit Committee on 11 May 2004 consequent to receipt of the Coroner's verdict on 30 April 2004.

Chapter 8 Case Review by Trafford ACPC

1.16 Following advice received from the Social Services Inspectorate (SSI) and the YJB, Trafford Area Child Protection Committee (ACPC) agreed to conduct a full Review of the case under the auspices of Chapter 8 of Department of Health guidance 'Working Together to Safeguard Children' 1999. An independent author was commissioned to prepare the Overview Report and also chair the multi-agency panel established to steer the review process. The Chapter 8 Case Review commenced work on 20 September 2002. The Trafford ACPC received and agreed the final Overview Report in the summer of 2004.

The Inquest

1.17 Mr John Ellery, H.M. Coroner for the Mid and North Division, County of Shropshire, conducted an Inquest into the circumstances of the death of Joseph Scholes at Shrewsbury between 19 and 30 April 2004. The Inquest was held with a Jury. The Inquest heard evidence, either in writing or person, from 55 witnesses. As well as receiving documentary evidence and the reports of investigations conducted by the agencies into the circumstances of the death, the Coroner commissioned his own Independent Psychiatric Report of the case.

1.18 At the conclusion of the Inquest, the Jury returned a unanimous verdict of "Accidental death in part contributed because the risk was not properly recognised and appropriate precautions were not taken to prevent it." The Jury made clear that this was primarily a systems failure and that Joseph's death was not attributable to any one individual or group of individuals.

1.19 Following the Inquest Mr Ellery wrote to the Home Secretary on 5 May 2005. Mr Ellery drew to the Home Secretary's attention to a number of concerns about the sentencing, placement, care and containment of Joseph Scholes that the Inquest had not been able fully to examine. The Coroner considered that these were policy and operational issues of such moment that only a public inquiry would provide a platform for their full consideration.

1.20 Chapter 2 of this Operational Review provides a summary account of each of the above four investigations and reports their main conclusions and recommendations for action and service improvement.

A matter of public concern - the Political Context

1.21 Following Joseph's death, his mother, Mrs Yvonne Scholes sought the assistance of her constituency MP, Mr Chris Ruane in pressing for a full

public inquiry. This resulted in the launching of a public campaign to support the call for an inquiry into the death and wider related issues. In December 2003 Mrs Scholes and her advisers met the Minister for Correctional Services, Mr Paul Goggins MP. Mrs Scholes was assured that the government was seriously committed to reducing the numbers of apparent self-inflicted deaths in custody and apprised her of the three-year Safer Custody programme. However, she confirmed that she still wished to press on with her call for a public inquiry in order that other wider-ranging issues of youth justice and penal policy could be examined.

1.22 On 28 January 2004 Chris Ruane MP asked the Prime Minister for his support for the call for a public inquiry. The Prime Minister replied in terms of the necessity to await the completion of investigations, including the Coroner's inquest, prior to providing a final reply.

1.23 The matter was then given a much fuller parliamentary airing in the House of Lords on 11 April 2004 when Lord Dholakia presented the case for the establishment of a public inquiry into Joseph's death and wider related issues of sentencing, penal policy and practice. Lord Dholokia was strongly supported by Baroness Stern, Baroness Howe, Baroness Walmsley, the Earl of Listowel and Viscount Bridgeman. Lord Bassam replied for the Government and also followed up with a written response to questions raised during the debate. Again the government's position was informed by the need to await the, by then, imminent outcome of the Coroner's Inquest.

1.24 On 30 June 2004 both Lord Dholakia in the Lords and Chris Ruane MP in the Commons, supported by 78 other MPs, raised again the question of the establishment of a public inquiry. The Government responded to this call in a Ministerial Statement on 16 September 2004.

Ministerial Statement

1.25 Following full consideration of the Coroner's recommendation that there be a public inquiry into the circumstances of Joseph's death, the parliamentary airing of that matter, the wishes and views of Joseph's family and continuing support for that course of action in the professional media, the Minister for Correctional Services, Mr Paul Goggins MP made the following Statement to parliament on 16 September 2004.

"I am now able to announce the measures I have taken and am taking to ensure that the matters arising from Joseph's tragic death and the coroner's recommendations are properly considered.

The issues fall into three broad categories. They are: the appropriateness of the sentence Joseph received; the effectiveness of relevant operational procedures in identifying, placing and safeguarding vulnerable young people in custody; and whether the juvenile secure estate has adequate accommodation to meet the needs of vulnerable young people.

The steps I am taking to deal with these are as follows:

- I have referred the circumstances in which Joseph received a custodial sentence on three counts of attempted robbery to the Sentencing Guidelines Council, requesting it to take this case into account in its current work to draw up guidelines on sentencing for robbery:

- I have appointed a former Assistant Chief Inspector of the Social Services Inspectorate to examine the operational issues raised by this case, including through the coroners Inquest. I have also asked him to provide a summary account of all investigations that have been conducted into Joseph's death;

- I have asked the Youth Justice Board, which is preparing proposals for its vision for the future juvenile custodial estate, to take full account of the points made by the coroner on the adequacy of custodial provision for vulnerable young offenders.

I consider that the above measures are the most effective means of addressing the matters the coroner has drawn to the Home Secretary's attention and what lessons should be learned from Joseph's death. I am grateful to the coroner, and to Joseph's family, for highlighting the issues that are of concern to them. Nothing can bring Joseph back, but I do want to ensure that everything is done to prevent the repetition of such a tragic event."

Terms of Reference for the Operational Review

1.26 Terms of Reference for the Operational Review were formulated by the Home Office and these articulate the objectives to be achieved by the review process. The agreed Terms of Reference are as follows:

The review will analyse:

- The policies, procedures and practices for the placement of young offenders, taking account of any recommendations that the Youth Justice Board or Home Office have made since Joseph Scholes's death, and whether further improvements can be made. The review will refer to the Prison Service investigation, the Serious Incident Review on Joseph Scholes undertaken by the YJB and the work commissioned by the YJB Placement Programme Board and the Trafford ACPC Chapter 8 review. These contain recommendations that encompass both correctional services and the safeguarding of children.

The review will consider:

- Whether the information and documentation that a Youth Offending Team (Yot) prepares for sentencers on young people at risk of a custodial sentence/placement is adequate and appropriate, taking into account the work that the YJB is doing on the management of risk in the community.

- Whether improved guidance is needed on the Yot's assessment of vulnerability or risk.

- Whether existing methods for the transfer of documentation between the Yot, the court, the Youth Justice Board Placements Team and the receiving establishment need improvement.

- The adequacy of YOI reception procedures and arrangements for the care of vulnerable trainees.

- The appropriateness of protective clothing for young offenders at risk of self-harm.

- Whether relevant changes are needed to staff training, in particular regarding the quality of the ***Asset*** assessment form, the risk of harm section and advice that the YJB is producing for Yots: and the reception and care of vulnerable trainees.

The review will be a fundamental part of informing the family of Joseph Scholes about progress and ensuring action is undertaken by the key agencies following his death.

The review, in addition to findings on the matters listed above, will include a summary account of all investigations that have been conducted into Joseph Scholes's death and the operational issues arising from them. It will outline any implications for the juvenile secure arrangements as a whole and identify any recommended improvements. The review may make recommendations to the Minister on any good practice that is relevant to or becomes apparent during the review.

Review process

1.27 There are two stages to the review process. First, a summary of the findings and recommendations of the four investigations into the circumstances of the death of Joseph Scholes at Stoke Heath YOI in March 2002. From this examination a set of key themes and issues are identified that will need to be addressed if improvements in services and in young people's safeguarding are to be achieved. Second, an examination and appraisal of the operational and procedural arrangements that are now in place to ensure the safeguarding of young people in custody in YOI. An important aspect of this appraisal has been to note any changes or improvements in the safeguarding arrangements that have been developed since the time of Joseph's death, with particular attention to the key issues pointed up in the investigations.

1.28 The primary purpose of this Operational Review has therefore been to assess whether the arrangements for safeguarding, in all its aspects, are robust enough to ensure that young people are held safely in custody and that their welfare remains paramount. The nature of this Operational Review does not include comment on the quality of performance within that safeguarding

framework by either the individual YOI or the juvenile YOI service as a whole. Such appraisals are available in the Thematic Studies and the inspection reports on individual institutions prepared by HM Chief Inspector of Prisons, and reviews of service published by the YJB. This Operational Review can therefore only assure that young people are going to be held more safely if there is effective performance against the safeguarding framework and its requirements.

1.29 The Operational Review has been conducted as follows:

- Examination and summary of the four investigations into the circumstances of the death of Joseph Scholes at HMYOI Stoke Heath
- Examination of documentation related to the YJB and Prison Service policies, practice guidance and operational procedures
- Examination of relevant research studies and Service Reviews
- Examination of inspection reports and studies published by HM Chief Inspector of Prisons
- Examination of relevant Serious Incident Reviews
- Briefing and discussion of relevant matters with the Chairman of YJB, Prison Service and YJB officials
- Briefing about the YJB Placements Function
- Visits of Observation to two YOIs, Warren Hill and Stoke Heath
- Consultation with Head of Youth Justice Service, Norfolk YOT
- Consultation with member of HM Prison Inspectorate.

CHAPTER 2

INVESTIGATIONS INTO THE DEATH OF JOSEPH SCHOLES

This chapter of the operational review summarises, in an abbreviated way, the investigations into Joseph Scholes's death at Stoke Heath YOI. Two of the investigations, conducted by the YJB and the Prison Service, also informed the case review conducted under the auspices of Chapter 8 of *Working Together to Safeguard Children 1999* by Trafford ACPC. That review in turn informed the Coroners Inquest.

2.1 Investigation by the Prison Service

Conduct of the Investigation

2.1.1. The death of Joseph Scholes at HMYOI Stoke Heath on 24 March 2002 was immediately investigated by the Prison Service. On the day following the death the West Midlands Area Manager for Prisons instigated an investigation to be conducted in accordance with Prison Service Instruction 1300 - Investigations. The investigation was conducted by Mr Neil Croft, the then Governor of HMP Hewell Grange. Mr Croft completed his investigation on 17 May 2002.

2.1.2 The investigation was required to find out what had taken place, to establish its cause and the manner in which it was managed. In particular the Senior Investigating Officer was to:

- establish the facts pertaining to the apparent cause of death
- establish the degree of compliance with Prison Service policy and the local strategy for the care of the suicidal
- establish whether any changes to the operation of the suicide awareness strategy should be recommended
- establish whether a separate investigation was required under the Code of Conduct and Discipline

In addition, the Investigation was required to make recommendations to prevent or avoid recurrence, specifically related to HMYOI Stoke Heath or the Service in general and on better handling of such incidents in future. The investigation was also invited to highlight for recommendation any examples of good practice.

2.1.3 Mr Croft conducted a very thorough Investigation that involved the detailed interviewing of all relevant members of staff at Stoke Heath and representatives of agencies outside of the prison who had knowledge of Joseph prior to his reception at Stoke Heath. The Investigation visited and inspected the accommodation where Joseph had died. The Investigation also reviewed the policy and procedures for the prevention of self-harm at Stoke Heath and related these to the YJB National Standards, with particular reference to their application to Joseph and his care. The Senior Investigating Officer also conducted additional enquiries following a response by Mrs Scholes to an invitation to contribute to the Investigation.

2.1.4 The Investigation, in recognition of the multi-agency aspects of the care and management of Joseph, also reported to an inter-agency advisory panel established to reflect these responsibilities. Membership of the panel included representatives from the Prisons and Probation Ombudsman's Office, the Prison Service Safer Custody Group, Shropshire Social Services Department, and the Youth Justice Board. The panel met to consider the initial and final reports of the Investigation. On those occasions they were joined by the Investigating team and the Governor of HMYOI Stoke Heath.

Main Conclusions and recommendations

Appropriateness of Sentence

2.1.5 The Investigating team concluded that there were questions to be asked about the appropriateness of Joseph's sentence to custody, in respect of both his own culpability and disposition to criminal behaviour, and in relation to the treatment of the other participants in the offence. The investigation came to a firm view that Joseph's background, family history and his psychiatric depression all contributed to an evident lack of self esteem that manifested itself through drugs, alcohol and self-harm. They considered that Joseph was a sad and depressed young man, who was not criminally minded, and whose shock and remorse at having inadvertently been caught up in a single episode of street robberies doubtless added to his feelings of worthlessness.

2.1.6 The Investigation recommended that the circumstances of the case be referred to the Prison Service Safer Custody Group. They were asked to consider whether the case should be drawn to the attention of the Lord Chief Justice.

Appropriateness of Placement

2.1.7 The investigation also examined the appropriateness of the decision to place Joseph at a YOI and not seek a placement in a Local Authority Secure Children's Home (LASCH) or Secure Training Centre (STC). The investigation notes that Joseph was placed at a YOI 'because of a lack of alternative spaces'. Having considered Joseph's circumstances in great detail the investigating team concluded that the more appropriate placement would have been a LASCH.

2.1.8 The Investigation recommended that there should be a review of the provision of places in the LASCH sector so that future allocation can be made on the basis of need rather than expediency. They also considered that facilities for young people demonstrably at risk of self-harm or suicide might be developed in the YOI sector. Such facilities might offer regimes more closely equated to the nature of care and containment provided by LASCHs. The Investigation appreciated that such developments would take some time to come to fruition and so recommended that the YJB should undertake a review of its approach to placements of highly vulnerable young people. This

review has taken place and forms a part of the YJB Strategy for the Secure Estate for Juveniles, a consultation paper issued in November 2004 [see paragraphs 4.16 to 4.22]

2.1.9. The Investigation noted that shortly after Joseph's reception at HMYOI Stoke Heath the community Yot worker had applied for him to be re-allocated to a LASCH as soon as possible. This was an appropriate course as it followed up on concerns expressed in his report to the court that had advised that a custodial sentence would present a serious risk related to Joseph's capacity for self-harm. However there was no consultation or liaison with Stoke Heath about this and the YOI remained unaware of this application.

2.1.10 The Investigation concluded that the procedure for handling and communicating about such applications appears unclear and so recommended that the YJB and the Prison Service jointly review the relevant operational guidelines contained in the YJB Secure Placements manual, with particular reference to applications to change initial placements. This work was completed in the first half of 2004 [see Chapter 6].

Quality of Care and Safeguarding

2.1.11 The Investigation concluded that, Joseph having been received at HMYOI Stoke Heath, all appropriate reception procedures were carried out satisfactorily and that Joseph received a high level of care and attention, wholly in accordance with Prison Service policies. Joseph's psychiatric history and history of self-harm were appropriately noted. The appropriate Self-Harm At-Risk Form (F2052SH) was opened. On admission he was located in the Health Care Centre, initially in a safer cell with CCTV observation, and later in an ordinary cell but still under at-risk supervision and observation.

2.1.12 The Investigation looked closely at the quality of information and assessment available to ensure a fully supportive care plan for Joseph. The Investigation concluded that more detailed medical information should have been available to support the basic information provided in the health record and the Risk Dossier. Some of this additional information came from Joseph's mother, Mrs Scholes, who had advised that compliant behaviour on Joseph's part should not be taken at face value and that this masked Joseph's 'at risk' disposition. The Investigation team were unable to conclude, however, that any additional information would have had any critical impact on Joseph's care given the high level of care already being given, and concern expressed by healthcare staff and others.

2.1.13 The Investigation also concluded that the YJB minimum standard that required a case review for individual trainees to be carried out within 10 days of arrival at YOI should attract revision, particularly in respect to young people assessed to be at risk. The Investigation recommended that in such cases an initial review should be held within 24 hours, followed by a more detailed review within 7 days.

2.1.14 The Investigating team considered the use of safer cells in Joseph's case and for similar circumstances. They concluded that in Joseph's case it would have been inappropriate for him to have shared a cell with others, but it was their view that such facilities should be provided if suitable accommodation was made available. At the time of the Investigation the team concluded that the accommodation was inadequate and so recommended that the Governor of HMYOI Stoke Heath review that form of provision.

2.1.15 The Investigating team adjudged that the quality of health care provided to Joseph at Stoke Heath was good and appropriate to his level of need. He had been fully assessed on arrival and his medication regime noted and continued. The Investigation commended the work of the staff in the Healthcare Centre, a setting that was considered by all to be an out of date and inadequate facility. The investigation noted Prison Service plans to replace this facility and urged expedition.

2.1.16 The investigation noted that Stoke Heath had a planned strategy to encourage Joseph to move from the Health Care Centre to a normal location on one of the training wings. It was noted that this was a strategy that had been adopted successfully in a number of previous cases when dealing with at-risk trainees. A week after his admission Joseph went to A wing for just a few hours on two occasions, the second occasion being the day prior to his death. Another trainee, known to Joseph outside the YOI, confirmed that they had talked about general issues and that Joseph seemed safe and happy during these brief visits. The Investigating team did not offer comment on this practice and its impact on Joseph.

Managing self-harm and suicide

2.1.17 The Investigating team concluded that in the circumstances of Joseph's death the procedures for responding to a serious incident of self-harm were correctly and speedily implemented. They also concluded that Stoke Heath's suicide awareness strategy is of good quality and that there was evidence that it was applied with care and determination throughout the YOI.

2.1.18 However, the Investigation felt that their examination of the care of Joseph Scholes demonstrated that there were grounds for further tightening of these procedures. On Saturday 23 March 2002, the day before Joseph took his own life he had telephoned his mother. A transcript of the telephone call showed that Joseph stated that he was not happy to be at Stoke Heath and wanted his mother to press for his transfer to a LASCH. In this conversation Joseph told his mother that he would hang himself to help expedite a move. He arranged to call his mother on the following Tuesday and she told him of her plans to visit him on the following Thursday. During this call his mother was supportive and encouraging.

2.1.19 YOI staff were not informed at the time of the content of Joseph's conversation with his mother – information that might have alerted them to his intentions. The Investigating team noted that although telephone calls are

routinely recorded, there are no arrangements to directly monitor the conversation of trainees under 'at risk' supervision and for relevant information to be passed immediately to staff supervising individual trainees. They recommended that such arrangements be introduced at HMYOI Stoke Heath and be considered for adoption throughout the Prison Service.

2.2 Youth Justice Board Serious Incident Report

Conduct of the Investigation

2.2.1 Investigations of Serious Incidents by the Youth Justice Board can be a one or two stage process depending on the nature of the serious incident*[Xref: Chapter 12]*. In the case of the death of a young person in custody the YJB provides its Chief Executive with discretion to commission a Serious Incident Review [SIR]. This may be completed by a senior member of YJB management or an independent consultant. YJB serious incident procedures also require the local Yot manager to prepare a Management Review report of the circumstances of the serious incident. This report is then forwarded to the YJB and, in the case of a death in custody, this contributes to the Serious Incident Review.

2.2.2 In the circumstances of Joseph's death a local Management Review report was prepared by the Operations Manager of the Trafford Yot immediately after the event. She completed her report on 17 April 2002. This report was forwarded to YJB in June 2002 and contributed to the Serious Incident Review being prepared by Mr Brendan Finegan, YJB Serious Incident Review Manager. Mr Finegan completed an interim Review and this was presented to the YJB on 18 September 2002. A final Report was prepared and presented to the YJB Audit Committee on 11 May 2004 consequent to receipt of the Coroner's verdict on 30 April 2004.

2.2.3 The YJB Serious Incident Review relied for its information and evidence on documentary sources, including the local Management Review and associated paperwork, a serious incident report provided by the YJB placement team and the interim Prison Service report. The Trafford Yot Management review does not say whether any members of Yot staff relevant to the case were interviewed in the course of the review.

Main Conclusions and Recommendations

Quality of Assessment of Joseph's vulnerability

2.2.4 The Yot completed an ***Asset*** assessment on Joseph in December 2001. This indicated that Joseph would be vulnerable due to his own behaviour and was at risk of self-harm or suicide based on information provided by his mother. No other evidence to support the judgement about vulnerability was provided in the ***Asset*** form. This assessment was forwarded to the YJB

Placements Team on 13 March 2002 who had already been alerted to the possibility of a custodial sentence for Joseph.

2.2.5 The Pre-Sentence Report (PSR) prepared on Joseph was of good quality and in the view of the YJB Serious Incident Reviewer provided a fair picture of the young person, his needs and abilities. The PSR indicated the scope of multi-agency contact with psychiatric health services and Social Services, and gave clear indication of Joseph's vulnerability to self-harm. The PSR reported that the psychiatric assessment had advised that a custodial sentence would escalate Joseph's self-harming and that if he were to be placed in a secure placement then he should have access to regular medical review with regard to his medication and disposition to self-harm. The PSR set out a robust plan for the supervision of Joseph in the community, based on a highly restrictive Community Punishment and Rehabilitation Order.

2.2.6 Following sentence a Post Court Report (PCR) was completed and this also stressed his vulnerability and provided explicit detail of his history of anxiety, depression, attempted suicide and self-harming behaviour, and his medication requirements.

2.2.7 The YJB Review concluded that there was a substantial body of evidence that supported an assessment of Joseph as an extremely vulnerable young person who would be likely to experience more risk if placed in custody. The YJB Review noted variation between the indifferent quality and impact of the initial ***Asset*** assessment of Joseph's vulnerability and the force of the information provided in the PCR. The Review therefore recommended that in future all information should be transferred into ***Asset*** documentation and that ***Asset*** judgements should be supported by clear evidence.

Placement of vulnerable young people in security

2.2.8 The YJB Review noted that on 13 March 2002 the YJB Placements Team were alerted to the possibility of a request for a secure placement on 15 March 2002. The Trafford Yot forwarded a Booking form and Section 14 of the ***Asset*** document. Based on the two documents the Placements Team, following internal 'Indicators of Risk' procedures allocated Joseph to HMYOI Stoke Heath.

2.2.9 The YJB Review examined this placement decision within the context of the differential availability of beds between YOIs, STCs and LASCHs across the juvenile secure estate. (No male STC places were available.) On the day of Joseph's placement there were 6 beds available for young men in LASCHs, but these were already allocated to 3 young people returning on secure remand, two 14 year olds sentenced to DTO and a bed for an 11 to 13 year old. The Review noted that LASCH beds were limited and therefore allocation depended on striking a difficult balance between competing risk and vulnerability factors presented by the young people. The YJB Review accepted that, despite the Prison Service deploying its best efforts to provide for the care and safety of juveniles, LASCHs will often be seen as a 'safer

placement' and not regarded as a 'prison' by those workers within the youth justice system who oppose custody for children.

2.2.10 The YJB concluded that more clarity and transparency needed to be introduced into the placement arrangements. The Review recommended that the Placements Team should develop new guidance on the decision making process and make this available to Yots and the providers of security. The guidance should articulate clear processes and criteria for decision making, including the matter of deciding between competing vulnerabilities, and for reviewing placement decisions. These improved processes should also allow for periodic (annual) auditing on a case and activity basis. The Review also recommended that definitive YJB placement policy be published that clarified the differences between the three sectors within the juvenile secure estate.

Issues of Communication

2.2.11 The YJB Review identified some possible frailties in the exchange of documentation both within the YJB and between the Yot and HMYOI Stoke Heath. As noted above the YJB Placements Team made their decision on a limited range of information, even though the Local Yot management review reported their understanding that the PSR, the PCR, the ***Asset*** and Risk ***Asset*** had been sent to the team. In fact the PSR was sent to the Placement team on 21 March 2002 when Trafford Yot made a further request that Joseph be transferred to a LASCH.

2.2.12 YJB National Standards require that the YOI and the Yot share the responsibility for the effective transfer of information to coincide with the arrival of the young person. The YJB Review concluded that evidently enough relevant information was transmitted to the YOI to inform an initial assessment by YOI staff of Joseph's vulnerability. Information confirms that the ***Asset***, PSR and PCR were forwarded to the YOI (but not all on the day of his reception) and that a Vulnerability Alert form was faxed through from the Placements Team. The Review notes that staff at Stoke Heath responded appropriately to these alerts and placed Joseph accordingly.

2.2.13 However, the YJB review expressed some uncertainty about the robustness of the onward transmission of detailed information from the Yot to YOI staff, particularly about Joseph's psychiatric history, and considered that this may have impacted on the quality of decision making about the arrangements for Joseph's care planning and oversight. The YJB Review recommended that the practice of information exchange between YOI health units and other locations in the establishment be subject to review, in particular for young people regarded as vulnerable. Overall the Review has recommended to the YJB that the transfer and quality of documentation, particularly that related to Child and Mental Health information needs to be improved

2.2.14 Shortly after Joseph's admission to Stoke Heath the YOI staff informed the Yot officer of the steps that they had taken to safeguard Joseph in view of his vulnerability. In response to this information the Yot officer made a formal

request, on 21 March 2002, to the YJB Placements Team that Joseph be transferred to a LASCH. There is no confirmation that this request was known by or discussed with the YOI. The YJB Review therefore recommended that the ability of units within the secure juvenile estate to request transfers on grounds of the level of risk that a young person presents or other issues of safety should be extended.

2.2.15 The YJB Review also explored a particular aspect of this case that concerned the fact that the Yot officer who had prepared the PSR was on sick leave at the time of Joseph's court appearance and sentence and that Joseph's case was passed to a new Yot officer. There was concern about continuity in this situation and support for Joseph and the YJB Review recommended that manning guidance for such situations needed to be reviewed.

Strategic Overview

2.2.16 An over-riding conclusion of the YJB Review was that the circumstances of the case reinforced the Youth Justice Board's strategy for the secure estate which, in its current draft, envisions the promotion of a service staffed by Governors and staff who are experienced and trained in dealing with young people and the development of special, intermediate units for the most vulnerable.

2.3 Trafford ACPC Chapter 8 Case Review

Conducting the Case Review

2.3.1 Following advice received from the Social Services Inspectorate (SSI) and the YJB, Trafford Area Child Protection Committee (ACPC) agreed to conduct a full Review of the case under the auspices of Chapter 8 of DH guidance 'Working Together to Safeguard Children' 1999. [A brief description of this process can be found at Annex 2]. An independent author, Mr Robin Hughes, was commissioned to prepare the Overview Report. Mr Hughes also chaired the multi-agency panel established to steer the review process. The Chapter 8 Case Review was commenced on 20 September 2002 and was completed by 19 May 2003. The Trafford ACPC has received and agreed the final Overview Report, but it remains confidential and has not been placed in the public domain.

2.3.2 To provide a structure for the Overview Report the ACPC agreed that the following three questions would set the parameters for the review:

- In view of the history of self-harm linked to anti-social behaviour over a period of years, what can we learn from the way that agencies worked together on Joseph's need for a risk-reduction strategy?

- Joseph having been convicted and sentenced to custody, what can be learnt from the decision to send him to HMYOI Stoke Heath?

- Joseph having arrived at Stoke Heath, what is to be learned from the way the prison is equipped to look after such a vulnerable child, including policies and procedures, the physical environment, specialist health support and what actually happened in Joseph's case?

2.3.3 The Overview Report draws together the evidence and conclusions collected and analysed through the individual agency management reviews. Agency management reviews were undertaken by Shropshire County Council, Manchester Social Services Department, Trafford Social Services and Education Departments, the YJB and Trafford Youth Offending Team, Greater Manchester Police, the Prison Service and relevant NHS Trusts. The Overview Report was a full and thorough work of analysis and presented its findings with an authority based on detailed evidence. The Chapter 8 Review made 40 recommendations for service improvement addressed to all relevant agencies. The following paragraphs highlight those most pivotal to the inter-relationship between the Trafford SSD, YJB, the Yot and the Prison Service.

Main Conclusions and recommendations

Quality of pre-sentence work

2.3.4 The Chapter 8 Review confirmed that the court received explicit advice about Joseph's vulnerability, his history of self-harm and attempted suicide. Remarks made by the Child and Adolescent psychiatrist who had treated Joseph since May 2001 were reported to the effect that Joseph had a history of depressive symptoms associated with substance and alcohol misuse, and episodes of deliberate self-harm [words omitted]. The court were also advised of concern, on the part of both the Yot officer and the Trafford Adolescent Support team, that Joseph would be at increased risk of self-harm if sentenced to custody. Both the Yot and Social Services staff reported positively on Joseph's response to supervision and residence in the children's home. The Yot proposed the imposition of a Community Punishment and Rehabilitation Order. In the event, Joseph was given a custodial sentence although the Chapter 8 Review noted that the trial judge, in referring to the Social Services advice, stated that their concern about Joseph's vulnerability would be passed on.

Placement of Joseph in Custody

2.3.5 The Chapter 8 Case Review concluded that a more effective early warning system needed to be developed as this would hold the potential for advance consideration of children's needs and could have allowed Joseph's name to be pencilled-in against possible placements ahead of sentence. The Review emphasised the importance of good information being available to the YJB Placements Team on the day of sentence and noted that there had been different views about what information had been made available and to whom. The Review concluded that, in the event, if only the ***Asset*** form and Risk-

Asset were available, this would be insufficient as they did not provide an adequate assessment of the full range of the child's needs. The Review recommended the need for improvement, focussing on the provision of fuller information, including medical information and a greater degree of interaction between the Yot officer and the YJB Placements Team.

2.3.6 Overall, the Chapter 8 Review concluded that Joseph would have been more appropriately placed in a Local Authority Secure Children's Home. The Review appreciated that there were problems with the availability and supply of such accommodation, but reflected on the fact that the sector had an excellent record for preventing self-harm and suicide. Clearly, given the current availability, it would always be necessary to make a strong and fully evidenced case for such a placement and the Review recommended that more explicit eligibility criteria for placement in a LASCH should be published and that referrers should be required to support their requests with information referenced to those criteria.

2.3.7 The Review noted that there had been some issues about what information had been initially provided to Stoke Heath. There were also problems finding a mutually convenient time for the Yot officer to visit the YOI. The review recommended that this area of practice should attract some tightening up and in those cases where it is considered that placement in a YOI carries unacceptable risk, the Yot should communicate with the YOI within 24 hours to ensure that everyone is fully briefed to contribute to a protection plan and then initiate a transfer request as soon as the disposal in court is made.

2.3.8 The Review also recommended that this action should take place well inside the required visiting time set by National Standards (10 days) and preferably within the 3 days recommended by the Trafford Yot Serious Incident report. It should be noted that YJB National Standards are minimum standards and do not preclude a meeting taking place within three days where a high level of risk is presented.

Care and Supervision of Joseph at Stoke Heath

2.3.9 The Chapter 8 Review expressed some serious concerns about the nature of the accommodation provided for Joseph and other trainees at the Stoke Heath Health Care Centre. The Review noted that both the Prison Service Investigation and reports by the Prison Inspectorate (Inspections in 2000 and 2001) had adjudged the unit as inadequate for purpose. The Review referred to a report by the Safer Prisons Unit (June 2002) that considered the Health Care Centre to be too small and inflexible in use, in poor physical condition and failing to meet reasonable standards for daily life and good health. This report had also identified dangerous features in all six cells. The Chapter 8 Review recommended urgent action to eliminate the unsafe features of the accommodation and provide continuous and direct staff surveillance of any child or young person considered at risk of self-harm. The Review noted that there were plans to replace the unit in 2005/6.

2.3.10 The Chapter 8 Review confirmed the view reported in the relevant agency management reviews that staff who looked after Joseph at Stoke Heath were diligent and professionally concerned to care for and safeguard him. However, this was a responsibility shared between a number of nurses and doctors, and the review concluded that for a young person in Joseph's situation a 'key worker' should be appointed within 24 hours of their arrival and be charged with the responsibility for oversight and coordination of all aspects of the young person's detention and care.

2.3.11 The Chapter 8 Review confirmed that when Joseph arrived at Stoke Heath, staff and doctors were aware that he was a young person at risk, but they did not know how serious was his vulnerability nor how his mental state affected his behaviour. It remains unclear who at Stoke Heath saw what reports and when. It was agreed that it was some days before his psychiatric history became available. This is a crucial issue in the review of the case and the Chapter 8 Review recommended a full review of the arrangements for ensuring that the YOI gets all relevant information and that this spells out respective responsibilities. The arrangements should ensure access to the information by relevant staff within the YOI. Where a risk of self-harm is identified then psychiatric histories should be available at admission or very soon after.

2.3.12 The Chapter 8 Review also drew attention to the arrangements for record keeping at the YOI Health Care Centre. Information about a young person is kept in four different, but interrelated folders. The Review concluded that this provided a potential for some confusion, not helped by the quality of some of the recording. The Review thus recommended a review of record keeping so as to reduce this possibility. In particular, non-medical staff with direct responsibility for a young person at risk of self-harm need to know what is happening even if the information is held on a medical file. This access should of course be subject, at all times. to the medical consent rules.

2.3.13 Joseph was seen by doctors on 20 and 21 March 2004. No further psychiatric records had been received up to this point nor, it is suggested, had Health Care Centre staff received the relevant information provided by the Yot. It would appear that Joseph's general attitude and behaviour during those early days in the Health Care Centre allowed staff to conclude that he was 'settling in'. He had not tried to harm himself and denied to staff any thoughts about doing so. During the first two days there were problems related to his eating and washing, but these passed and the records describe a compliant, undemanding boy making a slow adjustment to his circumstances. Staff remained alert, however, to concerns about his state of mind and medical notes record on 22 March 2004 that 'Joseph is a very depressed, damaged young man. He will require a lot of support and close monitoring'.

2.3.14 Joseph remained in the Health Care Centre, but preparations were made for his eventual transfer to A Wing. The Chapter 8 Review reports his expressed opposition and anxiety about this move and this concern is evidenced in a series of logged reports. As noted, staff at Stoke Heath

actioned a careful plan to introduce him to that possibility. However, Joseph remained resistant to the notion and continued to express his unwillingness to move to the last.

2.3.15 When in the Health Care Centre Joseph was subject to a prescribed 30 minute observation regime. As Joseph died within 20 minutes of the last recorded observation, the Chapter 8 Review recommended that YOIs adopt a 15 minute observation interval where young people are assessed as at serious risk of self-harm and are accommodated in a 'safer' cell. If the cells are not deemed 'safe' then the Chapter 8 Review recommended continuous, direct observation. In all circumstances, managers should monitor compliance with these arrangements on a daily basis.

Assessment and Planning

2.3.16 In Joseph's case assessment and planning for his period of detention had hardly begun. Information had not been systematically collected, collated and assessed. Although there were plans to hold the initial planning meeting within the 10 days prescribed time-scale, the Chapter 8 Review considered that this represented too long a period in the case of a young person with the degree of risk presented by Joseph. A period of 24 hours is recommended for any young person subject to the serious risk procedure. Such an early meeting would allow for an assessment of the quality of specialist information available, a consideration of the possibility of a transfer application to the YJB Placements Team and the possible need for further specialist consultation, particularly from a Child and Adolescent psychiatrist.

2.4 Coroner's Inquest, Mid and North Division, County of Shropshire

The Coroner's Inquest

2.4.1 A Coroner's Inquest into the circumstances of the death of Joseph Scholes was conducted at Shrewsbury by Mr John Ellery, H.M. Coroner for the North Division, County of Shropshire, between the 19 and 30 April 2004. Coroners are required to hold a jury-led inquest for all deaths in prison custody. The Inquest was held with a Jury. The Inquest heard evidence, either in writing or person, from 55 witnesses. As well as receiving documentary evidence and the reports of investigations referred to earlier in this chapter, the Coroner commissioned his own Independent Psychiatric Report of the case. This was prepared by Dr. Malcolm Bourne, Consultant Child and Adolescent Psychiatrist, a member of the C.A.T.T Partnership. Dr Bourne conducted his own investigation and also drew on the Trafford ACPC Chapter 8 Review prepared by Robin Hughes. The Coroner commended both reviews.

2.4.2 At the conclusion of the Inquest, the Jury returned a unanimous verdict of "Accidental death in part contributed because the risk was not properly recognised and appropriate precautions were not taken to prevent it." The

Jury made clear that this was primarily a systems failure and was not attributable to any one individual or group of individuals.

2.4.3 Following the Inquest Mr Ellery wrote to the Home Secretary on 5 May 2004. Mr Ellery drew the Home Secretary's attention to a number of concerns about the sentencing, placement, care and containment of Joseph Scholes that the inquest had not been able fully to examine. The Coroner considered that these were policy and operational issues of such moment that only a public inquiry would provide a platform for their full consideration. A summary of those points and issues follows.

Main Conclusions and Recommendations

Quality of Pre-sentence Information

2.4.4 The Inquest concluded there were weaknesses in both the quality and handling of information at the pre-sentence stage. Although the Jury accepted that the ***Asset*** format was an appropriate way to bring together relevant information about the young person, they were critical of the Yot for its completion of the ***Asset*** assessment material and drew attention to the 'Don't Know 'responses to key aspects of the ***Asset*** framework that they considered inadequate. Attention was drawn towards the importance of providing additional documentary evidence to support the ***Asset*** judgement, especially where vulnerability was the issue. The Coroner emphasised throughout the importance of providing a good psychiatric assessment of the young person and ensuring that the court and all relevant parties were in possession of this material.

Allocation Arrangements

2.4.5 The Inquest was unanimous in its conclusion that the placement of Joseph in a YOI was not appropriate and that he should have been placed in a Local Authority Secure Children's Home. The Inquest heard evidence about the allocation arrangements and the difficulties in matching young people's needs and appropriate services given the limited capacity of the local authority secure sector. The Coroner expressed great concern about this situation and also drew attention to those vulnerable 16 year olds who, because of their age, appeared even less likely to be able to access a secure children's home.

2.4.6 The Coroner also recommended that the system for placement should hold open for a longer period the possibility of transfer to more suitable accommodation. Young people who are disturbed and vulnerable need to feel, and be made aware, that their initial placement may be reviewed. The Jury recommended that young people such as Joseph should be held in some temporary intermediate provision outside the main YOI estate while such considerations took place.

Quality of communication

2.4.7. The Coroner and Jury were concerned by what they perceived as failures in the communication arrangements and the passing of information between professionals. They made a general recommendation that these arrangements should be subject to review and improvement. In particular, they drew attention to their concern about the availability of the psychiatrist's report and the gaps in communication between the Yot and Stoke Heath in respect of the transfer application. They also felt that more prominent means should be found by which to signal levels of risk.

Stoke Heath YOI Health Care Centre

2.4.8 The Inquest concluded that the care and attention given to Joseph by the medical, nursing and YOI staff at Stoke Heath Health Care Centre was provided in an appropriate way. However, there was unanimous condemnation of the building and its facilities.

Use of Safe Clothing

2.4.9 The Inquest learnt that Joseph had spent his first four days and nights in the Health Care Centre wearing only safer cell clothing with no underwear. Although this clothing was issued for Joseph's self protection, the Coroner and his Jury were concerned with the possible de-humanising aspects of this approach and recommended that the practice be reviewed.

CHAPTER 3

MAIN THEMES AND ISSUES ARISING FROM THE INVESTIGATIONS

This chapter of the Operational Review draws together, from the four investigations, a set of key themes and issues that need to be addressed if improvements in services are to be achieved. These matters are addressed in the various later Chapters of this Operational Review as indicated.

3.1 Appropriateness of Sentence

3.1.1 The Prison Service Investigation was concerned that custody was not an appropriate sentence for a young man with Joseph's level of risk and limited criminal history. They recommended that the circumstances of the case might be used to inform future sentencing policy.

3.1.2 There was also implied criticism in the Trafford ACPC Case Review, and by the Coroner, of the appropriateness of the sentence for a young person with Joseph's needs.

3.2 Appropriateness of Placement

3.2.1 All of the investigations concluded that young men who presented Joseph's level of risk are not appropriately placed in a YOI and that every effort should be made to secure their placement in a Local Authority Secure Children's Home.

3.2.2 The four investigations appreciated the current problems of supply and accessibility of this accommodation and supported an urgent review of the sector.

3.2.3 More explicit eligibility criteria for placement in a LASCH should be published and referrers should evidence their applications against those criteria.

3.2.4 There should be consideration of the development of discrete facilities within the YOI sector for young people demonstrably at risk of self-harm or suicide. This proposal accords with the YJB's draft Strategy for the Secure Estate for Juveniles.

[See Operational Review, Chapter 4]

3.3 Quality of Pre-Sentence Assessment Work

3.3.1 The investigations concluded that the Pre-Sentence report prepared by the Yot was of high quality and provided a good picture of Joseph, his needs, abilities and vulnerability. By contrast, there was criticism of the quality of the Yot officer's assessment of Joseph provided through the ***Asset*** assessment format. Attention was drawn to the need to complete ***Asset*** in a full and

unambiguous way, and to provide evidence to support the assessment markings.

3.3.2 The investigations concluded that, by one means or another, the court had received explicit advice about Joseph's vulnerability, his history of self-harm and attempted suicide. It had also been made clear that there were concerns about an increased risk of self-harm if he were sentenced to custody.

3.3.3 The YJB Serious Incident Report recommended that all information, including that acquired post-court, should be transferred into ***Asset*** documentation, and the ***Asset*** judgements be supported by clear evidence.

[See Operational Review, Chapter 5]

3.4 Placement of Children at High Risk in the Secure Estate

3.4.1 All the investigations closely examined the operations of the YJB Placements Team. There was a general conclusion that, accepting the complexity of the team's task and the difficulties inherent in managing three sectors of provision with differential levels of availability, more transparency needed to be introduced into the placement arrangements, and a more clearly defined and better informed process for determining placements.

3.4.2 The Placements Team should develop new guidance on arranging secure placements and make this available to Yots and the providers of security. This guidance should articulate clear processes and criteria for decision making, including the matter of deciding between competing vulnerabilities, and for reviewing placement decisions.

3.4.3 There are issues about the quality of information required by and sent to the Placements Team. The Trafford Review concluded that where only the ***Asset*** materials were available, this would provide an inadequate assessment of the child's needs. Fuller information was needed and a greater degree of interaction between the Yot and the YJB Placements Team.

3.4.4 When a child presents with an extreme level of risk, then a more effective early warning system should be developed.

3.4.5 The investigations also examined the arrangements for post-initial placement transfer applications, an area that had not been handled satisfactorily in Joseph Scholes's case. The arrangements for making such transfer requests need to be clarified and relevant operational guidelines reviewed.

[See Operational Review, Chapter 6]

3.5 Reception at YOI – Issues of Communication

3.5.1 On admission to the YOI all appropriate reception procedures were carried out satisfactorily and Joseph received a high level of care and attention, wholly in accordance with Prison Service policies. His history of mental health problems and self-harm were noted and he was placed in the Health Care Centre, initially in a safer cell with CCTV observation, and later in an ordinary cell but still under at-risk supervision and observation.

3.5.2 However, all four investigations express reservations and uncertainty about the robustness of the transmission of information between the Yot and the YOI. They express particular concern about the availability of Joseph's psychiatric history and the impact that any absence may have had on the quality of decision making at the YOI about arrangements for his care planning and oversight.

3.5.3 It was possible to conclude that enough information was available at the time of Joseph's reception at the YOI to identify him as a vulnerable young man, but that the full picture was not available until much later. There is a strong general recommendation that arrangements for the transfer and quality of documentation, particularly that related to Child and Adolescent mental health information, be reviewed and improved.

3.5.4 The investigations also highlight the need to review, and improve the quality and closeness of, collaboration between Yot officers and staff at the YOI. These concerns focus on both the need to more tightly manage the case planning process, including ensuring the continuity of cover for Yot case holders, and effective sharing of information to enable applications for placement transfer to be made by other members of staff.

[See Operational Review, Chapter 8]

3.6 Care and Supervision Issues at YOI

3.6.1 All four investigations concluded that the care and attention given to Joseph by the medical, nursing and YOI staff at the YOI Health Care Centre had been provided in an appropriate manner. The quality of health care provided was good and appropriate to his level of need.

3.6.2 However, the investigations were unanimous in their criticism of the physical environment of the YOI Health Care Centre and the accommodation provided. Prison Service plans to replace the facility were welcomed and expedition recommended.

[see Operational Review Chapter 11]

3.6.3 All the investigations looked closely at the quality of information and assessment available to ensure the drawing up of a fully supportive care plan. As noted above, more detailed medical information should have been made available at an earlier stage.

3.6.4 In terms of good care planning practice in the case of a young man at very high risk such as Joseph, the investigations each conclude that this should take place as soon as possible and well within the maximum ten day standard set by the YJB National Standards. The Prison Service investigation proposed that this might be a two stage process, an initial review meeting taking place within 24 hours, followed by a review meeting in 7 days.

3.6.5 The Trafford ACPC Review drew attention to the fact that the care of young people in custody is a shared team responsibility. In the case of a young person identified as being at very high risk it is suggested that a personal officer (key worker) be appointed within 24 hours of their arrival and be charged with responsibility for coordination of all aspects of the young person's detention and care.

3.6.6 The investigations expressed concern about the arrangements for recording at the YOI. Information is maintained at a number of file locations and a more integrated arrangement needs to be developed. There were also issues about the onward transmission of information between units within the YOI. There is a particular issue of making information held on medical files available, with appropriate safeguards, to non-medical staff with direct responsibilities for a young person at risk. These arrangements would benefit from review.

[See Operational Review, Chapter 9]

3.7 Safeguarding – managing self-harm and suicide

3.7.1 Overall, the investigations concluded that the YOI's suicide awareness strategy was sound and that there was evidence that it was applied with care and determination.

3.7.2 However, some tightening up is advised. The Prison Service investigation recommended that arrangements should be made to directly monitor the telephone conversations of trainees under 'at risk' supervision and to pass on relevant information to staff supervising those trainees.

[*See Operational Review Chapter 10]*

3.7.3 There are issues to be considered about the balance between safer cell use and levels of observation in ordinary accommodation. Joseph Scholes had been subject to a 30 minute observation regime when accommodated in a normal cell. Regrettably he died within 20 minutes of the last recorded observation. Where safer cells are used the Chapter 8 case review recommended that the observation period be 15 minutes. If the room is not deemed 'safe' then continuous, direct observation is recommended.

[See Operational Review, Chapter 11]

3.7.4 The Coroner's Inquest was concerned to learn about the use of safer cell clothing and recommended that this practice be reviewed.

[See Operational Review, Chapter 11]

CHAPTER 4

THE JUVENILE SECURE ESTATE

4.1 Since 1 April 2000 most young people under the age of 18 years who commit offences and are sentenced to a period of custody receive a Detention and Training Order (DTO). The Youth Justice Board is responsible for the placement of these trainees. The length of a DTO sentence can be for any period of time between 4 months and 2 years, with the first half spent in custody and the second half spent under supervision of a local Youth Offending Team (YoT) in the community. Under the terms of this order young people can spend their sentence in either a Young Offender Institution (YOI), a Secure Training Centre (STC) or a Local Authority Secure Children's Home (LASCH). Young people awaiting trial or sentence can also be remanded in custody. One third of the capacity in YOIs is utilised by un-sentenced young men on remand.

4.2 The Prison Service is responsible for the placement of young people sentenced for longer periods of custody under sections 90 and 91 of the Powers of Criminal Courts (Sentencing) Act 2000. This measure replaced detention for grave crimes under section 53 (1) and (2) of the Children and Young Persons Act 1933.

4.3 The YJB is responsible for commissioning secure provision for young people and for purchasing individual places within the secure estate. The Board determines how much of its total budget should be allocated to purchasing. In the year 2004/5 the purchasing element is set at £259.5m, resulting in 3% growth over the level for 2003/4. The purchasing budget is 67 % of the YJB overall budget for the year (£377.9m). **[Ref 1. YJB Corporate and Business Plan 2004 /7]**

4.4 The secure juvenile estate is comprised of three sectors: Young Offender Institutions (YOI), Secure Training Centres (STCs) and Local Authority Secure Children's Homes (LASCHs). At October 2004 the configuration of the secure estate was as follows,

	Boys	**Girls**	**Total**
YOI Places	2612	88	**2700****
STC Places	174	100	**274***
LASCH Places	182	53	**235***
Total	**2968**	**241**	**3209**

* Some of the places in STCs and LASCHs can be used for both boys and girls.

** The YJB also takes up 200 beds from 600 additional Prison Service beds allocated to the YJB in connection with the Street Crime Initiative.

Young Offender Institutions

4.5 The bulk of the provision (83%) for young men sentenced to DTOs is in the YOI sector, managed by the Prison Service. The YOI sector currently offers a capacity of 2700 beds. The places are spread throughout the YOI estate which comprises 13 Establishments, with capacities varying between 28 and 360, giving a mean capacity of 216 places. Split sites, where young people are accommodated alongside YOI provision for 18 to 21 year olds, account for 55% of the capacity. There are four sites solely for juveniles. During 2003/4 there was an average occupancy level of 83% in YOIs and the average annual unit cost was £50,000.

Secure Training Centres

4.6 There are four STCs in England and all are contracted by the YJB from private sector providers of correctional services. The sector provides 274 beds in four purpose built centres of roughly equal size that offer education and care in secure conditions to young people up to the age of 17 years. The STCs offer high staff to child ratios and are consequently more expensive than YOIs. Contractors agree to provide services against a contract agreed with the YJB. In 2003/4 the average annual unit cost was £150,000. 92 % of STC provision was occupied that year.

4.7 It should be noted that in 2002 at the time when the decision where best to place Joseph Scholes was being made, there were only three STCs in operation, thus limiting access to that sector. As noted by the investigations into his death the discussion about preferred placement centred on the choice between a YOI and a LASCH. Placement in an STC does not seem to have been considered and this may have been due to the fact that they were no vacancies in that sector.

Local Authority Secure Children's Homes

4.8 LASCHs work with a much wider range of children and young people, both in terms of age but also in the extent of the reasons for their accommodation at the children's home. The focus of their work is on very vulnerable children who present a range of challenging behaviours that are commonly very difficult to manage, and who have serious physical, emotional and psychological problems. The reasons that children and young people are placed in LASCHs vary considerably. Some of the children will be Looked After children placed for entirely welfare or behavioural reasons. Other children will be placed, either on secure remand or DTO sentence, for criminal justice reasons. LASCHs enjoy high adult to child staffing ratios compared to YOIs.

4.9 The YJB contracts for 235 places in this sector across the country. The YJB also has the capacity to spot-purchase places in units that are not under

contract. In 2003/4 the reported annual occupancy level in LASCHs was 111%. This level includes spot-purchases over and above the contracted level. The average unit cost was £165,000. Understandably, access to places in this sector is difficult and there is often a situation of excess demand for the accommodation by both the care authorities and the YJB.

Young Women in Custody

4.10 The YJB places most girls and young women, including 17 year old young women assessed as at risk of self-harm or suicide, in a LASCH or STC. Other 17 year old young women are placed in the three YOIs for women where 88 beds are available for juveniles. In certain circumstances young women are also placed at Holloway prison. For example there were 7 young women accommodated at that prison in October 2004. A recent initiative will, however, see all 17 year old girls being placed in 5 small self-contained units.

4.11 This small population of girls and young women has highly complex and varied needs and difficult decisions have to be made about the appropriate placing of individual young women. Whilst the aim is to locate young women in YOI as near to their home as possible, increased numbers beyond agreed capacity at the establishment of choice can cause the young people to be housed nearer to young adult offenders. Because there is inflexibility in the system due to the small number of establishments, placements are sometimes made at long distances from the young person's home, so causing problems with the maintenance of links with family, Yot workers and their home community.

4.12 The female secure estate has peculiarities that complicate the arrangements for the safeguarding of the young women. These establishments also house young women who are pregnant, young women who have babies and young adult offenders with their babies in Mother and Baby Units. There is a general lack of appropriate facilities to accommodate the needs of young women with children. Housing young women with children on an adult Mother and Baby Unit is considered unsatisfactory and this group of young mothers need specific support to enable them to care for their babies and be cared for themselves.

YJB Placement Policy

4.13 There are marked differences between the three types of provision and an understanding of these differences is key to determining a placements policy and any arrangements for the placement of individual young people. The key to ensuring appropriate and safe placements of young people is a clear understanding about which young people need to be placed where and why. The inherent complexity of the balance between demand and supply in respect to the availability of suitably tailored accommodation within the current configuration of the secure estate makes this even more important. This is an issue that is currently being addressed by the YJB as the third element of the Minister for Correctional Services' plan of action following the death of Joseph

Scholes. The re-formulation of the YJB strategy for the secure estate should offer more flexibility and a wider range of placement options.

4.14 A contemporary assessment of the level of demand for places for those children and young people identified as 'vulnerable' still indicates that there are, and will continue to be for the foreseeable future, insufficient places for such children outside the YOI sector. This is a situation of concern and has been commented on by both the investigations into the death of Joseph Scholes and by David Gilroy in his YJB Serious Incident Review into the death of Gareth Paul Myatt at Rainsbrook STC, June 2004 **[Ref 22].** Gilroy notes that over 4000 15 and 16 year old young people assessed as vulnerable were placed in YOIs in 2003/4. At the heart of this issue is the need to define more precisely what is meant by 'vulnerability' and this is explored more fully in later sections of this Operational Review. Certainly the YJB would contend that it should be possible for a substantial number of the 4000 young people currently identified as vulnerable to be provided with appropriate educational and health services within the YOI sector.

4.15 Strategic planning for the secure estate is made more difficult by the fact that demand is subject to changes in the external world, particularly variations in sentencing policy and practice. The YJB is obliged to accommodate all young people sentenced to a DTO or remanded to custody and the level of such demand, both in terms of number of placements and their length, is not in the gift or control of the YJB. It is therefore difficult to accurately match demand and supply over time.

4.16 The YJB has an overall strategy to reduce the use of custody and reduce the number of secure places by the development of more intensive and effective community based interventions; in particular the Intensive Supervision and Surveillance Programme (ISSP). Some progress towards this goal was made in 2003/4 that delivered a 13 % reduction in the use of custody for young offenders, but these gains have been lost in 2004 by a rise in sentences of custody. There is some current debate about whether this reverse in progress towards the target may be due to an unplanned and unpredicted increase in the number of young people receiving custody as a result of breaching their Anti-Social Behaviour Orders (ASBOs).

4.17 Given the above, it is important that the YJB should have a clear Placements 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. To that end the YJB issued a Placement Policy statement in July 2004 [placed at Annex 3A]. This statement commits the YJB to place children and young people in a secure establishment that can most effectively manage their needs and risk factors as identified by Yots and make decisions based on the best 'fit' between the risk presented by the young person, the availability of places within the three sectors and the needs of other young people already placed. The YJB commits to place all under 15 year olds in the LASCH and STC sectors.

4.18 The YJB Placements Policy also provides for the maintenance of a dedicated Placements Team that is adequately resourced and trained to deal with placement decisions. The Placements Team will work collaboratively with other relevant stakeholders to ensure the effective operation of the placement system, detail the processes and criteria for placing young people in secure accommodation, and maintain an out-of-hours service for placements and incident management. The detailed workings of the Placements Team are examined in Chapter 6 of this Operational Review.

Draft YJB Strategy for the Secure Estate for Juveniles

4.19 In October 2004 the YJB prepared a Consultation Paper **[Ref.2]** that set out a broad vision for the secure juvenile estate for the next three years. The strategic vision takes into account the Governments policy intentions as set out in the Green Paper *Every Child Matters* and its companion paper *Youth Justice-the Next Steps* **[Ref. 5C]**. The strategic vision is based on the following operational principles.

The YJB believes that all institutions within the secure estate should:

- Be run by staff committed to working with children and young people, who are adequately trained in this area of work, and who have completed nationally approved training in effective practice work with juvenile offenders
- Minimise the likelihood of harm to young people, through rigorous safeguarding measures which include well developed self-harm, suicide and bullying prevention programmes, measures to prevent harm from adults, and provision of independent advocacy services
- Provide high quality physical and mental health services, and substance misuse services
- To the greatest extent possible be separate from facilities for adults
- Comprise relatively small living units, even if within larger institutions
- Have regimes which are fundamentally geared to the individual educational training, recreational cultural and personal development needs of juveniles and which are not disrupted by unnecessary transfers
- Employ an approach to behaviour management that emphasises to the greatest possible extent, positive encouragement and reward rather than physical restraint or negative sanctions
- Cater to the diverse characteristics and equally valid needs of young offenders in a manner which does not discriminate on the basis of gender, sexual orientation, race, ethnicity or religion
- Be located as close to the young offenders' community ties as possible
- Be characterised by end-to-end sentence planning arrangements focused from the outset on the resettlement of the young persons in the community
- Foster to the greatest extent possible, consistent with their well-being, young offenders links with their families or carers and community ties, and the community-based agencies with whom they dealt prior to their

incarceration and with whom they will have to deal following their release
- Be subject to regular inspection and continuous accountability arrangements.

4.20 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.

4.21 The YJB accepts that it will take some time to achieve its ambition and much will depend on sentencing trends over the next three years and the level of funding available to the juvenile offender sector. The Board remains committed to a reduction in the use of custody and the additional development of community based punishment options for dealing with offending. The YJB's stated aim in the Consultation Paper is a reduction of 10% in the daily population of juveniles in custody by the end of the 3 year planning timeframe.

4.22 The YJB Consultation Paper proposes the following reconfiguration of the juvenile estate,

- All boys under 15 years old and all girls under 17 years will continue to be cared for in STCs or LASCHs. The overall number in these sectors will not exceed 510, unless further significant resources become available

- 17 year old girls will remain in Prison Service accommodation, but will be housed in dedicated units separate from adult women prisoners.

4.23 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.

4.24 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. These proposals are welcome and recognize the fact that the juvenile population in custody is not a homogeneous group.

4.25 This Operational Review is predominantly concerned with the capacity of the YOI sector to keep young people safe and ensure their welfare, particularly in respect of those young people who self-harm or threaten suicide. It is encouraging therefore to note that, in the YJB Consultation Paper, the YJB restates its commitment to maintaining a strategic safeguarding policy for the YOI estate. In the next three years the YJB is committed to:

- Implement, with the Prison Service, and where affordable, the recommendations arising from the recent review of safeguarding arrangements in YOIs

- Fund, in line with the recommendations of the ADSS/LGA/YJB report on the ***Application of the Children Act (1989)*** **to** ***Children in Young Offender Institutions****,* 25 local authority staff to undertake duties under the Children Act 1989 in YOIs

- Complete the roll out of advocacy services in YOIs

- Review behaviour management arrangements, with particular attention to physical restraint and segregation, and to implement a Code of Practice in relation to these matters

- Develop a more stable, specialised workforce for juvenile establishments.

CHAPTER 5

THE ASSESSMENT AND MANAGEMENT OF VULNERABILITY AND RISK

YJB Assessment Policy

5.1 The YJB's assessment policy is based on the belief and understanding that all young people who come into contact with the criminal justice system have a multiplicity of personal needs and difficulties. Planning action and services to meet these needs can only proceed on the basis of a comprehensive assessment that takes into account the full extent of a young person's personal circumstances, attitudes and beliefs. As this population of young people continue to present an ever more challenging range of maladaptive behaviours, then the need for the development and practice of high quality and confident assessment becomes essential.

5.2 This fact has been recognised by the YJB from the outset and high quality assessment is seen as central to achieving the YJB's overall objective of reducing offending by young people. To achieve this end the YJB introduced ***Asset*** in April 2000. ***Asset*** is a structured assessment tool used by all Yots across England and Wales on all young offenders who become their responsibility. The assessment instrument is designed to look at the young person's offending behaviour and identify a multiple of factors or circumstances that may have contributed to that behaviour. Information gathered in this way can be used variously to inform the court process, post court intervention programmes or plan for action and services to meet the particular needs of the young person.

5.3 Following the introduction of ***Asset,*** a validation research study of the Assessment instrument was conducted at the end of the first 18 months by the Centre for Criminology, University of Oxford **[Ref 2]**. This research provided a well-evidenced profile of 3,395 young people (from 39 Yots) and demonstrated the worth and potential of the approach for greater understanding of offending by young people, both in general and in particular groupings. The results of the study led to the issuing of a second validated version of the assessment tool in 2002. It is that version that has been examined by this Operational Review **[Ref. 3]**.

The *Asset* assessment process

5.4. The ***Asset*** assessment tool provides a structure for recording and analysing a wide range of relevant information. This information is obtained by the Yot assessor through interviews with the young person and their family, and by gathering evidence from other sources including reports and other relevant information from professionals in other agencies with whom the young person has had contact. The ***Asset*** form requires the assessor to bring all this information together. This process is completed either electronically or

by hand. A series of questions are posed that the assessor needs to answer with reference to the information and evidence available. The assessor is then asked to make a judgement about the information and decide a ranking between 0 and 4 that indicates whether the issue under consideration is associated with the likelihood of further offending by the young person. Detailed guidance is provided to the assessor within the ***Asset*** framework document, as are scoring exemplars to assist the assessor with rankings.

5.5 As well as analysing the young person's offending behaviour, the core ***Asset*** assessment framework identifies 12 'dynamic risk factors', as follows:

Living arrangements, Family and Personal relationships, Neighbourhood, Education, Training and Employment
Lifestyle, Substance use, Physical health, Emotional and mental health
Perception of self and others, Thinking and behaviour, Attitudes to offending and Motivation to change.

These 12 risk factors are all assessed and ranked. An aggregation of scores through the rankings is considered to give a general indication of the extent of offending-related factors in the young person's life. (The higher the total score the greater the likelihood or further offending.)

5.6 The core assessment framework also requires the assessor to identify any positive factors in the young person's life that might curb or stop offending. The assessment finally requires the assessor to make judgements about the young person's vulnerability to self-harm or suicide and also to their capacity to cause serious harm to others. If these factors are present then further detailed assessment related to these issues is required. Sometimes this may include the completion of a mental health screening tool.

Completion of *Asset*

5.7 Whilst there is no doubt that the ***Asset*** provides a valuable, well designed and validated assessment framework, as with any instrument of this nature its effectiveness relies heavily on the quality of information gathered and the skill and judgement of the assessor. As noted, the investigations into the death of Joseph Scholes drew attention to the fact that the ***Asset*** form prepared and presented to the court was inadequately completed and not satisfactory.

5.8 The jury at the Coroners Inquest into the death of Joseph Scholes made a particular point about their unhappiness with 'don't know' responses within the ***Asset*** report. Some guidance on the use of 'don't know' responses is given in the Introduction to the ***Asset*** framework. This guidance states that the assessor should not tick the 'don't know' box as an easy option to reduce the time required for an assessment, nor allow it to be seen as a sign of an inadequate assessment. The guidance advises assessors to use the option of 'don't know' constructively by, for example, indicating in the evidence box the reasons for the lack of knowledge or identifying what additional information needs to be obtained so as to inform a decision. The response 'don't know'

can also act as a signal to other colleagues who may become involved in the case or acts as a marker when the assessment is reviewed.

5.9 In all instances, details about why there is an information or judgement gap needs to be provided. Unless this is the case then degrees of uncertainly will remain in the minds of those who have cause to utilise the ***Asset*** report to inform their own decisions. The YJB consider that removing the 'don't know' option is likely to lead to assessors either just leaving questions blank or feeling forced to give a yes/no answer that may actually be inaccurate. This point links with the more general issue of ensuring that judgements are clearly and substantially informed by evidence. This is a matter that needs to be strengthened, perhaps by management action to reinforce the notes of guidance and through professional training and supervision.

5.10 By their nature and design, Yot teams are made up of individual officers who come from a range of relevant disciplines and professional backgrounds. Their experience of assessment activity in those disciplines and agencies may vary substantially, either because assessment may have not been a significant activity for them in their former role or because the techniques of assessment or case planning used by their former agency were substantially different. One of the strengths of the ***Asset*** approach is that it provides a standardised framework, supported by preparation and training tailored to the approach. Different disciplines drawn from a balanced agency mix should bring strength to the various components in the assessment process, and whilst sharing expertise and experience across teams should lead to better informed assessments, pressures of work are more likely to develop in Yot staff a 'jack of all trades' disposition.

5.11 The investigations into the death of Joseph Scholes drew attention to the fact that there was a qualitative difference between the completed ***Asset*** and both the Pre-Sentence Report and the Post-Court report. It is important for Yot managers and their staff to ensure that these documents are completely compatible in both information content and quality of assessments. The YJB confirm that ***Asset*** should include information received post-court and this is clearly stipulated in the current training for ***Asset*** and in In-Service training for APIS (Assessment, Planning Interventions and Supervision). The ***Asset*** should be conceived as an ongoing document that is accessible to updating and review as new information becomes available or the circumstances of the young person change.

Broadening the basis of Assessment

5.12 The Government's Green Paper ***Every Child Matters****,* issued in September 2003 **[Ref. 5A]** as the consultation stage leading up to the introduction of the Children Bill (now the Children Act 2004), proposed the development of a common assessment framework [paragraphs 4.13 to 4.17]. The Government had noted that children and young people, especially those identified as in special need, were likely to be subjected to a range of assessment and assessment techniques during their childhoods. The Government took the view that there may be grounds for the development of

a common assessment framework that would reduce unnecessary duplication of agency- or discipline-based assessments, and also lead to improvements in inter-professional relationships.

5.13 This policy proposal has been welcomed. In their response to the consultation in March 2004 ***Every Child Matters – the Next Steps*** the Government confirmed the production during 2004/5 of a common assessment framework that would build on existing assessment tools:- the Department of Health Assessment framework for the assessment of children in need and their families, the Connexions Assessment, Planning, Implementation and Review (APIR) system, the Special Educational Needs code of practice, assessments conducted by health visitors and the YJB ***Asset*** tool. This work provides a further opportunity to enhance aspects of the ***Asset*** assessment, and whilst continuing to recognise the importance of the tool for assessing offending there will be more opportunity to pursue a more focussed needs-based assessment for individual young people **[Ref. 5B]**.

Young person's Views

5.14 Another of the strengths of the ***Asset*** framework is the opportunity that it provides to learn about the young person's own views about their needs and circumstances through the completion of the 'What do YOU think?' format. The investigations into Joseph Scholes's death demonstrate how vitally important it is to listen to young people and build those perceptions of their situation, some of which may be very different to those of the worker, into case assessments, care plans and decisions about appropriate intervention. The format also provides the opportunity for the young person to draw attention to issues that they are worried about and which may be hidden from the Yot worker. The format can also be used to assist the development of a constructive relationship between the Yot worker and young person.

5.15 The ***Asset*** guidance accepts that the 'What do YOU think?' form is a limited instrument and advises flexibility in its use. What is important is to engage with the young person and use the format to obtain the best possible picture of their views and feelings. This is an area of practice where experience and expertise play an important part and Yot workers, as with all other professionals working with children and young people, should receive skill training in communicating with young people. This is especially necessary when working with vulnerable, disadvantaged or disabled children or young people. A helpful reader can be found in 'Communicating with Vulnerable Children' David Jones. **[Ref. 6]**

Management of Risk

5.16 The Operational Review has noted that the YJB has currently commissioned revised guidance on the management of risk from Wilkinson and Baker entitled **'Managing Risk in the Community'.** A draft of this guidance has been made available to the Review. **[Ref. 7]**. In this draft guidance **'Managing Risk in the Community** ' establishes a set of principles that should be applied to the management of risk whether it be risk of re-

offending, risk of serious harm to other people or risk of vulnerability. This Operational Review strongly supports these principles.

- The focus of engagement with a young person should be the reduction of risk, recognising that eradication may not be possible;

- Practice should be risk-led and the needs of young people that are most closely connected with increasing risk should be given priority. This will also involve balancing the rights and freedom of an individual young person against the risks they may pose to themselves and others;

- It is important that wherever possible the young person is actively involved in risk assessment and management. This will require us to pay attention to diversity - of young people, of their circumstances, of their patterns of behaviour - in order to deliver a responsive service;

- Risk led practice should be based on specific descriptions of risk in terms of behaviour, circumstances etc, rather than generalised labelling of an individual young person;

- In the youth justice system ***Asset*** is at the heart of risk assessment and risk management which are linked and ongoing processes. ***Asset*** should be used in all cases to ensure that risk decision making is evidence-based, that decisions are properly recorded and reviewed and that they lead to appropriate action;

- Risk assessment and management are the responsibility of the organisation as a whole and require appropriate policies, systems and resources to be in place: however each individual member of staff must also take personal responsibility for their own actions.

5.17 **'Managing Risk in the Community'** offers a detailed examination of the management of risk in both a policy and practice context. The guidance is comprehensive in its coverage of matters related to the assessment and management of risk and the preparation and support of Yot staff who have to implement it. The guidance contains a range of information to help managers improve practice in this area and help create an environment in which practitioners feel more confident about working with risk.

5.18 The guidance provides sound advice about the following components of arrangements for managing risk:

- There must be clear definitions of the risks under consideration and the identification of different levels within each category of risk
- There must be suitable arrangements for the allocation of cases, along with decisions about prioritizing and about the intensity and nature of interventions related to the type and levels of risks identified
- There must be clear procedures for managing all types of risk and specified procedures for various groups of staff, sections within the

Youth Offending Service and external agencies, the secure estate and the courts

- There must be arrangements that minimize the risk to staff
- The management arrangements should clearly articulate roles and responsibilities for staff and managers within Yot and interagency relationships with courts, other agencies and the secure estate
- The arrangements should articulate the qualities, skills and knowledge needed by all members of staff in direct linkage to their roles and responsibilities in relation to risk
- The management arrangements should encourage working together as a team, including the most appropriate use of specialist skills and knowledge within the Youth Offending Service
- Work should be planned with other agencies, including the promulgation of local information sharing protocols, availability of specialist resources and coordination of interventions
- Issues of confidentiality and disclosure should be agreed within and between agencies drawing on current legislation and YJB guidance
- There should be arrangements for the monitoring and review of risk management at all levels and of aspects of the process from individual case audit through to inter-agency working arrangements.

5.19 This Operational review endorses the approach set out in **'Managing Risk in the Community'** and considers that the publication, implementation and integration of this guidance into Yot practice should represent a major step towards improving the understanding and management of this challenging area of work.

Indicators of Vulnerability

5.20 The validation research by Oxford University quoted above noted that approximately 20% of the young people were considered vulnerable to harm because of the behaviour of other people, specific events or circumstances. The study reported that 25% were vulnerable because of their own behaviour and 9% were considered to be at risk of self-harm or suicide. This figure rose to 15% in the case of young women. This represents a substantial number of young people at risk and underlines the need to ensure that the assessment framework is able to capture them and reflect the degree of their individual vulnerability in the ***Asset*** report.

5.21 Vulnerability in this context has been defined in terms of the young person being faced with specific and direct risks such as being the subject of physical abuse, bullying or threatening behaviour, emotional or sexual abuse, or concerns about self-harm and suicide. This is a more limited definition than one that might see all young people who become young offenders as vulnerable and disadvantaged by virtue of their circumstances. It is appreciated that it is sometimes difficult to maintain a clear distinction between these two 'loose' categorisations, but one of the problems that has beset the identification of the more vulnerable young people, and the effective matching of their needs with appropriate resources, has been that they have

been ‘masked’ by numbers of the less clearly defined ‘vulnerable’ young people.

5.22 It is therefore important that staff of Yot teams are well informed about this complex area, both through their training and by being given access to specialist resources to assist their understanding and practice. One view fielded from Yots during this Review is that the ***Asset*** framework emphasises concerns about risk of dangerousness and re-offending, but is weaker on vulnerability and self-harm. There appears to be an expectation that professionals will already know about this area from their former training and professional work, but this confidence may be misplaced. More information and preparation would appear to be required. Whilst the Introduction to the ***Asset*** framework provides some helpful guidance, this only gives a basic understanding of this area of experience and practice.

5.23 If this important area of practice is to be more fully understood, then the availability of specialised guidance would be beneficial. In **‘Managing Risk in the Community’** a graduated approach to defining levels of vulnerability is posited and this may suggest itself as a reasonable move towards a more refined understanding of vulnerability.

5.24 **‘Managing Risk in the Community’** proposes a four-tiered categorisation of vulnerability.

Low Vulnerability: in this situation there are no specific behaviours, events or people currently indicating risk

Medium Vulnerability: some specific vulnerability, but this might be of such a nature that it can be addressed as part of the normal supervision process

High Vulnerability: in this situation there are clear indications of specific vulnerability that require attention in the near future and may require the involvement of other agencies, people or specialist professionals. The management of the young person’s case may need additional supervision and monitoring (e.g. case oversight by middle or senior managers)

Very High Vulnerability: in these cases the circumstances or the behaviour of the young person would be assessed as meeting the statutory child protection threshold for ‘significant harm’ and/or immediate action might be required to prevent imminent harm to the young person, primarily in respect to an episode of actual or threatened self-harm or suicide. Immediate action may involve intensive multi-agency working, support and monitoring.

5.25 This categorisation has merit and although it is appreciated that the categorisation does not have hard boundaries, it does ‘unpack’ the concept of vulnerability and allow differential approaches and interventions to be thought about and adopted. **‘Managing Risk in the Community’** suggests that if vulnerability is assessed during completion of the core ***Asset*** at Medium Vulnerability level or above then a **Vulnerability Action Plan** should be prepared. As noted above, the core ***Asset*** provides an overview of all the risk

and protective factors and acts as a gateway for commissioning more specialist assessment where this is required. In many instances where a high level of vulnerability is focussed on self-harm or suicide then the completion of the **mental health screening tool** will be an essential component of a full assessment of needs.

5.26 **'Managing Risk in the Community'** builds on the current guidance on vulnerability in the ***Asset*** framework and provides well-informed advice geared directly to the various judicial and practice processes undertaken by Yot teams. The draft guidance points to professional reference sources on both self-harm, suicide and mental health issues that will assist practitioners to more fully understand the needs of young people displaying these behaviours and so inform judgements about appropriate preventative, management and therapeutic responses.

5.27 At the end of the process of assessment of a vulnerable young person it will be important to complete a Vulnerability Action Plan, if the assessed level is Medium Vulnerability or above. **'Managing Risk in the Community'** makes it clear that these plans should indicate:

- What information needs to be shared and with whom
- What referrals need to be made or systems triggered
- Whether monitoring is required and how this is to be done
- What interventions and support need to be put in place
- What external (e.g. monitoring) or internal (e.g. enhancing young person's ability to deal with stress/self directed anger) controls need to be put in place.

These factors have informed the design of the **Vulnerability Management Plan** form [Version 2-August 2004]. This layout is currently on one side of paper and would not appear to do justice to the amount and complexity of information, advice and planning that needs to be conveyed if the young person is to be adequately protected.

5.28 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 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.

Risk of Serious Harm

5.29 The ***Asset*** framework also requires assessors to undertake additional assessment work if the young person is identified as having engaged in harm-related behaviour directed at others. In these circumstances a Risk of Serious

Harm (ROSH) full assessment form has to be completed. Again this recently revised format is limited if not supported by good quality evidence and information.

Issues about Information

5.30 The effectiveness of any assessment conducted within the ***Asset*** framework is highly dependent on the quality and relevance of information gathered to inform the assessment, either by interview, case history work or reports sought from other agencies relevant to the young person's life and family. In recent years much progress has been made in enjoining agencies, particularly in the field of safeguarding children and young people, to share information on an open and confident basis. It is appreciated, however, that some obstacles still remain, particularly with respect at the interface with mental health services and psychiatry and how information from those sources is handled within the Yot. This relates to issues about patient confidentiality and the particular interpretation by the NHS of the Caldecott rules on access to patient identifiable information (Data Protection Act 1998).

5.31 The Operational Review has noted that the YJB has issued guidance on Information Sharing and has agreed an information sharing protocol between Yots and the police. Local Yots also have mutual information sharing responsibilities by virtue of their linkage with interagency fora such as the local Multi-Agency Public Protection Arrangements (MAPPA) and the Area Child Protection Committee. As noted above, the Government through the Children Act 2004 is committed to the creation of an integrated set of services for children and young people and an important part of that resolve is to engineer a shared information base about children. This resolve should provide leverage to overcome any residual problems.

CHAPTER 6

PLACEMENT POLICY AND MANAGEMENT

YJB Placements Policy

6.1 As noted earlier in Chapter 4, in July 2004 the YJB issued a Placement Policy [Annex 3A] that commits the YJB to:

- maintain a dedicated Placements Team that is adequately resourced and trained to deal with placement decisions
- place children and young people in a secure establishment that can most effectively manage their identified needs and risk factors identified by Yots
- make decisions based on the best 'fit' between the vulnerability of the young person, the availability of places within the three sectors and the needs of other young people already placed
- place all under 15 year olds in the LASCH and STC sectors
- detail the process and criteria for placing young people in secure accommodation
- work collaboratively with other relevant stakeholders to ensure the effective operation of the placement system
- maintain an out-of-hours service for placements and incident management.

This policy statement represented the culmination of a considerable amount of service review and development work within the YJB Placements Team over the past two years.

Independent Review of the YJB Placement Function

6.2 In December 2003 the YJB commissioned an independent review of the placement function and work of the Placements Team. This review was conducted by Mr Matthew Dieppe and reported in February 2004. **[Ref.8]** The aim of the independent review was to assess the robustness of placement procedures and practice, so as to ensure that decisions made by the Placements Team maximised the safeguarding of the most vulnerable young people. As well as examining the policies, procedures and practice of the Placements Team, Mr Dieppe's review was informed by the YJB Serious Incident Report and the Trafford ACPC Review into the death of Joseph Scholes, together with reports of six other Serious Incident Reviews of deaths in the secure estate.

6.3 In his appraisal of the work of the Placements Team Mr Dieppe emphasised the difficulty of the team's work and considered that they were able to demonstrate some considerable achievements. The team had the capacity to:

- achieve the primary task of making placements successfully on a day to day basis. They ensure all court remands and sentenced young people under the age of 18 are placed each day
- maintain capacity within the system to respond to fluctuations of demand for placements, and support the wider management of the secure estate
- retain the confidence of the secure estate. Placement requests and bookings to the secure estate are rarely challenged
- remain a learning and evolving team, committed to the task and keen to explore ways of improving practice
- maintain a good record of retaining staff and a commitment to the support and development of staff
- learn and address most of the main lessons from the Serious Incident Reviews.

6.4 However, the independent review also identified a range of challenges to the effective functioning of the team and the placement process, challenges that would need to be addressed if the YJB's aspirations for a high quality placement service were to be achieved. Mr Dieppe concluded overall that he felt unable to affirm confidence in the ability of the Placements Team to make effective and informed judgements about placement decisions, due primarily to the lack of information of an acceptable quality from some Yots when supporting requests for placements. He also considered that the system for Vulnerability Alerts operating at that time captured too many children and young people. The Alert system failed to sufficiently discriminate and identify those children most at risk.

6.5 The independent review also drew attention to a number of other factors that limited the effectiveness of the placement function. Some of these factors related to the processes for the transfer of information, including under-developed computer based information retention and retrieval systems, and the continued use of Fax that had show itself to be unreliable. Other factors related to resource availability, especially accessible provision within the secure state for vulnerable young people and specialist services, such as psychiatry.

6.6 The independent review recommended a number of important service improvements [placed at Annex 3B] and these have been actioned by the Placements Team consequent to the review. In the main these improvements are now enshrined within the Placements Policy (July 2004) and a revised Placements Protocol, issued in September 2004.

YJB Placements Protocol, September 2004

6.7 At the time of Joseph Scholes's death the YJB Placements Team operated on the basis of a Placement Protocol, placed as Schedule 7 to the 2001/2 Service Level Agreement between the YJB and the Prison Service. A similarly worded protocol is extant as part of the SLA for 2004/5. The protocol sets out some very broad principles for placement decisions primarily based on YOI catchment areas and the wish to minimize distance from home. It

advises that young people considered vulnerable should, if possible, be placed outside the Prison Service estate or be made the subject of a 'Vulnerability Alert'. The Placements Protocol also covers arrangements when beds are out of commission, the placement of young people subject to section 90 or 91 detention, young people placed in adult prisons and arrangements for young women.

6.8 The YJB has now revised the Placements Protocol in the light of the independent review [Annex 3C]. This now gives prominence to the identification of risk and provides clearer guidance on the placement process and the information required to make a well-informed placement decision. The Protocol also sets out arrangements and requirements for the safeguarding of vulnerable young people on their admission to YOI. The Protocol also sets out the process by which transfers of young people between establishments can be achieved. Generally the revised Protocol is very focused on the needs of children and young people and has a strong safeguarding thread running through it.

The Placement Alert Form

6.9 One of the key changes in the administration of the placements function in the light of the service reviews has been to improve the arrangements for Yots who are seeking placements. This has been facilitated through the completion of a Secure Facilities Placement Booking Form. This provided basic information about the young person, their home, ethnicity and offence circumstances and where their case had reached in the judicial process. The form also asked the Yot officer to indicate degrees of vulnerability and attach any supporting evidence.

6.10 This Booking Form has now been replaced with the **YJB Placement Alert Form**. This new form is issued to Yots and travels with very clear and informative guide-notes that set out procedures to be followed for the different categories of young person [court ordered secure remand, DTO or section 90/91 sentence]. The new form and guidance also recognizes that some young people may now, because their offence may have been of a violent or sexual nature, be subject to the Multi-Agency Public Protection Arrangements (MAPPA). There is also now added emphasis on the provision of quality information about the assessment of risk.

6.11 As a consequence of the Joseph Scholes review both the new form and guidance ask the Yot to specify their preferred sector for the young person's placement and provide information about placement policy in the three sectors (see paragraph 6.16). Overall this new application form is a marked improvement on the earlier format and should provide the Placements Team caseworker with better quality and fuller information about the young person and their placement needs.

Follow-up to Placement Decisions

6.12 The Placement Protocol now requires the Placements Team caseworker to review all placements where an alert has been sent within three working days. If sufficient concerns about suitability of placement are identified, prior to the next court appearance (if the young person is remanded) a move of placement would be considered. In all cases the Placement caseworker will continue to monitor all vulnerable placements made to YOIs. This may include attendance at a case review at the YOI in order to consider together with staff and the young person's Yot worker whether a move is appropriate.

The Assessment of Risk

6.13 The revised Placements Protocol now sets out in much greater detail the information about vulnerability that is required from Yots who have primary responsibility for making that assessment. Whilst the full completion of the ***Asset*** documentation remains at the heart of the assessment process, the Placements Team now require as much supporting evidence as possible. Armed with this it should be possible for members of the Placements Team to distinguish with greater confidence the varying levels of risk that children present.

6.14 In coming to these judgements the Placements Team members utilize an internal 'Key Indicators of Risk' framework. The information is assessed under the following three headings:

Risk of harm to self	Previous serious suicide attempt Previous self-harm attempt Potential self-harmer Expressing or displaying depression Bullying victim
Welfare Indicators	On Child Protection Register or previous Looked After child or on Care Order Mental health treatment or concerns Physical/emotional immaturity Learning Difficulties
Risk to Others	Previous conviction for violent crime Convicted sex offender Previous or current inappropriate sexual or aggressive behaviour

6.15 Both Mathew Dieppe and David Gilroy in their respective reviews consider that useful as the 'Indicators of Risk' instrument is for bringing together all the available information to inform the judgement, which is the instrument's stated purpose, more work is required to identify criteria for ranking vulnerability. They both suggest that there should be a further review of the choice of indicators, the process of assessment and final judgments and the development of appropriate skills and training.

6.16 Some movement in this direction may be achieved if the proposed four tiered categorization of risk factors articulated by **'Managing Risk in the Community'** [see paragraphs 5.22- 5.26] is incorporated into the placements application process. This will bring some congruence to the assessment and hopefully facilitate even-playing field discussions about prioritization between Yot Officers and the Placements Team case workers.

Priority Setting

6.17 The Placements Protocol provides important advice about the prioritisation of requests for placement in LASCHs and STCs. All 12 to 14 year old boys and 12 to 16 year old girls are given priority access to these facilities. The next priority group are 15 to 16 year old young men, whom the Yot must have assessed as vulnerable on the grounds that either there has been, or there is a serious risk of, an incident of self-harm or suicide. Or the Yot has assessed the young man as vulnerable because there are a high number of other risk factors present. The final priority is offered to 17 year old young women who have made, or are at risk of making, a serious attempt at self-harm or suicide.

6.18 As the case of Joseph Scholes indicated, it is the quality of information about the nature and seriousness of risk that best informs the decision making in these circumstances. It is important to note that it is Yots that retain overall case management responsibility for all young people, including those assessed as vulnerable and placed in a YOI. If a Yot has any concerns about a young person placed in a YOI the Placement Protocol advises them to discuss these directly with the YJB Placements Team. Given the limited availability of accommodation suitable for the most vulnerable there will always be situations where a preferred placement cannot be made for lack of available beds. However, lessons from the reviews of Joseph Scholes point to the possibility of Yots making it clear at the earliest possible stage that they will be seeking such a bed and preparing a case for transfer immediately post-sentence.

6.19 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.

6. 20 Perhaps 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 Placements Team. In the YJB Serious Incident Report into the death of Joseph Scholes some ideological tension was noted between those Yot officers who believe that placement in a YOI should be avoided at all costs and the reality of the situation and the limited availability of alternative accommodation. Fears were voiced in that report that there might be a danger of Yot 'over-egging' the vulnerability assessment to achieve such a place. This Operational Review has been assured that that is not the case, although there are concerns about regimes at some YOIs. Whilst some of this may be historic, it is important that Yot staff are provided with good quality and contemporary information about positive developments within the YOI estate.

Transfers

6.21 The investigations into the death of Joseph Scholes at Stoke Heath YOI concluded that the application to transfer Joseph out of the YOI and into a LASCH after his admission had not been handled satisfactorily and that the arrangements for making such requests needed to be clarified and relevant operational guidelines reviewed. This work has now been completed by the Placements Team and incorporated into the new Placement Protocol.

6.22 The Placement Protocol confirms that it is possible for young people to be transferred across the secure estate depending on their circumstances and in some instances the 'needs' of the estate. In all cases the Yot and the receiving establishment is consulted before a move is made. There are four different kinds of transfer

6.22.1. **Planned transfers**

These transfers can be for a number of reasons including:

- Increased or decreased vulnerability
- To improve closeness to home
- To meet special individual needs not available in existing placement
- To provide access to a particular course or programme
- Where the young person's behaviour or the behaviour of others towards the young person is giving serious cause for concern
- Change of legal status.

6.22.2. **Emergency transfers**

Emergency transfers may be made due to a sudden increase in vulnerability, placement breakdown or because of a serious one-off incident.

6.22.3. **Prison Overcrowding Drafts**

Prison overcrowding drafts may have to be made to free up beds in YOIs to make room for new admissions from court. A protocol for the selection of young people and procedures to be followed in such circumstances has been jointly agreed between the YJB and the Prison Service. The destabilising impact of Overcrowding Drafts on good practice at YOI was seriously criticized in the joint **Child Protection and Safeguards Review** conducted in 2003 **[Ref 9]**. The review teams were informed that commonly several young people of an unknown disposition would arrive together with little or no documentation so that the completion of safeguarding assessments for vulnerability by reception staff proved an impossible task. The Safeguards Review concluded that this was a practice that should warrant serious attention to ameliorate its impact on effectiveness.

6.22.4. **Transfers following placement review**

Transfers may be made following a review of the placement by the YJB Placements Team or through the review process required by the YJB National Standards. All 15 year olds and over placed in LASCHs or STCs are regularly reviewed to see if they still require the level of support and programmes provided by establishments in these two sectors.

Improvements in the Placement Function

6.23 The YJB Placements Team plays a vital part in ensuring that the juvenile justice system works to the best of its capacity when it becomes necessary to deal with a young person's offending by a period of care and training in security. The team is well placed to play that role and has been very responsive to the need to create a service environment that protects both the young people and the public interest. The Placements Team deals with a high volume of work on a daily basis in terms of the numbers of placements that need to be negotiated. But these also present qualitative challenges in terms of the complexity of judgements and the management of a constantly moving and changing balance between demand and supply.

6.24 As noted in the foregoing paragraphs the Placements Team has responded positively to the lessons from the Joseph Scholes reviews and the independent review. The Placements Team now awaits, together with other parts of the YJB organisation, the introduction of a secure email network. The introduction of this facility should considerably enhance the organisation's capacity to move vital information quickly and appropriately between these three systemic elements - the community based Yot, the Placements Team and the receiving sector providers within the secure estate.

CHAPTER 7

DEVELOPING A SAFEGUARDING POLICY FOR YOUNG PEOPLE IN YOI

Fundamental Concerns

7.1 In order to commence any critical examination of the safeguarding arrangements it is important to attempt to gain an understanding of the issues that confront young people during their experiences of custody and those aspects of that experience that make them feel unsafe or give rise to concern about their safety. To achieve that understanding this Operational Review has turned to two research based studies conducted around or shortly after the death of Joseph Scholes. The two studies are **1. 'Juveniles in Custody'**, a research study by HM Inspectorate of Prisons of 1222 young people in YOIs between September 2001 and March 2003 **[Ref. 10]** and **2. 'Perceptions of Safety'**, a study conducted by the Prison Service Safer Custody Group of the views of young people and staff living and working in the juvenile secure estate between March and May 2003. **[Ref.11]**

7.2 **'Juveniles in Custody'** presents a broad survey of the life of young people whilst in a YOI. The research survey was completed by 44% of the juvenile prison population, a total of 1089 young men and 133 young women then accommodated at 16 male YOIs and 5 YOIs and prisons for women. Of interest to this Operational Review is the information about personal safety. Overall, 36 % of the young men and the same proportion of the young women reported that at some time they had felt unsafe. There were variations between the responses from different YOIs, with in some cases nearly one half the respondents reporting that they felt unsafe. By contrast two YOIs reported that only one quarter felt unsafe.

7.3 The research describes the impact that a range of intimidating behaviours and environmental aspects can have on the young people. For the young men this included such behaviour as experiencing threatening shouting from the windows on their first arrival (49%), subjection to initiation tests (17%), and insulting remarks by both other young people (41%) and staff (22%). A smaller proportion of young people reported having been picked on (13%), with 9% feeling that this had been because of their race or ethnic background. Just under one quarter of the young people said that they had been hit, kicked or assaulted by other young people while in custody.

7.4 '**Perceptions of Safety'** surveyed a sample of 113 young people and 51 members of staff in 9 juvenile establishments including two special units for long-sentenced detainees, an STC and a Local Authority Secure Children's Home. The study reported that the majority of the young people (83%) said that they were never or hardly felt unsafe and that their feelings of safeness strengthened as they progressed longer into their sentence. This was emphasised in the specialised units and the non-YOI establishments. Again, a quarter of the young people said that they had been assaulted by another trainee in their current establishment.

7.5 A quarter of the young people reported a history of self-harm. The study concluded that there appeared to be an association between experiences of bullying and thinking about self-harm. All those young people who had thought about and had actually self-harmed said that they had been victims of negative behaviours from other young people. The majority of those who had self-harmed in their current establishment had used negative behaviours against other young people. The study also sought to understand the dynamic that lay behind this state of affairs where there appeared to be some sense of overlap between the victim and victimised roles.

7.6 The study emphasised the key role that staff could play in this area, although it highlighted what more could be achieved. With their personal problems young people were more likely to go to staff than any other source, including their peers or their own family. However, with some exceptions, it generally appeared that young people did not, or were reluctant to, go to seek staff support for issues like bullying or self-harm. The study concluded that there were significant implications for support and training for existing staff and for recruitment policies. Where staff were motivated to engage with the issues, this played an important part in reducing risk for vulnerable young people.

Prison Service Order PSO 4950 (Regimes for under 18 year olds), July 1999

7.7 The legal, policy and practical arrangements for care and detention of young people by the Prison Service are set out in **Prison Service Order 4950**. **[Ref 12A]** This was originally issued in July 1999 and encapsulated a new approach to the custody and care of under 18 year olds and formed the Prison Service's contribution to the reform of the youth justice system instigated by the Crime and Disorder Act 1998 and was also a response to HM Chief Inspector of Prisons' "Thematic Review of Young Prisoners"`. The PSO 4950 sets out in great detail the principles that underwrite the development of YOI regimes and the good practice that should be achieved at establishment level.

7.8 PSO 4950 enshrines a general approach to safeguarding a young person's welfare that is broader and more encompassing than any consideration of child protection in its more narrow sense as defined by the Children Act 1989 and subsequent guidance. The approach is built on the following elements:

- A Reception and Induction process that provides the young person with the opportunity and be informed about measures to safeguard and protect, and encourages feelings of safety
- Personal Officer and individual casework arrangements that foster a culture of care and that assist young people to discuss their concerns and difficulties
- Anti-bullying strategies which tackle bullying as an issue and pre-empt the development of aggressive behaviours as well as protecting victims
- Pastoral care arrangements and other advice services

- A requests and complaints procedure that is accessible to all young people and especially responsive in cases where harm is present or likely
- A rigorous Investigation procedure with an independent element
- Monitoring arrangements by Boards of Visitors (now the Independent Monitoring Board) who have a duty to satisfy themselves as to the treatment of individual young people.

7.9 Following the publication of inter-governmental child protection guidance 'Working Together to Safeguard Children' in 1999, advice about collaboration with other agencies was included in the PSO and this signalled the need to work more closely in order to achieve better safeguarding. This was strengthened by the addition, in October 2001, of a Child Protection Protocol as an annex to the Order. The Child Protection Protocol built on existing arrangements, but these were strengthened by the establishment of a Child Protection Committee at each YOI, the nomination of a Child Protection Coordinator and deputy Coordinator, the customisation of Child Protection procedures at YOI level by the use of a policy/practice template and the encouragement of appropriate working arrangements with the local Area Child Protection Committee (ACPC).

7.10 The Child Protection Policy template introduced into Prison Service culture and practice the concept of 'significant harm' and an awareness of the procedural framework promoted by 'Working Together to Safeguard Children' to investigate, register and work with children and families where child abuse is an issue.

Joint Chief Inspectors' Safeguarding Report, 2002

7.11 In October 2002 the eight Chief Inspectors for services concerned with the delivery of child protection and other safeguarding services published a joint report **[Ref.13]**. In Chapter 8 of that joint report, major concerns were raised about the arrangements for safeguarding young people in YOIs. Earlier, in his Annual Report for 1999/2000, HM Inspector of Prisons had reported concerns about unacceptable levels of bullying and advised that steps should be taken to address this. The Joint Inspectorate Report cast their examination of safeguarding more broadly and confirmed that there was a need to strengthen procedures and the arrangements for investigations of assault and abuse by young people. It was felt that complaints systems and similar protective protocols needed to be endowed with increased credibility.

7.12 The Joint Inspectorate Report concluded that young people in YOIs still faced grave risks to their welfare, particularly in respect to harm from bullying, intimidation and self-harming behaviour. They also concluded that ACPCs needed to make a major commitment to the welfare of young offenders, both those receiving services from Yots and those in YOIs. The Joint Report recommended that the Home Office and the YJB issue revised guidance to the Prison Service and the ACPC member organisations on the requirements and arrangements to safeguard children in YOIs.

The Children Act 1989 Judgement, November 2002

7.13 An important turning point in the development of a robust safeguarding policy for YOIs was provided on 29 November 2002 by the Administrative Court ruling of Mr Justice Munby in testing by judicial review the assertion by the Howard League for Penal Reform that the Children Act 1989 applied to children in Young Offender Institutions **[Ref.14]**. Mr Justice Munby decided that although the Children Act 1989 did not confer or impose any functions, powers, duties, responsibilities or obligations on the Prison Service or the Home Secretary, duties that a Local Authority would otherwise owe to a child under Section 17 or Section 47 of the Act do not cease to be owed merely because a child is currently detained in a YOI. In that sense the Children Act 1989 did apply, but he allowed that these duties took effect and operated subject to the necessary requirements of imprisonment.

7.14 The judgement also confirmed that the Prison Service had a legal obligation to safeguard the well-being of children in its care by virtue of section 6(1) of the Human Rights Act 1998 and Article 8 of the European Convention on Human Rights.

7.15 Mr Justice Munby considered that the Prison Service's policy for this sector as set out in Prison Service Order PSO 4950 was essentially sound and addressed obligations set out under Human Rights law. He was concerned, however, about the quality and pace of implementation of these policies. In consideration of the possible ramifications of his judgement, Mr Justice Munby also raised some key questions about the future shape of policy. These questions were:

- Should the Children Act be amended to make it apply to YOIs or impose an express duty on the Prison Service to promote the welfare of children in YOIs?
- Should the standards required in LASCHs also be required in YOIs?
- Should child protection work in YOIs be led by local authorities and other child protection agencies?
- Should the Prison Service be fully integrated into the child protection system and local authorities allocate more time and resources to children in YOIs?

Child Protection and Safeguards Review 2003

7.16 Following the Joint Chief Inspectors' Report and the judgement of Mr Justice Munby, the Prison Service in partnership with the YJB undertook a thorough Review of the juvenile estate's current arrangements for protecting and safeguarding the welfare of children in its care. The Review **[Ref. 9]** took place between May and November 2003 and was undertaken by a multi-disciplinary team drawn from the Prison and Probation Services, Local Authority Social Services and the Social Services Inspectorate (SSI). The review team was supported by a steering group representative of all relevant stakeholders.

7.17 The aim and purpose was to undertake a full review of child care and safeguarding arrangements and in doing so to compare and contrast different establishments' approaches with a view to highlighting and sharing good practice. The review was also concerned to assess to what extent effective inter-agency partnerships were present or being developed. The Review closely examined nine key areas of practice:

- Measures in relation to the prevention of suicide and self-harm
- Measures in preventing harm from other young people
- Measures in relation to preventing harm from staff and other adults
- Impact of cell and building design in relation to safeguarding children
- Measures in place to address the consequences of historic abuse
- Arrangements for the monitoring of serious safeguarding incidents
- Arrangements in place with the local ACPC and other agencies to keep children safe and protect them
- Managerial arrangements for driving forward the safeguarding agenda
- Training arrangements for safe custody and child protection.

7.18 The review concluded there was a growing awareness and understanding on the part of those agencies with a statutory safeguarding function that they have responsibilities towards children in Prison Service custody. The difficulty in making progress appeared to be the lack of a clearly defined framework in which to operate. Within Prison Service establishments safeguarding policies were generally clear and comprehensive but were not juvenile specific, particularly on split sites. The review found that there was better continuity and consistency of care, and understanding of juvenile issues, where there was a dedicated staff group or cross-deployment on split sites.

7.19 The review concluded with a set of key recommendations for improvement and development. These are outlined as follows:

- The Prison Service and the YJB should develop a central *Child Protection and Safeguards Policy* exclusively for use in establishments that hold children;

- The Prison Service should undertake a comprehensive training needs analysis for staff specifically working with juveniles, which should include all aspects of safeguarding;

- The Prison Service together with the YJB should develop a comprehensive and modular *Child Protection and Safeguards Training Package* for staff training;

- The YJB should seek to reconfigure the Juvenile Estate where possible in order to commission places in children only sites;

- In the meantime, in order to safeguard children on split sites where services and facilities are shared with young adult prisoners, the YJB

and the Prison Service should work closely together to achieve maximum separation of children from adults and no cross-deployment of staff;

- Local authorities with Social Services responsibilities that have YOIs in their areas should devote permanent and significant dedicated staffing resources to provide safeguarding services for children held in YOIs;

- The DfES with assistance of the Prison Service, the Home Office and the YJB should issue national guidance to local authorities and YOIs setting a detailed and comprehensive framework for their relationship. This would include advice to ACPCs with YOIs in their area, setting out how their responsibilities in relation to safeguarding children in YOIs should be undertaken;

- Children looked after by the Prison Service should be accorded the same status and rights in law, as children looked after by local authorities. This would include entitlement to Leaving Care Services under the Leaving Care Act 2000;

- Integrated, coordinated safeguarding arrangement should be put in place within each YOI;

- The Prison Service and the YJB should establish a task force to cost and implement the recommendations of the review.

7.20 The **Child Protection and Safeguarding Review, 2003** provides a broad agenda of action that needs to be continually addressed and progressively developed and monitored over future years. The review made a wide range of recommendations for improved services and practice, and these have now been considered by the Minister of Correctional Services who has indicated his support for their implementation, subject to affordability and the future availability of funding. The assessment of the quality of policy and practice and the identification of any existing shortcomings provide a well-informed starting point for the examination of many of the matters that will be considered in later sections of this Operational Review [see paragraph 9.19 et seq.]

Local Authority Circular LAC (2004) 26, July 2004

7.21 These initiatives and developments have now been coordinated across local authorities and service providing agencies by the issuing of **'Safeguarding and Promoting the welfare of children and young people in custody' LAC (2004) 26** by the Children's Safeguards Unit at the Department for Education and Skills in September 2004. The circular, issued under section 7 of the Local Authority Social Services Act 1970, sets out a range of actions that relevant parties need to address. These actions will be secured by YJB funded arrangements to enable service level agreements to be agreed between local authorities, the Juvenile Group at the Prison Service, custodial establishments and the YJB.

7.22 The full text of LAC (2004) 26 can be found at Annex 4. The circular sets out two sets of requirements. For those local authorities of areas where there is a YOI, prison or STC, the following action is required:

- Ensure that they have agreed local protocols with custodial establishments in their area for referral, assessment and the provision of services to children in custody in line with legislation, guidance and local procedures, including the local Area Child Protection Committee (ACPC) child protection procedures. This must include procedures for addressing third party abuse (i.e. where a child discloses information about the abuse of another child);

- Ensure that the governor of the custodial establishment is invited to be a member of the ACPC;

- Ensure that the ACPC considers what arrangements they need to put in place in order to ensure that the welfare of children in custody is safeguarded. This might include, for example, agreeing local child protection procedures with the local custodial establishments, liaison arrangements for undertaking section 47 inquiries under the Children Act 1989 where there is reasonable cause to suspect that a child is suffering significant harm, and holding strategy and other meetings;

- There should be agreed arrangements for representation on the YOI's safeguarding committee. Further it should be agreed that ACPC child protection procedures including those relating to serious case reviews, cover the involvement of custodial establishments, where appropriate;

- Ensure that local protocols are in place in the event of the death of a child in custody, taking into account any national guidelines from the Youth Justice Board, DfES and Prisons and Probation Ombudsman.

7.23 All other local authorities with social services responsibilities are asked to take the following action:

- Ensure that they fulfil their statutory responsibilities for contact with any children for whom they have parental responsibility who are placed in custody;

- Where they were previously responsible for accommodating a child who is now in custody, or where a child who is now in custody, who was previously looked after by another local authority under section 20, plans to live in their area on release, establish arrangements to promote and safeguard his or her welfare on release;

- Where their area contains a prison with a Mother and Baby Unit, agree with the establishment, local child protection procedures for safeguarding children living in the Unit, which are consistent with the ACPC's procedures, to ensure that there are mutual arrangements in place for responding to all concerns raised about a child in such a Unit;

- Where their area contains a prison, ensure that mutually agreed arrangements are in place for safeguarding children visiting the prison.

Prison Service Order PSO 4950 (Regimes for Juveniles), September 2004

7.24 In September 2004 the Prison Service published a revised version of PSO 4950 **[Ref.12B]**. The purpose was to capture all the main changes in policy and practice that had occurred since the PSO was originally published in 1999. The revised PSO 4950 has now a much stronger emphasis on safeguarding and child protection, and on developments in the area of learning and skills for young people. A detailed discussion of key aspects of PSO 4950 as it relates to general matters of care and safeguarding follows in Chapters 8 to 11 of this Operational Review.

CHAPTER 8

RECEPTION OF YOUNG PEOPLE INTO YOI

Standards set by PSO 4950, July 1999

8.1 At the time that Joseph Scholes was admitted to Stoke Heath in March 2002 the 1999 version of PSO 4950 was in force. The Order set YOI Governors the objective a making arrangements that would ensure that each young person who is received into custody is treated humanely so that their safety and dignity are safeguarded during the first 48 hours after their arrival. In brief, the PSO set out the following mandatory requirements:

- Ensure that every young person is lawfully detained and held in lawfully certified accommodation
- Ensure arrangements to obtain information critical to the identification of each young person's immediate needs
- Screen every young person on day of arrival for all immediate physical and mental health needs, including likelihood of self–harm or suicide, and substance misuse
- Make arrangements for every young person to be interviewed within two hours of arrival, provide information to reduce anxiety, tension and uncertainty during their first night
- Offer the young person the opportunity to telephone someone concerned with their well being within two hours if such an opportunity has not been available earlier in the day
- Inform night duty staff if there are concerns about the young person, particularly where there are concerns about possible self-harming
- Provide next of kin with information about visiting and matters associated with the young person's training plan within 48 hours
- Calculate key sentence and release dates for the young person and present them in writing with an oral explanation within 48 hours
- In the 24 hours following reception prepare an in-depth assessment of the young person's physical and/or mental health needs to inform further assessment, treatment or management as appropriate
- Maintain accommodation in reception areas to a high standard of decoration and repair.

8.2 These requirements were supported by careful advice that sought to emphasise the need to be sensitive to the young person's situation as they prepared to spend their first night at the YOI after what was often a long and stressful day in court, followed, not infrequently, by a long escorted journey. The guidance stressed the importance of treating the young person in such a manner that they do not feel subsumed by the procedural processes for reception into custody, but should be able to feel safe. The guidance advised that this was as likely to be as true for those experienced in custody or who presented as arrogant, aggressive or careless as it was for the frightened, ill or socially ill-adept young person.

Standards set by revised PSO 4950, September 2004

8.3 As a result of the developmental work that has taken place within the YJB and Prison Service over the past two years, a revised **PSO 4950** was issued in September 2004. At **Chapter 5: Enabling personal development** the revised PSO seeks to address improved practices and procedures in the field of Reception into Custody and initial Assessment. The obligations remain on Governors to ensure that the young people are lawfully detained in certified accommodation and that reception areas are maintained to a high standard. The PSO also advises that best practice suggests there should be separate reception facilities for juveniles on split sites which also deal with young adult prisoners. The PSO then provides revised guidance on some key areas of reception and assessment practice. This Chapter of the Operational Review will examine and offer comment on those areas and associated matters.

Management of Information

8.4 PSO 4950 now requires Governors to ensure that they have a system in place for recording the receipt of key documents related to the reception of the young person. Key documents are listed as:

- ***Asset*** Documentation
- Pre-sentence Report
- Post Court Report
- YJB Risk Alert
- Suicide/self-harm warning form

The YOI should have arrangements for informing the YJB of any missing documentation and for ensuring that this is received as soon as possible. The YJB/Prison Service SLA sets a one-hour time limit (or 9.a.m. next working day if out of hours) for alerting the local Yot to missing ***Asset*** or Pre-Sentence reports. If these reports have not been received within 24 hours then the YJB is to be informed. The YJB have selected performance in this area as one of the 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.

8.5 For those young people whose documentation is missing or is so incomplete that it gives rise to well-placed uncertainty about the vulnerability of a young person, then PSO 4950 requires that the young person be managed as ‘vulnerable’. Decisions about the most appropriate first night placement of young people in this situation are based on what little information there might be, a health care screening, the completion of form **T1:V, Initial Custodial Reception Assessment** and the cell sharing risk assessment. The notes also advise, wisely, that all staff should be made aware of this status and be asked to give increased supervision and support to the young person, particularly in the first few days.

8.6 At Stoke Heath YOI reception unit staff are required, in the circumstances where documentation is missing, to complete a local form **F2053V, Juvenile Vulnerability Alert Document**. The guide-notes to this form advise staff that trainees are to be treated as vulnerable and assessed as 'High Risk' until further information in the shape of the ***Asset***, PSR or PCR become available so that a better informed assessment can be made. F2053V also reminds reception unit staff of the 'chasing –up timescales. The form is careful to remind staff that giving young people vulnerability status in this format does not replace the **F 2052SH Self-harm At Risk Form** or process.

8.7 The findings of the Joseph Scholes' investigations suggest that there are variations in the quality and extent of information and that it is important to obtain as full a picture as possible at the earliest possible point. If the proposal to require Yots to support their completion of the ***Asset*** assessment with contributing evidence is followed then this material should also travel with the young person. In general it would appear that the 'fail-safe' arrangements work in a satisfactory way and information is being received. [*source: testimony of the two YOI reception units visited*].

8.8 The introduction of secure email for the transfer of information should ensure that relevant information, if available, is accessible. Suitable flagging arrangements might be included in the system that could quickly signal non-receipt. However, there will still remain quality and interpretation issues and these will only be addressed through improved skills and awareness on the part of Yot staff.

Screening for Risk

8.9 PSO 4950 requires that every young person is screened on the day of arrival to ensure their safety and identify any immediate health needs. The framework for this screening is set out in the YJB's Key Elements of Effective Practice (KEEP) guidance manual **'Assessment, Planning Interventions and Supervision'**. This screening must include an assessment by a member of the YOI health care team of the likelihood that the young person would harm themselves and a further in-depth assessment of the young person's physical, mental health and substance misuse history. For young women the screening should include consideration of any sanitary, child care or pregnancy issues.

8.10 All young people must be interviewed by reception unit staff within one hour of their arrival (two hours in exceptional circumstances) to start the assessment of needs process and adjudge level of vulnerability. At this point reception unit staff complete the T1:V form. Reception and Induction staff are advised that they should remain aware of any apprehension and anxiety on the part of the young person and take this into account when interviewing and completing the forms.

8.11 Form T1:V is a valuable assessment instrument. Although in some circumstances where information is missing the judgements made may need to err on the side of caution, the format asks the right type of question with

respect to vulnerability and potential victimisation or risk to others. The **Review of Child Protection and Safeguarding, 2003** recommended [Practice Area 1. Rec. 3] that staff receive specific training in the completion of T1;Vs, as well as in broader techniques of assessment. This Operational Review would strongly support that proposal.

8.12 Where a risk of self-harm is identified then appropriate action has to be taken in accordance with **PSO 2700, Suicide and Self-harm Prevention**, to minimise that risk. Reception unit staff are then required to open a form **F2052SH** on the young person and should be trained and competent to do this in discussion with health care staff. As a consequence of the completion of a F2052Sh form a decision is made as to whether the young person should be located for their first night in the YOI Health Care Centre if this provides an inpatient facility or on a normal residential unit. This is clearly a matter of professional judgement, but in some circumstances this judgement may be conditioned by the availability of vacant beds in the Health Care Centre.

[For a fuller discussion of the F2052SH process see Chapter 9].

First Night Arrangements

8.13 The YJB has recognised that the initial experience, and particularly the first night, of a young person's time in custody, is critical to gaining some sense of safety and have taken steps to alleviate as much as possible any feelings of anxiety and uncertainty. As well as preparing and training YOI reception unit staff to be alert and sensitive to these concerns, the YJB has introduced 'first night' packs for all new admissions. These packs include phone cards, toiletries, reading material, pen and paper, sweets and a drink. This is a very sensible and supportive innovation. The revised PSO 4950 reinforces the advice that night duty staff need to be clearly informed about new young people where there are concerns about vulnerability or the possibility of self-harm.

Role of YJB Performance Monitor

8.14 Whilst YOI Governors retain responsibility for ensuring that the YOI has appropriate systems and procedures in place to ensure the safety and welfare of the young people as they are admitted, YJB Performance Monitors, allocated according to Prison Service Areas, play a key role in monitoring practice. The YJB Performance Monitor utilizes the Effective Regimes Monitoring Framework as a tool to measure effectiveness of systems and raises any concerns with the management of the establishment. The Monitor automatically receives a copy of either the 'Risk Alert' or 'First Night Alert' and may be called upon by the Placements Team caseworker to review the action taken by the YOI to secure the young persons safety. This is particularly important where concerns are raised on admission of the young person about aspects of their care. The YJB Performance Monitor can also be asked to sample and advise upon specific cases. Where situations are adjudged to be particularly serious, the YJB Performance Monitor can report direct to YJB senior management.

Provision of Information and Assistance

8.15 The revised PSO 4950 provides fuller advice about the approach that needs to be adopted when meeting the mandatory requirements to provide telephone contact, to help young people resolve any immediate problems and to put in place arrangements to make contact with next of kin in respect to visiting and other matters. The advice as drafted is supportive and respects situations where the young people may be in some distress, particularly in relation to their families, including the possibility of concern as young parents about their own children. Reception staff are encouraged by advice in the PSO to make the process of admission an interactive one for the young person and be ready to answer questions as well as giving or soliciting information.

8.16 As part of their first night pack, young people are provided with information at this stage and this is provided in the form of an information pack, booklet or leaflets. These provide basic information about the rules, facilities and timetables of the regime. The exact details of sentence and release dates are made available. Young people also receive information about complaints, the role of the Independent Monitoring Board (IMB), advocacy services and the Prisons and Probation Service Ombudsman. Young women also have access to information about mother and baby units. Governors are strongly advised to make available, wherever possible, translations in languages other than English of relevant information or provide interpretation.

Initial Health Assessments

8.17 PSO 4950 requires the provision of 24 hour health care facilities at all YOIs that receive young people directly from court (unless exempted by agreement between the YJB and the Prison Service). All young people must be medically examined and assessed by a qualified nurse or doctor within 24 hours of their reception and this assessment must include an assessment of levels of risk of self-harm or suicide and substance misuse. National Standards require that these assessments commence within one hour of arrival at the YOI. The assessment for substance misuse should be conducted by a clinician in accordance with the National Specification for Substance Misuse. The assessment for vulnerability is achieved by the completion of the T1V form.

8.18 Following this assessment a Health Care Plan for each young person must be prepared and arrangements made to provide appropriate treatment and medical services. This as an important part of the young person's overall sentence plan.

8.19 The YJB is strongly committed to the provision of this service and has selected this as another of the eight Secure Estate Performance Targets in

2004/5. At May 2005, provisional Prison Service performance figures for 2004/5 appear to show that almost all (99.5%) young people admitted to YOIs were assessed as required.

Maintaining Security – Body searches

8.20 The revised PSO 4950 provides important advice to reception unit staff that seeks to ensure that a young person's welfare is respected during this experience. The PSO stresses that a full body search remains an essential and important part of the reception procedure, but it must be conducted with consideration and courtesy, and should not be experienced by the young person as undignified or stressful. The advice reinforces this approach by reference to the significance of the age and level of risk of the young people and the likelihood of them having experienced physical or sexual abuse earlier in their lives.

8.21 If this advice is followed and such full searching is conducted with due sensitivity then young people should not experience the practice as abusive or invasive. It has to be recognised that there are genuine security issues to deal with here, including the illicit concealment of drugs or potential weapons, all informed by wider issues of trainee safety and security.

Achieving best practice

8.22 The procedural framework and best practice guidance examined in the course of this Operational Review in respect to the provision of safe and responsive reception arrangements would appear generally satisfactory and appropriate to the task. The YJB and the Prison Service have clearly recognised that the experience of admission is a crucial one for young people and that all should be done to make that a safe and supportive experience. However, as with many of these issues of best practice, the success of the arrangements is determined by the manner in which they are delivered at grass roots level and by the quality of resources made available to achieve desired outcomes. In respect to reception arrangements there are still a number of systemic factors in the current delivery of services that will continue to inhibit best practice until actively addressed.

8.22.1 **Combined Reception Units:** some YOIs still deal with both juvenile and adult admissions to YOI in the same reception suites. This makes for difficulties in management and inhibits the fullest achievement of the objective of a reception regime dedicated to the needs and interests of juveniles. The YJB should continue with the drive to provide such dedicated facilities.

8.22.2 **Late Arrivals:** it is reported that there are circumstances where young people will arrive late at reception having experienced a long day in court followed by a long journey, both in time and distance, under escort to an unfamiliar destination and YOI. Although this was not an aggravating feature in the case of Joseph Scholes, the additional stress for the young person induced by this situation is not difficult to appreciate and requires great sensitivity on the part of reception unit staff if a satisfactory reception process

is to be experienced. The **Child Protection and Safeguards Review 2003** reported that staff had complained of young people arriving tired and hungry, totally disoriented and having no idea where they were in the country. Some reported that it was not possible to complete any meaningful assessment of vulnerability and staff had to work hard to reassure them about their safety.

8.22.3 Some of this derives from the difficulty in achieving placement of the young person within the 50 miles from home target. Some of it derives from the transport arrangements. Both negative factors will continue to operate whilst the secure estate is under conditions of heavy demand for both remand and DTO places. 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.

8.22.4 **Numbers of young people admitted:** as noted above, the reception processes are not simple and, if carried out comprehensively, require time and sensitivity on the part of the reception unit officers. The reception of batches of young people at any one time clearly makes that objective more difficult to achieve and this might also be compounded by having a mix of juvenile and adult trainees to process. This situation can only be managed by the availability of adequate staffing and clear organisational arrangements`.

8.22.5 **Quality of Accommodation:** reception suites at YOIs experience heavy usage and by young people who are, on occasion, under some considerable stress. It is therefore important that attention is paid to environmental aspects, including the condition of secure rooms and holding cells, and the ambience of the unit. To allow deterioration in the state of this accommodation can give out a message that this is an unsafe place for young people and bodes poorly for their capacity to settle constructively to their period of training.

8.23. 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. As noted, two of the eight Secure Estate Performance Indicators for 2004/5 are targeted on the point of admission. There are also other aspects of the reception arrangements that can be subject to regular monitoring and review, and which might complement the monitoring remit of the regional YJB Performance Monitor.

CHAPTER 9

SAFER REGIMES IN YOIs

YOI regimes for Adolescents

9.1 In the introduction to the revised PSO 4950 the Prison Service presents its commitment to the importance of regimes for young people being different from those for adults. The statement lays emphasis on the status of the detained trainee as an adolescent child and argues that every care should be taken to ensure that conditions of custody and regimes are designed to promote their well-being and healthy growth. YOI staff are enjoined to take into account the developmental and behavioural characteristics of adolescents. This approach is sustained by a belief that YOI regimes that can move beyond mere containment can wield a positive influence on the young people who, as adolescents, do have the capacity to change.

9.2 It is also important to note that the adolescent population in YOIs has some characteristics that make it a very vulnerable and disadvantaged group of young people. In November 2003, a joint YJB/Prison Service statement reported the following profile of the current juvenile population of 2,500 young men and 100 young women:

- 40-49% of the young people had a history of local authority care. (In **Safeguarding Children, 2002 [Ref 13]** the Chief Inspector of Prisons had reported that although 50% of children had been, or were still in care, many had lost contact with their Social Services Department.)
- 40% of young women and 25% of young men had suffered violence at home
- 33% of girls and 5 % of boys reported sexual abuse
- 50% of girls and 66% young men reported hazardous drinking
- 85% of the young people showed signs of a personality disorder
- 66% of young women and 40% of young men reported anxiety or depression
- 12% of young women under 18 years old were pregnant and 3 girls had babies in adult mother and baby units.

9.3 **Perceptions of Safety, 2003 [Ref.11]** also demonstrated that the vulnerability of many young people in custody was related to a history of care and self-harm, coupled with difficult and disrupted childhood experiences. Young people had been exposed to parental violence, relationship break ups, and involvement in offending and drug-use, often beginning at a young age and usually associated with exclusion from education. A significant number of young people said that they had learning and concentration difficulties, including some children diagnosed with ADHD. Some young people had experienced multiple placements with family members, foster carers, residential units, and failed plans for adoption before coming into custody. These experiences were associated with the young people having problems in managing feelings, particularly around trust and anger, and they found managing relationships difficult, both with their peers, and with adults.

9.4 This is therefore a unique population of young people whose need for safeguarding is substantial and critical. This chapter of the Operational Review examines some key aspects of the safeguarding framework as it impacts on the general regime for all trainees, but it is important to repeat that PSO 4950 sees safeguarding as an essential theme that runs through and underpins all activities at YOIs. This chapter examines,

- Induction and Sentence/Care Planning
- Roles and responsibilities of Personal Officers
- Anti- bullying strategies
- Child Protection and liaison with ACPCs.

Induction

9.5 PSO 4950 requires Governors to make arrangements for every young person to be introduced to the culture, rule, opportunities, and standards of behaviour expected. This should be provided within a structured Induction period of at least one week's duration. An essential aspect of the Induction arrangements is the provision of information. Much of this information is quite difficult to digest, especially for a young person who may be very unfamiliar with the YOI context, yet it is important that the young person quickly understands the regime and the requirements, rights and obligations that detention brings.

9.6 Good quality Induction is achieved by bringing together the necessary information and presenting it to the young person in a form that can be clearly and easily be understood, and the early identification of an adult who will guide the young person through the Induction process and beyond. This role falls to the Personal Officer. The Induction is conducted through a week long programme, with Education and Gymnasium Induction programmes running alongside. This programme approach means that the information can be carefully explained and digested.

9.7 The provision of information in a form accessible to the young people is key to satisfactory induction. An Induction booklet prepared for A Wing Inductees at Stoke Heath YOI offers a model of good practice in this area. The booklet is well laid out, has a clear text and is excellently illustrated. The booklet provides a wealth of information both about the YOI, the staff and the regime, but also about Requests and Complaints, health care and sexual health care, bullying, race awareness and anti-racism, substance misuse and self-harming.

Assessment and Sentence Planning

9.8 One of the key issues identified by the various investigations into the death of Joseph Scholes at Stoke Heath YOI related to the arrangements to plan for his stay at the YOI. There were issues about the organisational arrangements for the planning meeting and its optimum timeliness. Some of

the investigations recommended that a much shorter time than the YJB National Standard [NSF 10.10] of within 10 working days of admission should now be adopted.

9.9 The revised PSO 4950 reinforces the requirements set out in the earlier 1999 version and places a responsibility on Governors and Yot managers to ensure that each young person's sentence plan, including an Individual Learning Plan, is drawn up within the 10 working days following reception. Plans should set specific, measurable, achievable, realistic and time-bounded objectives for each young person and these should inform their daily programme of activity at the YOI. The plan should also look ahead to the young person's resettlement in the community.

9.10 The PSO also sets out a framework for good practice in care and sentence planning. This advises that:

- Young people should be encouraged to take an active role in the planning process, including the signing-off of the sentence plan
- All relevant staff, families and outside agencies should have the opportunity to contribute to the plan
- Permanent, private and secure records must be maintained
- Progress through the sentence should be constantly monitored and regularly reviewed within timescales set out in the PSO
- Individual sentence plans should be open to development as the result of a review
- Vulnerable young people, those experiencing great difficulty in achieving their objectives or adjusting to life in detention, can be subject to a special review
- Consideration may be given to the benefits of location and possible relocation.

9.11 This would appear to provide a very reasonable framework for sentence planning and review. Again, quality issues in respect to the availability of information and assessments about the young person, the quality of recording, and the commitment and presence of relevant people in the process, including the young person and possibly their family, all impact on the effectiveness of the plan. The investigations into the death of Joseph Scholes were concerned about the working of this planning framework in respect to responding to the needs of a very vulnerable young man. There were recommendations about the timing of the planning meeting, the quality of recording, and issues about multiple storage locations and differential access to records, particularly medical records.

9.12 All of the Investigations recommend that care planning for young people deemed to be at greatest risk should be well within the 10 day maximum limit set by the YJB National Standard. Although the National Standard does not preclude a planning meeting taking place within a shorter period if a high level of risk is presented, there is case for proposing that it is made mandatory for a shorter, say 3-5 day, timescale to be applied to those young people who are adjudged as seriously at risk on admission (defined as being subject to F

2052SH status). This should not preclude the proposal that a full initial assessment that focuses on issues of vulnerability takes place within 24 hours as suggested by both the Prison Service Investigation and the YJB Serious Incident Report. This Operational Review would support and recommend such an amendment.

9.13 The development of an efficient record storage, access and retrieval system across the secure juvenile estate is an important matter that needs to be addressed by the YJB and the Prison Service on an ongoing basis. It was considered outside the scope of this Operational Review, and the time available, to thoroughly scrutinise those administrative arrangements. Issues related to access to personal records between professional disciplines should be satisfactorily addressed by reference to best practice and the recognition that the young person's needs are paramount, especially with the more serious at-risk cases.

9.14 Most reviews and enquiries into the quality of public services have identified deficiencies in case recording and disciplined record keeping as an aspect of practice that inevitably contributes to less than satisfactory outcomes for service users. The Investigations into the death of Joseph Scholes add yet more evidence of the impact of that understanding. This need to bring improvement to the quality of recording is a matter that is recognised by the YJB and Prison Service and calls for management to make arrangements for the provision of suitable ongoing staff training and development programmes.

Personal Officers

9.15 PSO 4950 requires Governors to establish and develop a personal officer or caseworker system that provides every young person with an advisor with whom they have frequent, purposeful contact that could provide the opportunity to establish good personal and supportive relationships. This personal officer should be assigned during the Induction programme. Once assigned, the personal officer has the responsibility of keeping in contact with the Yot supervising officer, the young person's family and relevant outside agencies.

9.16 The PSO advises that the personal officer should be seen to act as a 'significant adult' and role model to the young person. Chapter 4 of PSO 4950 spells out in some detail expectations of staff and how they are to perform their duties so as to set an example to the young people and in so doing influence their behaviour and attitudes. Personal officer status carries important responsibilities and arrangements have to be made to ensure that these are achieved. The responsibilities are to ensure that:

- each young person understands to whom they can turn to discuss all issues of concern, including settlement
- each young person's sentence plan is formally reviewed and, where necessary, amended

- the personal officer attends each sentence plan review meeting and, where possible, the first review following transfer back to the community
- there is appropriate contact with, and involvement of, each young person's family and Yot supervising officer.

9.17 The personal officer system can be seen to provide a cornerstone to the safeguarding arrangements and the development of the role is vital if more effective and safer regimes are to be delivered. In practical terms there is some tension in this that may still need to be resolved. Experience of key worker systems elsewhere suggests that there is always merit in one person being given prime responsibility for this role. However, complementing arrangements, including arrangements for working conditioned hours, shift working and holiday absence cover, militate against this in all types of residential provision offering care or custody. The 1999 version of PSO 4950, in force at the time of Joseph Scholes's death, considered that arrangements that depended on a single personal officer were likely to be unsatisfactory, and promoted a team approach whereby a team of officers were jointly responsible for the through care and resettlement work of a group of young people.

9.18 This approach was criticised in the Trafford ACPC Case Review on the grounds that it did not lead to a fully integrated view of Joseph, his situation and his needs. There is strength in this argument and given the pivotal role of the personal officer in the sentence plan, it should be managerially possible to resolve these matters through forward timetabling and some arrangements for deputisation or pairing where one partner has the lead and the other provides support and cover. This would seem to offer a pragmatic solution to the very real practical problems associated with the one-on-one option.

Anti-Bullying Strategy

9.19 The investigations into the death of Joseph Scholes all agreed that one aspect of YOI life that he feared or that fed his apprehension about his sentence was the threat or belief that he would be subject to bullying should he move from the Health Care Centre to a residential unit. Although Joseph was a very vulnerable and depressed young man, it has to be acknowledged that his misgivings were not without foundation. **Perceptions of Safety, 2003** reported that bullying featured as an ever present and significant issue during their study. It was present in varying degrees and took various forms, but there was always some concern and fear about bullying and its impact. The study concluded that some strategies for managing bullying had too high thresholds and that most young people were either afraid that something would happen to them before support became available or they did not have confidence in the system to protect them.

9.20 **Perceptions of Safety** also examined the place that violent behaviour played in the every day lives of the children and young people. A number of the young people in the study viewed use of violence as a legitimate form of conflict resolution, retaliation or mechanism to gain influence, in some

circumstances using violence in a premeditated way. Again many of the young people had been or expected to be victims of violence at some point. This unattractive view of the world from a young person's perspective is concerning and has to be forcefully addressed through effective anti-aggression and anti-bullying strategies and practice. Revised PSO 4950 requires at Chapter 2.7 that Governors operate an anti-bullying policy approved by the Prison Service Area Manager. The appointment of an Anti-Bullying Coordinator at senior level is also required.

9.21 Anti-Bullying arrangements were an important area of practice examined by the joint YJB/Prison Service **Child Protection and Safeguards Review 2003**. The Review concluded that this was an area where there were serious service deficits and recommended a robust programme of improvement. The review found that although there were anti-bullying policies at YOIs these were generally of a reactive rather than proactive nature. There was a lack of clarity and consistency within the staff group about acceptable levels of behaviour and at what point intervention would be appropriate. The Review was particularly concerned about what appeared to be a complete lack of training for staff with regard to managing bullying and anti-social behaviour by adolescents. This situation was compounded by the limited availability of support services for young victims and limited intervention programmes for both perpetrators and victims of bullying.

9.22 The **Child Protection and Safeguards Review 2003** made the following important recommendations:

- The Prison Service should develop central policy for use by all establishments that hold children and young people. This policy should include:
    - Clear definitions of different types of harm (e.g. Bullying, intimidation and verbal abuse)
    - Clarity on levels of acceptable behaviour
    - Development of programmes for perpetrators
    - Development of measures to support victims
    - A focus that includes antisocial behaviour generally
    - Zero Tolerance
- Establishments should ensure that anti-bullying policies and practice are juvenile specific.
- Establishments should ensure that all anti-bullying policies are pro-active rather than reactive
- Establishments should review their personal officer scheme and strengthen it where necessary
- ACPCs should offer establishments training support, assistance and guidance in the drafting of safeguarding policies and also ensure that establishments have access to casework advice.

9.23 Although the above analysis suggests that this is an area of practice where much remains to be achieved, the Review did identify some positive developments and imaginative ideas to combat bullying and make regimes safer. Most YOIs have instituted an Anti-Bullying Committee and there is no

doubt that staff at all levels appreciate the serious effect that bullying can have on the regime of the YOI and the lives of individual young people who reside there.

Child Protection and Liaison with ACPCs

9.24 In Chapter 7 this Operational Review has described how child protection policies have evolved over the past two years, culminating in the issue of LAC 26(2004) in September 2004. The current formulation of a YOI's child protection responsibilities draws heavily on the findings of the **Child Protection and Safeguards Review, 2003**. Their overall recommendations have been set out earlier at paragraph 7.19. Following the publication of the Safeguards Review an Implementation team was established to examine and cost the proposals. The Implementation team reported in October 2004.

9.25 The revised PSO 4950 gives new prominence to YOI Governors' child protection and safeguarding responsibilities and requires these to be performed by applying the principles and standards established by the Children Act 1989 and associated regulations and guidance. To achieve this each YOI must put in place a child protection framework that relies on three key elements, the appointment of a member of the senior management team as Child Protection Coordinator, the establishment of a Child Protection Committee and the development of working relationships with local ACPCs and their constituent agencies.

9.26 The PSO sets out a challenging set of objectives that have to be achieved by the YOI Child Protection Committee. These in turn create a programme of work and service development in child protection matters. These objectives are set as follows:

- Establish a common understanding of the purpose of child protection procedures
- Agree clear child protection procedures for the YOI, based on the model outline Child Protection Policy annexed to PSO 4950
- Ensure that procedures are implemented and usage monitored
- Establish a common understanding of the role of the local ACPC
- Agree the YOI child protection procedure with the ACPC
- Identify a named Social Services Department (SSD) officer whom the YOI is to contact to make a referral or seek advice/consultation
- Advise the Governor on the selection and training of the YOI Child Protection Coordinator and Deputy
- Agree the criteria for assessing child protection incidents that may lead to a referral to SSD and agree in what circumstances a referral should be made
- Agree a procedure for dealing with historic incidents of abuse or neglect occurring prior to the young person's admission to custody
- Agree liaison arrangements for handling cases
- Draw up a programme of child protection training, and monitor effectiveness.

Child Protection Coordinators

9.28 This is a key element in the Safeguarding Framework. Recognising that safeguarding is both a general approach and a specific set of activities, it is vitally important that one person with appropriate authority is charged with coordination and oversight of the programme. The **Child Protection and Safeguards Review, 2003** found that in only a quarter of YOIs had a senior Child Protection Coordinator been appointed, although in a further three YOIs there was an intention to create such a post. In the remaining YOIs the responsibility was sometimes confused. PSO 4950 removes any ambiguity and this is should mean that implementation across the YOI estate should become more consistent.

9.29 **The Child Protection and Safeguards Review, 2003** recommended that, given the crucial nature of the safeguarding agenda, these posts should be developed, preferably as dedicated senior **Safeguards Manager** posts with ring-fenced funding. Their view was based on an assessment of the commitment of time and resources required to deliver against the specified responsibilities of the post; responsibilities that were difficult to do justice to if combined with other senior or middle management remits. There was already some experience of this type of appointment and these posts had demonstrated that it is possible to achieve significant progress and cultural change both within the YOI and in working relationships with a range of external statutory and voluntary agencies. At the present time not all YOI have the resources to situate the Safeguards Manager post at senior management team level. The Prison Service Safeguards programme is seeking to address this, subject to the availability of funding.

9. 30 This Operational Review strongly supports this regenerated approach to child protection and safeguarding enshrined within revised PSO 4950. The appointment of Safeguards Managers and the establishment of the Safeguards Committee at each YOI should deliver more effective and improved safeguarding arrangements across the range of relevant policy and practice areas. The suggested integration of these arrangements at individual YOIs with similar ones already in place to drive forward programmes directed at self-harm, anti-bullying and substance misuse is also strongly supported. This inter-relationship between these areas of work and concern is well-understood.

Making Complaints

9.31 PSO 4950 also requires Governors to ensure that there are arrangements for dealing with complaints and requests, and for investigating incidents, that deal with those matters speedily, rigorously and fairly. The arrangements must be sensitive to the age and maturity of the young person complaining or requesting assistance. The young person should also receive assistance from an Advocacy Service or access to the Independent Monitoring Board, if that is appropriate.

Reporting Abuse and Significant Harm

9.32 The new PSO 4950 now also requires Governors to establish arrangements with the local ACPC for dealing with incidents in which a child or young person has or may have suffered significant harm. The **Child Protection and Safeguards Review, 2003** found this a less than well-developed area of practice. In terms of how YOIs handled information or disclosures of historic abuse perpetrated before the young person came into custody or in an earlier placement, the Review found that staff felt ill-equipped and inadequately trained to take on this task. There was commonly no systematic approach to addressing the problem and no clear means of dealing with disclosure. Young people were often unaware of how to disclose and to whom.

9.33 The Safeguards Review recommended that the Prison Service and YJB should commission an investigation into how the issue of historic abuse may be addressed safely and systematically. The review proposed that YOIs should then develop a range of appropriate services for children who do disclose serious historic abuse, including services such as counselling. Specific training and support should be offered to Personal Officers and other staff who deal with the complex challenges that occur in the period following disclosure.

9.34 The issue of the categorisation of incidents that take place within the everyday life and regime of a YOI as 'significant harm' and their investigation is a difficult area. The issuing of LAC (2004) 26 should bring some structure to this process and ensure that YOIs and associated ACPCs and their member agencies work together to set out some protocols on the identification, referral and investigation of significant harm incidents as they occur in YOIs. The guidance on significant harm and the definitions of physical, emotional and sexual abuse and neglect as set out in the guidance **'Working Together to Safeguard Children,1999'** (and as restated in joint practice guidance **'What to do if you're worried a child is being abused' 2003**), define the parameters to understanding abuse **[Refs. 15A&B]**. However, it is easy to see that some aspects of life in YOIs may be construed as significantly harming by the young people or some commentators, but not necessarily be categorized as such by the adults or some of the young people concerned. Greater clarity about what constitutes the significant abuse threshold and its relationship to the residential setting needs to be undertaken and incorporated into staff training and development work.

9.35 The **Child Protection and Safeguards Review, 2003** found that this was an area where much more work needed to be done. There was a perceived over-use of internal YOI investigation processes prior to any consideration of a referral to the statutory agencies, (Social Services and Police) who have a duty to deal with child protection enquiries. There was also little evidence of more general engagement between YOIs and local Police Child Protection Units and Social Services Departments. This

appeared to run in both directions. Circular LAC (2004) 26 now makes clear what action is required to strengthen the inter-relationship.

New Social Worker Posts

9.36. To help achieve maximum effectiveness of the child protection arrangements and safeguarding in YOIs, the YJB has recently agreed to fund the appointment of 25 local authority social worker posts for the sector. These social workers will be located throughout the YOI estate. At individual YOIs they will facilitate the introduction of child protection matters with YOI staff and address the improvements required to ensure that local authority obligations to children and young people in their care are appropriately discharged. This represents a very welcome and significant new safeguarding resource.

Looked After Children

9.37 As noted earlier in this Review, a substantial proportion of trainees at YOI had been, or remained, the responsibility of local authorities as looked after children or children who had been accommodated. Mr. Justice Munby's judgement has now made it clear that the local authority's duties towards those children still apply when they are in custody. This is a very helpful clarification, but means that there is a good deal of work to be undertaken to ensure that the young people concerned receive the full range of services, advice and support that the Children Act 1989 and the Leaving Care Act 2000 allow.

9.38 Circular LAC (2004) 26 specifies the action that local authorities with social services responsibilities must now take to achieve these ends (see paragraphs 7.21 to 7.23).

Liaison with ACPCs

9.39 When the **Child Protection and Safeguards Review** conducted their work in 2003 they revealed a very patchy picture of liaison and joint working. Although all juvenile YOIs had made contact with their local ACPC, in many areas engagement by the ACPC with the YOI was poor or non-existent. There was little Governor representation on local ACPCs and for their part ACPCs did not formally monitor safeguarding arrangements within YOIs. For individual cases it seemed to be difficult for some YOIs to acquire consistent and appropriate advice or assistance with the handling of child protection enquiries. Although there was evidence that some YOIs were beginning to make more significant progress a more consistent approach across the YOI estate was required.

9.40 This should now be possible given the combined force of the revised PSO 4950 and the issuing of LAC (2004) 26. The passing of the **Children Act 2004** in November 2004 also provides an excellent context to move forward with this agenda. The Act requires local authorities to establish **Local Safeguarding Children Boards (LSCBs)** by April 2006. The LSCBs will take the place of ACPCs, but with enhanced remits and responsibilities. LSCBs will

be regulated statutory bodies. The Children Act 2004 (section 13.3) establishes both Governors of YOIs and Directors of STCs as statutory members of the LSCB and thus, alongside other agencies, responsible for the operation of the Board and the effective discharge of its functions. The Act also places on Governors direct responsibility for safeguarding the welfare of children within their custody. During 2005 a great deal of developmental work will therefore be taking place on a local basis as ACPCs engage in transition programmes. It will be vitally important that YOIs take a full part in this activity.

CHAPTER 10

MANAGEMENT OF SELF-HARM AND SUICIDE IN YOI

1. POLICY AND PROCEDURES

YJB/Prison Service Policies

10.1 The prevention and management of self-harm and suicide in prisons and YOIs has been a matter of great concern over the past years. The past 20 years has seen a growing programme of activity and procedural developments within the Prison Service to address this issue. This Operational Review will concentrate on examining the manner in which those developments have impacted on the care and treatment of young people held within the YOI estate. In order to ensure the closest integration of relevant policies with operational practice and support, the Home Office created in April 2001 the **Safer Custody Group** whose remit is to have oversight of all policy and practice matters related to safer prison design, issues of self-harm management and suicide prevention, and violence reduction.

10.2 The Safer Custody Group works within policy parameters set by the Safer Custody Strategy, February 2001. This strategy was launched following the HM Chief Inspector of Prisons' thematic review **'Suicide is Everyone's Concern' 1999** and the Prison Service's review of policy **'Caring for the suicidal in custody'**. The key principles and features of the strategy are as follows:

- A move from *awareness* towards *prevention.* This includes a commitment to achieve a reduction in the number/rate of self-inflicted deaths;
- The strategy is risk-based, focusing additional resources where the risks are highest;
- An acknowledgement that suicide and self-harm cannot be dealt with in isolation. A holistic approach is needed, focusing on a supportive prison culture based on good staff/prisoner relationships, constructive regimes and a reduction in bullying/violence. This holistic approach is concerned with the safety of all who live and work in prisons;
- A physically safe environment plays an essential role in the holistic approach, including reducing the opportunities for harm, by introducing crisis suites and environments that enhance a sense of well-being;
- Close collaboration with other units to tackle the increased risk of suicide among prisoners who are undergoing detoxification and those with mental health problems. This involves close work with the Healthcare Policy Unit and Drug Policy Unit to introduce dedicated detoxification units and in-reach mental health teams in high-risk prisons;
- Strong partnerships with the voluntary sector, particularly the Samaritans;

- o The development of a new organisational structure to deliver this strategy.

10.3 The Safer Custody Group report for 2001 **'Self-inflicted deaths in Prison Service Custody' [Ref 16]** provides strong testimony to the seriousness of this matter for the Prison Service. During the calendar year 2001 a total of 73 self-inflicted deaths were reported and this compared with 42 deaths ten years earlier in 1991, an overall increase of 72%. That period showed a marked increase in both the number and rate of deaths in respect to the prison population although it should be noted that by the end of the period rates seemed to show a reduction from a high point in 1999. During the period May 2000 to September 2004 a total of 10 young men under the age of 18 died whilst in custody.

10.4 **'Self Inflicted deaths in Prison Service Custody**' 2001 concluded with a range of findings from the statistical analysis that had a direct bearing on the direction of future policy and better practice. Although the analysis is of all deaths, predominantly of adults but including a small number of juveniles, some of these findings relate closely to aspects of the circumstances of Joseph Scholes' death:

- Deaths are most likely to occur soon after prisoners have been received into custody;
- Most deaths occur as a result of hanging or self-strangulation. The most common ligature point is a window and the most common ligature is bedding;
- Few prisoners had been identified as being at increased risk at the time of death. There is also some evidence that the period immediately following the closure of an F2052SH is a high-risk time;
- Most prisoners are on ordinary location at the time of death. However, a disproportionate number of deaths occur in Health Care Centres, segregation units and vulnerable prisoners units;
- Most prisoners are in single cells at the time of death. Those who die in shared cells are usually alone at the time of death;
- Less than half of self-inflicted deaths received a verdict of suicide at inquest (the others being classed as misadventure, accidental death, open verdict or natural causes).

10.5 The analysis from the above annual report and the findings of Serious Incident Reports and investigations into the deaths of individual young people have, over the past 3 years, informed the development of current policy, procedures and best practice. From these reports or investigations has emerged a profile of an extremely vulnerable adult or young person who may become the victim of a self-inflicted death. This person presents as having multiple mental health and social problems. These may include, in any combination, some psychosis or neurotic illness, commonly in the form of depression or extreme anxiety. There may be a history of drug or alcohol misuse, of self-harm, of social isolation and a life history marked by family break-up, periods in local authority care, exclusion from school or joblessness.

10.6 The situation with respect to the management of self-harm in custody is an equally serious matter. Research conducted by the Safer Custody Group in 2003 **'Reported Self-Harm in HM Prison Service in 2003' [Ref. 17]** based on an analysis of F213SH (recorded self-harm) returns reported that in that year there were 16,214 recorded self-harm incidents, a rate of 222 incidents per 1000 of the prison population. A quarter of these incidents involved young people under the age of 21 years, with 65% of young women under 21 years harming themselves compared to 10% of young men. Women were also more likely to harm repetitively, on average up to five times during the year. By contrast, young men on average only self-harmed twice. The most common method of self-harm was cutting or scratching, but other incidents involved self-strangulation, hanging and poisoning. Other methods included head banging, wall punching, wound aggravation, burning, ligature making and suffocation.

10.7 Such prisoners and young people challenge the capacity of the Prison Service to respond adequately to their needs and keep them safe. The current strategy articulates an approach based on consistency, care and compassion coupled with vigilance and an effective suicide prevention system. The purpose of this Operational Review is to appraise whether that strategy appears to be robust enough in practice.

PSO 2700 - Suicide and Self-harm Prevention

10.8 Prison Service Order 2700 **[Ref.18]** came into effect on 1 January 2003. It brought together a number of earlier procedures or instructions related to this area of work and as such provides the current framework for the prevention of self-directed harm, The introduction to the PSO is careful to note, however, that it is not the last word and that the PSO will be revised substantively once other relevant aspects of the Safer Custody programme are assessed and codified. This revision is planned for redrafting and publication in 2005. Planned developments include new guidance on working in this area of practice with women prisoners and with juveniles, further development of the guidance on self-harm and the management of challenging behaviour.

10.9 PSO 2700 provides detailed guidance to Governors at the strategic, managerial and practice levels. The guidance covers the entire prison estate and is not, at any point, specific to YOIs or juveniles. Governors have overall responsibility for the implementation of the local suicide and self-harm prevention strategy and for procedures within their own establishment, but these are annually validated at Area Manager level. A model framework specifying the areas of policy and practice to be covered by the strategy is found at Annex A of the PSO.

10.10 Each establishment is required to appoint a Suicide Prevention Team leader (SPTL), who might be supported by a deputy SPTL and/or a Suicide Prevention Coordinator. The SPTL also leads the Suicide Prevention Team that has to meet on, at least, a regular three monthly basis; it is reported that

most meet more frequently. The remit of the Team is not only regularly to review the implementation of the local preventative strategy, but also to examine and monitor all self-harm incidents and the quality of, and compliance with, F2052SH self-harm procedures. With the growing awareness of the broader safeguarding agenda, some juvenile YOIs have combined the Suicide Prevention meeting with those called for Child Protection and anti-bullying/violence reduction to form an integrated safeguards meeting.

10.11 PSO 2700 picks up directly on the finding in **'Self-inflicted deaths in Prison Service Custody' 2001** about the critical significance of the immediate post-admission period and spells out the necessity of providing properly sensitised reception and first night arrangements that recognize this. These matters have been examined earlier in Chapter 8 of this Operational Review. The PSO also provides advice and guidance about action to be taken or reports prepared following an incident of self-harm or suicide. Instruction about emergency action and procedures is given at Annexes C and D of the PSO.

10.12 At the core of PSO 2700 is advice and instruction on the management of prisoners identified as at risk of self-directed harm and on the operation of the F2052SH Self-harm form. PSO 2700 is supported by the Safer Custody Group's publication of some much more detailed good practice guidance '**Suicide Prevention Strategies- Guidance on preventing prisoner suicide and reducing self-harm: the role of Samaritans; and safer custody cells protocols'**. This guidance came into effect on 1 January 2003 **[Ref. 19].** The guidance is generalized for the entire prison estate and not specifically tailored for juvenile offenders.

10.13 Additional guidance in support of PSO 2700 has also been published by the Safer Custody Group to assist staff to understand and deal successfully with self-harm and suicide, or provide support. These publications include:

Working with people who harm or injure themselves in prison
[Refs 20 A and 20B]
Two booklets: 1. Information for prison staff

2. Information on Interventions

Good practice guide for peer support schemes
[Ref 20C]
Published by the Safer Custody Group with the Samaritans. This form of support has recently been bolstered by the introduction, at a number of YOIs, of the Insiders peer support scheme.

Safer Custody and Self-Harm Toolkit

The Self-Harm Toolkit is the latest word in the provision of comprehensive guidance on self-harm and suicide. Published by the Safer Custody Group in September 2004, the Toolkit is available in CD Rom format and on the Prison

Service intranet. The Self-Harm Tool kit brings together all relevant information and guidance on best practice and also includes a training package **'Understanding Self-Harm'** that can be delivered by non specialist trainers or used by individuals. The Self-Harm Toolkit also provides case studies that aid understanding.

10.14 The introduction and implementation of the Self-Harm Toolkit can only strengthen the support that is available to staff working in this challenging area.

F2052SH Procedures and practice

10.15 The processes to be followed following an incident of self-harm are set out in PSO 2700, both in the body of the PSO and in its Annexes. Annex B sets out the F2052SH procedures. In outline, these require YOI staff to:

- Open a F2052SH Self-Harm At Risk form and complete a F213SH Record of Self-Harm Incident form
- Be aware of all young people on open F2052SH forms in their charge and take steps to brief other staff
- Be cognisant of observation requirements and content of support plans for such young people
- Inform the young person about the F2052SH process and record their comments and any other relevant information in the daily supervision and support section

Initial Action

- Consult health care staff and decide, in consultation with them, whether the young person is to be managed on a residential unit or be referred to the Health Care Centre
- If young person is placed, or remains, on a residential unit, take action to support and assist the young person
- Provide an opportunity for the young person to speak to a Samaritan
- Ensure that a case review is held within 72 hours

Health care assessment

- Young people who are referred for health care assessment and treatment under F2052SH procedures must be interviewed by a health care officer or nurse as soon as possible
- There should be a referral to a doctor as soon as possible and in any event within 24 hours of referral
- A doctor or nurse must decide, in consultation with other members of staff involved, where the young person should best be immediately located

Case review and Support Plan

- An agreed support plan must be drawn up in consultation with all relevant departments and agencies
- Managers of the unit where the young person resides must ensure that the support plan is implemented
- Staff must ensure that further multi-disciplinary reviews are held as necessary. They should seek guidance from health care staff and cooperate with related case reviews
- When a young person resides in the Health Care Centre they will have a nursing care plan that will take the place of routine case reviews unless they harm themselves or are due for discharge from the Health Care Centre when a case review will be conducted
- Young people being discharged from the Health Care Centre must be seen by a member of the health care team prior to the move

Closing the F2052SH

- F2052SH will be closed at a case review when the young person appears to be coping satisfactorily
- The case review must agree after-care or follow-up arrangements
- Reasons for closure and after-care plans must be carefully recorded
- Closure must not take place at the point of discharge from the health care unit to another location.

10.16 Further detailed guidance on how individual YOIs and their staff may perform these procedures with confidence and provide safer support to young people is provided in sections 3 and 4 of **Suicide Prevention Strategies**. This guidance covers care planning, a range of good practice suggestions for support plans and more detailed advice on accommodation options. This latter matter is examined further in Chapter 11 of this Operational Review.

Role of the YJB Performance Monitor

10.17 As noted at paragraph 8.14 of this Operational Review, YJB Performance Monitors allocated according to Prison Service Areas are responsible for ensuring that the YOI has appropriate systems and procedures in place to ensure the safety and welfare of the young people. YJB Monitors automatically receive a copy of either the 'risk alert' or 'first night alert' and may be called upon by the Placements Team caseworker to review the action taken by the YOI to secure the young persons safety. This is particularly important where concerns are raised on admission of the young person about aspects of their care. The YJB Monitor can also be asked to sample and advise upon specific cases.

10.18 The YJB Monitor plays an important role in quality assuring the safeguarding procedures in respect to the management of self-harm. YJB Monitors are required to undertake sampling exercises with vulnerability or first night alerts to ensure that systems are working effectively. In the course of these exercises, YJB Monitors may identify young people whom they think may not be placed appropriately. This can trigger a discussion with the Placements Team about a possible transfer. An outline sampling framework is

provided in the YJB Placement Protocol. The YJB Performance Monitor should:

- Ascertain the location of the young person within the YOI and check that the alert has been received at that location
- Check whether the young person has been placed on an open F2052SH
- Check on adequate measures to reduce the potential for bullying, especially if the young person is a 'high-profile offender'
- Check on the young person's medication regime
- Make an overall assessment of the safeness of the young person and the appropriateness of their care.

Critique of the current arrangements

10.19 Although it was not possible within the time available to the Operational Review to undertake a first hand appraisal of the quality of work in this area of practice, reference has been made to the findings of the joint **'Child Protection and Safeguards Review 2003'** and to various inspection reports prepared by the HM Chief Inspector of Prisons. During the course of this Operational Review it was understood that HMIP were also focusing their current series of inspectorial visits to YOIs on safeguarding issues.

The key issues of concern identified by these appraisals of current practice are as follows:

YOI policy on suicide and self-harm

10.19.1 Although suicide and self-harm policies are generally clear and up-to-date, and respond to the requirements of PSO 2700, they are not juvenile-specific. YOIs need to take action to achieve this goal. Such policies and local guidance need to strike a balance between the provision of an overall environment that recognizes and safeguards the potential vulnerability of all young people accommodated and the special needs of those young people identified as most vulnerable.

Early identification of risk

10.19.2 Most YOIs acknowledge high risk during the early phase of custody and adopt various means to ameliorate this. This can include fast-tracking through reception, enhanced first night care and increased observation or surveillance. There has been some suggestion that the YJB-funded first night cover has not been used as specified. There were also concerns that the quality of recognition of juvenile-specific needs can be missed at split YOI sites with shared reception facilities.

10.19.3 It was noted that the completion and quality of the T1:V Initial Custodial Reception Assessment form at reception varied widely and that the form was completed by a range of staff. A strong case has been mounted for YOI staff to be specifically trained in assessment and planning for the needs

of vulnerable young people. This would include training in the completion of T1:Vs [see also paragraph 8.11].

Understanding vulnerability

10.19.4 In general, staff at YOIs had a basic understanding of the vulnerability of young people, but staff consistently articulated a need for more training in risk assessment and in understanding vulnerability. Whilst some YOIs proactively promoted training and awareness of safeguarding practice, this was variable across the YOI estate. It was noted that most YOIs placed the support role for young people on front-line staff and these staff required a clear support structure. There was also an identified need for the development of enhanced support and supervision arrangements for staff working with self-harm and suicide. Where staff working in this practice area had access to support from colleagues with a mental health locus, this was much appreciated.

Transfer of Information

10.19.5 As exemplified through the investigations into the death of Joseph Scholes there appear to be consistent problems with the timely availability at the point of reception of ***Asset***, PSR and PCR documentation from Yots. At one of the YOIs visited during this review it was reported that this was now less of an issue. But it has to be noted that 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.

Quality of F2052SH Practice

10.19.6 In general, the F2052SH procedures are being followed satisfactorily but there is a recognized need to bring the quality of recording within the format up to a standard that more accurately represents the level of work and support offered to the vulnerable young people. In YOIs with more young-person focused environments there appeared to be a lower incidence of the use of F2052SH procedures, due no doubt to an awareness of alternative care and support strategies. Experience suggested that more still needed to be done to highlight issues of practice specific to young people.

10.19.7 The quality of work in this area of practice is, of course, determined by ensuring that there are adequate and appropriate resources available to secure an optimal response to the needs of the young people. The picture that emerges from this review and other reviews in this area is that, in general, staff in YOIs want to be responsive to young people who self-harm and are serious in their approach to achieving a safe environment. Managers and staff have, in this respect, being considerably assisted by the practice development and training support work driven by the Safer Custody Group and this will continue to deliver improvement as recent initiatives provide

additional strengthening. But there are still some factors that can be seen to have the potential to inhibit further progress.

Mis-matching of demand against staff resources

10.19.8 There is some concern that as the number of young people who might be assessed as having some level of vulnerability grows within the juvenile offender population, then the obligations imposed on staff by virtue of F2052SH status will become increasingly difficult to meet at a satisfactory level. In these circumstances prioritization of staff resources to meet the challenges posed by the most seriously vulnerable young people will almost inevitably weaken the network of care provided for the still not insignificant number of young people who would appear to present less serious concerns. Whilst the safeguarding of this group of young people will hopefully benefit from the general development of safer regimes and more young person focused programmes of care and support, without close individual oversight some less vulnerable young people at critical or very stressful moments can collapse and present very serious management problems.

10.19.9 This issue can be seriously exacerbated where the YOIs are faced with having to manage one or more extremely seriously disturbed and/or disruptive young people. The management of these young people will be extremely consuming of staff resources, time, energy and emotional commitment. Their extreme behaviour normally gives rise to great anxiety on the part of staff who are trying to care for them. There is the understood anxiety and concern that all must be done to inhibit the young person's destructiveness, whether directed towards themselves or to their immediate environment, including their carers. But there are also strong feelings about the staff's own capacity to manage the situation successfully and what others will say and do, including the wider world, if they are seen to fail in this duty to protect.

10.19.10 In these extreme situations it is important for staff to feel and know that they have all possible resources available to them. When working with young people who are serious self-harmers, staff need to feel that as well as being equipped with as much knowledge and understanding as they need, they are going to receive support and assistance from their colleagues and from specialists. In most cases this will mean access to medical, and especially psychiatric, resources that will help them care for the young people who have health needs with greater confidence.

Mis-matching of demand to physical resources

10.19.11 Where a young person is assessed as exhibiting the likelihood of behaving in a serious self-harming manner then decisions need to be taken as to whether they can be managed in a normal residential location or might best be treated and accommodated in the Health Care Centre. The F2052SH process makes this an early explicit decision. However, accommodation in Health Care Centres represents a resource with finite and limited capacity and

most young people subject to F2052SH status are managed outside Health Care Centres.

10.19.12 Any substantial growth in the number of young people with F2052SH status will introduce pressure into this situation and more of such young people may find themselves on residential units at times when their distress is such that they should be in health care. This could lead to local management being tempted to keep beds in the Health Care Centre as free as possible so as to offer a flexible and responsive service when it is most required. This is understandable from a resource management perspective, but is not practical or realistic. It could possibly lead to a situation where young people might be encouraged to consider moving out of the Health Care Centre prematurely.

Arrangements for Support

10.20 It is important that young people who are at risk of self-harm or suicide have easy recourse to confidential support, counselling and advocacy services. This is fully recognised by the Prison Service and, through the Safer Custody Group developmental initiatives, a great deal has been achieved to bring such schemes and facilities into establishments. The three main planks of this strategy are the involvement of the Samaritans, Samaritan–supported Listener schemes, and peer support. The involvement with the Samaritans is of very long standing and they have played a vital role in the Suicide Prevention Strategy for many years. Their role is codified in Chapter 5 of PSO 2700 and additional detailed guidance is provided at Section 5 of practice guidance **Suicide Prevention Strategies**.

10.21 The Samaritan-supported Listener scheme has also been developed throughout the adult prison estate. This is a scheme whereby selected prisoners are trained and supported by Samaritans to listen in confidence to their fellow prisoners at times of crisis, when they may welcome a sympathetic ear. It has been agreed that this scheme is not suitable or appropriate for juveniles. Currently the YJB is working with 13 voluntary agencies who are involved with the development of helplines, to provide an advocacy service to individual YOIs. This development is commended by this Operational Review.

10.22 Peer support is another initiative that might provide an additional tool to assist with the management of young people in distress. It is understood that, following a successfully evaluated pilot scheme. This service, known as the Insiders peer support scheme, has been introduced at some YOI to support young people during their reception. It should be noted that this is not a confidential service.

ACCT (Assessment, Care in Custody and Team work)

10.23 As part of the Prison Service Safer Custody Programme, Manchester University were commissioned to evaluate the existing F2052SH (Self-Harm At-Risk Form) system in 2002. The research has identified both the strengths and weaknesses of the old system, and laid the groundwork for the introduction of ACCT (Assessment, Care in Custody and Teamwork)

approach. During the 2005/6 it is intended to replace the F2052SH with ACCT with a target of its introduction at all prisons by the end of 2006.

10.24 ACCT has been designed to build on the strengths of the F2052SH system whilst addressing its deficits including the inflexibility of the F2052SH (for example, in the management of people with a long-term pattern of self-injury); the emphasis on watching rather than care; poor communication between healthcare and other staff and action plans not being carried out. ACCT is seen as a means whereby staff can work together to provide individual care to prisoners who are in distress in order to help defuse a potentially suicidal crisis or help individuals with long-term needs (such as those with a pattern of repetitive self-injury) to better manage and reduce their distress.

10.25 The ACCT approach is planned to differ from the F2052SH in its overall approach to caring for at-risk prisoners. It focuses on individual assessment, uses accountable Case Managers, trained Assessors and flexible care. The ACCT approach promotes teamwork by joining up care provided by residential staff with healthcare systems for mental health care and drug/alcohol withdrawal. It provides a much clearer emphasis on post-closure and post-release care with a stress on “people not processes”, and a culture that involves prisoners more directly, treating them as individuals and ensuring they feel cared for.

10.26 The proposed introduction of the ACCT approach to replace the F2052SH arrangements post-dated the compilation of this Operational Review. This new approach is to be welcomed as it seeks to address some of the accepted shortcomings of the present system. Early evaluation of the ACCT approach at pilot sites has elicited a positive view of the new arrangements, citing increased prisoner involvement/ responsibility in care planning, more individual, flexible and holistic care, more appropriate referrals to healthcare, an awareness of increasing sign of risks/ triggers to future self-harm, and some evidence of a culture change whereby staff were more concerned with care than form filling.

10.27 A briefing note describing the introduction of ACCT prepared by the Prison Service [now the National Offender Management Service (NOMS)] has been attached at Annex 6

CHAPTER 11

MANAGEMENT OF SELF-HARM AND SUICIDE IN YOIs

2. SAFER PRACTICE

CARE IN HEALTH CARE CENTRES

YJB Health Promotion Policy

11.1 As noted in Chapter 3, the four investigations into the death of Joseph Scholes at Stoke Heath YOI were unanimous in their condemnation of the physical environment and accommodation provided at the YOI Health Care Centre in 2002. It is pleasing to report that the situation in 2004 has been greatly improved with the provision of a new, purpose-designed and equipped Health Care Centre. The £4 million Health Care Centre now provides first class facilities for health care, including suites for medical and dental examination and consultation and a range of suitable accommodation (12 beds) for the medical care and treatment of the young people. This accommodation includes suitably designed and equipped cells for the care of very distressed young people.

11.2 Since taking on responsibility for developing the secure juvenile estate in 2000, the YJB has committed itself to a major enhancement of the quality of health care available to the young people. This has included the provision of funding for 24 hour health care in all YOIs that take children and young people straight from court, and screening arrangements for both physical and mental health. The YJB has also moved to integrate YOI health services into mainstream NHS management arrangements by agreeing the transfer of responsibility for YOI health provision to local Primary Care Trusts (PCTs). It is hoped that through these developments young people will experience a high quality of support for their health needs, recognizing that the population of young people in YOIs present higher risk factors in mental health and substance misuse than the general population of their age group.

11.3 **PSO 4950, September 2004** spells out YOI responsibilities for maintaining the physical, mental and social health of each young person. The policy adopts a ‘public health’ approach based on prevention and the promotion of healthy behaviour and lifestyle. PSO 4950 also sets out requirements for the implementation of a substance misuse strategy within YOIs. These policies and practices must accord with standards and good practice guidance set out in the Prison Service Health Performance Standard: Health Services for Prisoners, the NHS Children’s National Service Framework and the YJB Key Elements of Effective Practice (KEEP) booklet on ‘Mental Health’.

11.4 The overall approach to the provision of health care services is one based on multi-disciplinary working. Where young people are identified as having significant health needs and are receiving support, either as in-patients

or on an out-patient basis, there should be a health care plan that is reviewed and discussed weekly by the multi-disciplinary team. Depending on the young person's needs, care planning may include support from specialist medical, mental health or substance misuse staff. This approach to health care and promotion is appropriate and given improved management and resourcing at individual YOIs should deliver improved services and benefits.

Mental Health Services

11.5 PSO 4950 requires that mental health services for the young people must be provided by a multi-disciplinary team trained in child and adolescent mental health. As has been demonstrated in the case of Joseph Scholes, the availability of specialist psychiatric support advice and services for distressed young people is essential if they and the nursing and other staff caring for them at times of crisis, are to be properly supported. As has been noted in Chapter 10 the effectiveness of the F 2052SH procedures are predicated on the availability and expertise of health care professionals, and in the most serious of cases, on the availability of suitable accommodation and staffing levels in the Health Care Centre.

11.6 Experience has shown however that the present service has some resource constraints that place limitations on the capacity of the service to always respond as well as it might wish. These have been noted, in part, at paragraphs 10.18.8 to 10.18.11. This situation is of considerable concern as the number of adolescents in the community who present serious mental health challenges would appear to be growing and a substantial proportion of these young people are sent to YOIs. As more challenging young people are accommodated, the task of maintaining a safe environment for other young people becomes that more difficult. The issue is one that bears down on both the level of mental health support that can be appropriately provided by a YOI Health Care Centre and the facilitation of alternative treatment options.

11.7 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, but comment about it has been included here as this serious and constrained resource issue will continue to act as a major inhibitor to the realisation of the safeguarding objectives set for Health Care Centres.

USE OF UNFURNISHED ACCOMMODATION AND SAFER CELLS

11.8 Best practice in the management of young people who self-harm suggests that successful intervention should be based on an active engagement with the young person, drawing on all available resources from social, educational and health care. Wherever possible this intervention

should take place in a normal residential setting and progress without recourse to the use of alternative facilities. However, as noted earlier, ordinary resources may, in the most serious and challenging of cases, be considered inadequate in the face of a determined attempt by a young person to inflict injury or death on themselves. In these instances steps need to be taken to place the young person in a safer physical environment that offers far fewer opportunities for self-harming.

11.9 The Prison Service has set out in **Suicide Prevention Strategies** the policy and good practice guidance in respect to the provision of both unfurnished and 'safer' accommodation. The guidance recognises that the Prison Service has received repeated criticism for the continued use of unfurnished cells for prisoners identified at risk of self-inflicted harm. Prisoners have reported that being placed in these conditions does not in itself lessen suicidal feelings and often has the reverse effect as they feel worse for the experience, degraded and punished. Evidence also suggests that fear of being placed in unfurnished conditions is a factor that discourages prisoners from disclosing suicidal feelings. The guidance accepts that the use of such accommodation can provide a temporary respite, but is not successful as a long term measure. The guidance concludes that the use of unfurnished cells alone is wholly inappropriate for use with prisoners identified as a risk of suicide or self-harm.

11.10 Whilst accepting this basic premise, the management of some very seriously disturbed prisoners can be facilitated by their accommodation in a safer physical setting to enable short term intervention at times of greatest crisis. The Prison Service has therefore developed the 'safer' cell specification. These are individual cells that are located in primary high risk areas in a prison or YOI. These locations have been specified as first night accommodation, induction units, Health Care Centres, detoxification units and 'care and separation' or segregation units. Safer cells are designed to make the act of suicide or self-harm as difficult as possible by the removal or reduction of all possible ligature points. Specially designed 'anti-ligature' furniture and fittings are installed as an integral part of the cell fabric. Detailed design specifications for 'safer' cells in each of the specific locations identified above are provided in the guidance.

11.11 **Suicide Prevention Strategies** reinforces the view that the use of a 'safer' cell cannot be considered safe in its own right. The accommodation is provided to complement a protective and care regime that is directed at understanding and helping the young person. The aim is to provide an environment that reduces stress in the individual and so allows the staff working with them to more fully address their needs and not just the manifestation of their self-harming behaviour. It is also important to note that no cell can ever be considered safe. Whilst the focus of concern is on the removal of ligature points, the opportunities for self-harming by head-banging or damage to limbs and cutting still remain, and experience has also shown that there still remains a risk of self-strangulation.

11.12 When in 2003 the joint '**Child Protection and Safeguards Review'** reviewed the accommodation provided, they reported that many cells that YOIs referred to as 'safer' cells did not meet the standard Safer Custody Group specification. There was also great variance in policies at different YOIs in respect to the use of 'safer' cells. The Safeguards Review therefore advised that the Prison Service should undertake a review of 'safer' cell installations within the juvenile estate in order to establish which did and which did not meet Safer Custody Group specifications. The aim was to bring all such accommodation up to specification as set out in guidance.

Closed Circuit TV (CCTV)

11.13 The use of CCTV for the surveillance and monitoring of young prisoners who self-harm or threaten suicide would appear to provide a useful, but secondary aid to their effective management. All Prison Service published guidance warns about over-reliance on this form of monitoring and advises that it is not a satisfactory alternative to a programme based on interaction and engagement with the young person. The joint **Child Protection and Safeguards Review 2003** noted that not all establishments had CCTV facilities; and where it was installed its usage and local protocols in regard to storing tapes was variable. In some YOIs the CCTV equipment was in disrepair.

11.14 The current Prison Service position on the use of CCTV is that whilst there are some perceived benefits to be gained from its installation, the facility does not offer a panacea and should be installed with careful thought and discretion. The Safer Custody Group's view is that CCTV is a good idea in some 'safer cells', but not all of them. CCTV can be useful in cases where young people are moving off constant observation.

11.15 The availability of CCTV can provide an aid to staff supervision, but is not an alternative. For instance, where a young person is moving off constant observation, recourse to CCTV surveillance does not allow for the interaction that occurs during that supervisory experience. In other situations the young person's care plan may indicate that they would find surveillance by CCTV disturbing and offer the potential to increase the risk of self-harm. It is important to stress that the facility becomes redundant if staff are not available to watch the monitor screen. Reported experience suggests that that could be the case and local protocols need to be drawn up to ensure this and to advise on the handling of those situations where observed prisoners or trainees have 'played up' to the camera by indulging in deliberate attention-seeking, provocative or offensive behaviour.

11.16 CCTV can be a useful additional tool and its use, whilst noting its limitations, should be further explored and developed by YOIs. The Safeguards Review recommended that CCTV should be installed in all juvenile YOIs and that a standard set of stringent and consistent protocols should be in place covering its use and the storage of recorded data for evidential purposes. That advice is endorsed by this Operational Review.

Observation and Supervision policy and practice

11.17 When Joseph Scholes was accommodated in the Stoke Heath YOI Health Care Centre he was subject to a prescribed 30 minute observation regime. His death occurred within 20 minutes of the last recorded observation. The Trafford ACPC Chapter 8 Case Review recommended that YOIs adopt a 15 minute observation interval where young people are assessed as at risk of self-harm and are accommodated in a 'safer' cell. If the cells are not deemed 'safer' then the Chapter 8 Review recommended continuous, direct observation. In all circumstances, managers should monitor compliance with these arrangements on a daily basis. This Operational Review has examined the practicability of that recommendation.

11.18 Guidance on the matter of observation levels and supervision of at risk prisoners is provided in PSO 2700 **Suicide and Self-Harm Prevention** at section 4.2 **Supervision of at-risk prisoners**.

11.19. PSO 2700 sets the parameters for **intermittent observation** which must only be authorised by a Governor in consultation with a doctor or nurse or vice versa. PSO 2700 already allows for intermittent observation at the level suggested by the Trafford ACPC Chapter 8 Review. This specifies that prisoners subject to intermittent supervision should be observed at least five times each hour at irregular intervals. Experience has indicated that deaths have occurred when a prisoner has been aware that checking will be taking place at a regular and predictable interval. A record of the checks must be maintained in the daily supervision and support record of the F2052SH.

11.20 The PSO also sets out the conditions for authorising and instituting a **constant observation** regime, again only to be authorised by a Governor in consultation with medical staff or vice versa. A judgement has to be made that the prisoner presents an acute risk of self-inflicted harm and that the risk is heightened by the awareness that the prisoner is immediately determined to carry out the act. Constant observation requires a designated member of staff to remain constantly in the prisoner's presence. The guidance stresses that this form of supervision, especially with the suicidal, should be active and include supportive contact and interaction rather than mere observation.

11.21 Constant observation is viewed by the Prison Service and the guidance as a measure to be used only in extreme circumstances and with prisoners who present the most acute and critical challenges to their satisfactory care. There is a recognition that these prisoners are most likely to require mental health intervention and the PSO points to the need to make an urgent referral once a decision to place under constant observation is made. The constant observation regime also requires local management to establish a very active and frequent case review process based on a four hour cycle during the first 24 hours of the crisis. Should the crisis extend beyond that period, the guidance requires that reviews be held at least three times each working day.

11.22 Although the approach towards care planning for at-risk prisoners is moving away from one of prescription to one that prioritises individualised care plans based on a broad range of interventions, there will still be situations where the depth of a young person's crisis means that they require constant observation, at least for the most critical period. Constant observation is, however, very resource intensive and cannot be perceived as a particularly constructive experience for staff and prisoners alike; indeed there is a view that constant observation can, if sustained for a protracted period, exacerbate the propensity to self-harm because of its perceived oppressive nature.

11.23 This Operational Review accepts that this is a very difficult policy and practice area. The availability of constant observation for all young people demonstrating acute at-risk behaviour is not feasible beyond its use as a very short term crisis-intervention tool. Without additional resources, the impact on individual staff and on staffing resources and deployment steers away from endorsing the Trafford ACPC proposal. The answer must lie, as with other matters noted elsewhere in this Review, with the development of more imaginative care planning and a wider range of more positive interventions.

Monitoring of telephone calls

11.24 The Prison Service team who investigated the death of Joseph Scholes at Stoke Heath YOI heard evidence of a telephone call between Joseph and his mother that might have alerted supervising staff to his intentions had a transcript of the conversation been promptly available or the conversation directly monitored. The Investigation noted that although telephone calls are routinely recorded, there are no arrangements to directly monitor the conversation of trainees under 'at risk' supervision and for relevant information to be passed immediately to staff supervising individual trainees. The Investigating team recommended that such arrangements be introduced at HMYOI Stoke Heath and also be considered for adoption throughout the Prison Service.

11.25 It has not been possible for this Operational Review to come to a clear view about this recommendation. The matter has been aired with Governors and operational staff during the course of the review and whilst there is general acceptance that the practice could provide additional and vital information that might better safeguard the young person and assist with their support, there are substantial issues of resourcing and practicability to consider. It is understood that at any one time there are an estimated 1,500 F2052SHs open across the secure estate. The proposal may take on more manageable proportions if limited to those young people at-risk and housed in the Health Care Centre and this solution is therefore suggested as a feasible compromise recommendation.

Alternatives to Safer Accommodation

11.26 As noted in **Suicide Prevention Strategies**, Prison Service guidance on this matter is strongly biased towards the minimum use of 'safer' cells for the management of self-harm and suicide. Although 'safer' cells can be seen as a supportive tool in preventing self inflicted harm, but the development of individualized support is more important. This approach is strongly supported by this Operational Review. The guidance provides advice to Governors about alternatives, accepting that each establishment is differently designed and resourced so that some developments may require longer-term implementation. The guidance offers some examples of effective alternatives that have been shown as successful in reducing, but not totally eliminating, risk:

- Increasing the level of observation and supervision
- Enhancing unfurnished cells by removal of obvious ligature points and refurbishment
- Installation of a gated cell to facilitate direct observation and interaction
- Use of CCTV
- Installation of a care suite, to accommodate both prisoner and Listeners
- Increased use of listeners or peer support
- Increased access to Samaritans
- Maximisation of multi-occupied ward accommodation in Health Care Centres
- Re-assessment of staffing levels and skill mix in Health Care Centres.

USE OF PROTECTIVE CLOTHING

11.27 At the conclusion of the Coroner's Inquest into the death of Joseph Scholes, attention was drawn to the jury's unhappiness with the use of safer clothing that Joseph wore for the first four days of his stay in the Stoke Heath YOI Health Care Centre. The Inquest also heard the opinion of Robin Hughes, author of the Trafford ACPC Chapter 8 Case Review, that he considered the practice 'de-humanising'. In the light of this concern it was agreed that this practice should be reviewed within this Operational Review.

Current Prison Service Policy

11.28 Prison Service statistics show that for the majority of the 237 self--inflicted deaths by hanging between 2001 and 2003 involved bedding as the ligature, not clothing. Around 70% of the deaths involved bedding, 25% involved clothing (including shoelaces and belts) and 5% involved other ligatures. However, clothing still has to be perceived as a readily available resource and it is important that there is a clear policy framework and practice guidance to support best practice.

11.29 The Prison Service accepts that depriving vulnerable prisoners of items of clothing, and by so doing drawing the attention of others to them in the process, can worsen their distress. It accepts that such practice may make them feel degraded and punished. Prisoners may have fear of losing their

normal clothing and this might act to discourage them from disclosing suicidal feelings. The current policy is that normal clothing, or individual items of clothing or possessions, must not be removed from at-risk prisoners as a matter of course. Decisions should be taken on a case-by-case basis as a last resort and as necessary for the immediate safety of the prisoner, and then only for the shortest time possible.

11.30 PSO 2700 **Suicide and Self-Harm Prevention** [paragraph 4,4] states that personal items including shoelaces and belts must not be removed from at-risk prisoners as a matter of course. PSO 1600 **Use of Force** [paragraph 4.5.2] states that a prisoner may be deprived of normal clothes only if this is considered essential to prevent self-harm or injury to others, or where the prisoner's clothing represents a hazard to their health, the health of other prisoners or to the staff. It is reported that in some YOIs, local management agrees that protective clothing can also used as an additional preventative measure during the night when supervision levels by staff are more limited. The prisoner's clothes should be returned at the earliest opportunity.

11.31 When the prisoner's normal clothing has been removed Governors are required to provide the prisoner with protective clothing so that they can be decently dressed [PSO 1600 paragraph. 4.5.1]. This decision has to be made in consultation with a health professional. The Governor is required to visit the prisoner prior to them being placed in protective clothing and thereafter the prisoner should be visited by a Senior Manager at least twice in every 24 hour period. The decision should also be notified as soon as possible to the Independent Monitoring Board (IMB) and reports about cases made available to IMB members on visits subsequent to the event. The decision to return a prisoner to normal clothing has to be taken by the multi-disciplinary team with oversight of the prisoner's care plan.

Protective Clothing

11.32 The term 'protective clothing' is now considered most appropriate to describe the alternative wear to normal clothing in these circumstances. The former terms, including the terms 'strip' or 'safer' clothing are not now considered appropriate as experience has demonstrated that there is really no such material as 'safer' clothing. No garments have yet been found that represent a safe and decent alternative to normal clothing. However, it is understood that the search for a suitable garment continues.

11.33 Whilst the Prison Service confirms that the use of protective clothing is to be avoided wherever possible, where it is considered that the young prisoner is at acute risk of taking their own life using normal clothing, then the young person is required to dress in a 'protective gown'. This is a 'dressing-gown' type of garment made from heavy duty flame retardant material. The garment is loose fitting and is worn without underclothing. The gown can be fastened by Velcro strip. The young person will also be issued with bedding in the same material. This 'protective gown' should only be worn in unfurnished or 'safer' cells and is very much part of a package of measures to manage the most serious of self-harming situations.

11.34 Certainly the garment is not 100% safe. YOI staff demonstrated how the garment could be unpicked at the hem and also exhibited a potential ligature that had been made from a strip of the 'safe' material.

11.35 The Prison Service also requires that the garment uphold the dignity of the young person wearing it. This is a more difficult matter to judge. Within the culture of a Health Care Centre setting it would not be unusual for patients to not be wearing their normal everyday clothing. However protective clothing is so different to normal night attire that this analogy does not hold. Accepting that the use of protective clothing is not meant to provide a long-term solution, and operational guidance reinforces its use for the shortest possible time, wearing the clothing is still a mark of 'difference'. Although in many cases the clothing is required to ensure the young person's safety or even survival, it can be potentially stigmatising and so add to their distress and poor self-image.

11.36 This Operational Review recognizes the realities of these situations and it must be appreciated that there are young people who, despite the very best endeavour of staff to help them with their self-harming behaviour by recourse to other means, do find themselves in situations where there appears to be no reasonable alternative to this course of action. In these difficult circumstances staff will require good practice guidance and support to help them assess the situation and more confidently explore alternative management strategies and approaches.

11.37 However, the fact remains that in the local authority secure sector it has not been found necessary to resort to the use of such 'safer' clothing. There are differences between the two sectors in terms of staffing levels and it is always difficult to say that the young people accommodated in such sectors represent equivalent levels of difficulty although it is generally accepted that LASCHs do care and contain some very seriously disturbed young people. YOIs also receive disturbed young people who are deemed unsuitable for LASCHs. But there is a view that difference is more likely to lie in the approach and culture of the two sectors. The YOI has the task of balancing the special needs of a small, but very demanding, group of young people against the general and more diverse needs of a very much larger group. The LASCH can focus their management sharply on the needs of a small group of young people who broadly present similar sets of needs for welfare, care, treatment and control. Accepting these differences, it would still seem useful to continue to encourage cross-fertilisation of ideas and practices between the two sectors.

Best and Safe practice

11.38 This Operational Review has noted that the Prison Service has developed new draft guidance on this subject to be attached to a revised version of PSO 2700 due for publication in 2005. This new guidance should be very valuable to staff and assist them with the management of very vulnerable young prisoners. The main messages from that draft guidance are

set out in the following paragraphs as they demonstrate good practice and reinforce what appears to be the resolve in the Prison Service to ensure that the dignity and welfare of young prisoners is safeguarded wherever and whenever possible.

11.39 It is important to note that this draft guidance has yet to be distributed for wider consultation, nor has it been through the Prison Service Operational Policy Group for approval. It should therefore be noted that the final published version may differ from the outline provided in this Review.

Alternatives to the removal of clothing

11.40 The Prison Service recognizes that the removal of clothing can only be considered as a short term preventative measure to manage the immediate threat of a self-harming episode. It does not address the underlying causes for the behaviour and this work should continue through care planning under the auspices of F2052SH. The draft guidance presents a range of strategies that the care planners may wish to consider that alleviate the need to remove normal clothing. In essence these proposals are based on ideas that actively engage the young person in the management of their own self-harming behaviour or allow for an environment that will be experienced as supportive and 'therapeutic' rather than demeaning.

11.41 The following alternative strategies are suggested in the draft guidance. They are not mutually exclusive and elements of most may feature in the care plans for the most vulnerable young people:

- Increase levels of staffing interaction and observation;
- Provide constant observation of the young prisoner in the most serious cases. This should be undertaken in accordance with guidance about authorisation and medical oversight. A case review should be held within four hours and at similar intervals during the working day;

- Use a safer cell as this may reduce the need for protective clothing as ligature points have been removed. But be alert to the possibility of self-strangulation;
- Devise protocols for checking that clothing has not been tampered with;
- Use CCTV. CCTV is an aid to staff supervision, not an alternative. There should be a local protocol to guide staff in the use of this aid;

- Consider placing in shared accommodation;
- Provide activities to encourage and engage the young prisoner e.g. in-cell TV and other creative activities/past-times;
- Help young person with more time out of cell;

- Utilise available therapeutic resources;
- Consider admission to the Health Care Centre;
- Seek professional help for those young people with drug or alcohol misuse problems;

- Provide practical help with problems;
- Increase use of peer supporters;
- Involve Chaplaincy;
- Involve external sources of support, including family, Samaritans and external agencies.

Initial decisions to remove normal clothing

11.42 The draft guidance reinforces the advice that the removal of clothing should be considered a last option in caring for vulnerable young people. In coming to that decision staff will need to make a judgement about whether the level of current presenting risk and knowledge about the young person's past history of self-harming suggest that clothing will play a significant part in any potential self-harm attempt. Staff may wish to consider the following factors:

- Is the young person going through a period of crisis?
- Has there been a significant event that has triggered the episode?
- Is the young person depressed or anxious?
- Is their behaviour unusual?
- Is the young person saying that they are going to self-harm or wish to die?
- Do they have a specific plan to self-harm?

- Has the young person self-harmed using clothing before?
- Are the current circumstances similar to earlier episodes?
- Is the pattern of self-harm worsening?
- Are incidents becoming more frequent or methods more dangerous?

Protecting Trainees' rights

11.43 A strong theme that runs through the draft guidance and is commended relates to the acceptance that the removal of normal clothing is a last option within any self-harm management plan. The draft guidance encourages staff to consider how the activities of the trainee can be normalized, but there are strong strictures about ensuring that trainees are not seen to be dressed in protective clothing when being moved about the YOI or on association. In these situations young people should be given the opportunity to change back into normal clothing, but additional staff supervision or escorting may be required.

11.44 In some circumstances prisoners will object to the wearing of protective clothing and will not cooperate. The draft guidance sets out the grounds for requiring the change of clothing by using authorized force, but stresses that this should be an absolute last resort, the justification for which must be proven to be necessary to prevent death. This action must be endorsed by the Governor and health care staff and clearly documented.

Reviewing the use of Protective Clothing

11.45 The draft guidance sets out the requirement for the circumstances to be reviewed at highly frequent and regular intervals. This requirement aims to protect the welfare of the individual prisoner and to use this exceptional mode of protective intervention in place for the minimum time possible. The draft guidance sets out the following agenda for review meetings:

- Consider how many hours each day, or night, the trainee should spend in protective clothing;
- What alternatives there are to protective clothing?
- How and when will the trainee be returned to normal clothing?
- Determine level and frequency of observation;
- Assess the trainee's behaviour;
- Assess the effect that wearing the protective clothing is having on the trainee.

Quality Assurance

11.46 The use 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. This should be achieved through the institution of regular sampling exercises by the YJB Performance Monitor.

CHAPTER 12

TRAINING MATTERS

12.1 Training for the *Asset* Assessment framework

12.1.1 This Operational Review has taken note of a number of training initiatives and developments that have been promoted by the YJB during 2004. These initiatives have been conducted within the YJB's National Qualifications Framework that provides youth justice services with a range of staff training and developmental tools to support better practice. A new qualification, the **Professional Certificate in Effective Practice (Youth Justice)**, is a higher education qualification for a broad range of youth justice workers that can be completed in nine months whilst remaining at their posts. The YJB has set itself a target of 80% of youth justice practitioners having achieved this award by 2006.

12.1.2 Module 1 of the programme is devoted to training in the understanding and completion of the ***Asset*** framework, with a strong emphasis on working with and managing risk. The YJB has also developed some new shorter skills enhancement programmes know as **Effective Practice In-Service Training** (INSET). These programmes have been available to Yots since June 2004 and cover each of the 15 Key **Elements of Effective Practice** (KEEP) subject areas. The YJB has indicated that it would like to see the INSET on training in *Asset* given some priority and so has, as a condition of funding, required Regional Human Resources (HR) Consortia to prioritise this programme from April 2004 so as to ensure that all staff can undertake detailed training in *Asset* based on local need.

12.1.3 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.

12.1.4 It has been noted that the planned INSET training on ***Asset*** takes between one to three days and concentrates on the completion of the core ***Asset*** and the importance of early identification of risk. The programme seeks to help staff feel more confident with their assessments of risk and underlines the importance of sharing information on risk with the young people and their families. To this needs to be added training on working with other agencies and coordinating bodies, such as the Multi Agency Public Protection Arrangements (MAPPA) or ACPC (to become the Local Safeguarding Children's Board in 2006), to highlight risk management approaches adopted

by those agencies that could link with the work of youth justice services. Experience also suggests that some additional force might well be included in the training programme related to seeing the ***Asset*** assessment as a 'living' document that is ongoing and should be open to constant updating and not just at the stipulated review intervals. This area will be covered in the risk training materials that are currently being finalised and which are to be rolled out to practitioners by the end of April 2005.

12.1.5 This Operational Review welcomes the training initiatives that the YJB has planned and resourced. They are closely linked with the important developmental work on the management of risk instigated by the YJB and the need to respond positively to changes in the external world of children's services with its strong emphasis on even greater and closer inter-agency working.

12.2 Juvenile Awareness Staff Programme (JASP)

12.2.1 The **Child Protection and Safeguards Review 2003** concluded that the Prison Service should commission a comprehensive analysis of training needs specifically of those staff working with juveniles. The Review found that the degree of safeguarding and child-focus across the YOI estate was very varied. In general, juvenile-only YOIs appeared to have an enormous advantage over spilt sites in managing children's safeguarding. Although some split sites were more successful than others, split sites were more likely to evidence:

- Lack of child specific policies
- Lack of staff trained specifically in the care of vulnerable children
- Inability to achieve a child-centred philosophy and regime where a 'whole prison' philosophy is pursued
- Cross deployment of staff between adult and juvenile sections of the YOI
- Targets and standards of practice more designed for adults.

12.2.2 One important way to address this was through the development of specialised training in safeguarding and vulnerability alongside action to bring about cultural change through management initiatives and regime design. The review recommended that the Prison Service and YJB should develop a comprehensive modular child protection and safeguards training package that would build on the recently revised Prison Officer Entry Level Training (POELT) scheme for staff working with under-18 year olds. The package of modules should cover:

- Self-Harm and suicide prevention
- Anti-bullying and anti-social behaviour
- Anti-discrimination and diversity
- Prevention of harm from other young people
- Prevention of harm from staff and other adults
- Investigations of significant harm.

12.2.3 This Operational Review strongly supports the commissioning of the training needs analysis and the development of the proposed safeguarding training package. It is anticipated that a positive input to this training development will be provided by the new group of social workers appointed under the safeguarding initiative. These staff should be able to provide an invaluable resource of child protection knowledge and information about local contacts and services.

12.2.4 It is understood that current Prison Service recruitment policies and processes do not necessarily give Governors the fullest flexibility to interview potential Prison Officers to determine their suitability for working with juveniles, a demanding and specialised aspect of prison work. It has been argued, with some force, that the key to the success and effectiveness of any safeguarding strategy is the availability of a workforce specifically selected to meet the requirements of the young people in the YOI's care. These features are clearly reflected in the wording, guidance and instruction provided by PSO 4950. It has not been within the remit of this Operational Review to examine and comment upon recruitment issues. Suffice it to say that well-designed and focussed training programmes will be that much more effective if targeted at staff who have been chosen, from the outset, by a process that seeks to establish their suitability for the specific job in hand.

12.2.5 The **Juvenile Awareness Staff Programme** (JASP) is a new development for YOI staff. JASP is a two week modular training package that has been developed for staff in the secure juvenile YOI estate. This Operational Review is remitted to comment on the JASP training programme for **Vulnerability Assessment**. This is a very focussed course based on 12 sessions that are programmed to be delivered by a trainer over a 7 day period; an initial 3 day course followed by a further 4 day period.

12.2.6 The ground covered by the Vulnerability Assessment module appears very appropriate to the task and the curriculum picks up on many of the training and preparation issues highlighted by this Operational Review, namely the importance of understanding the ***Asset*** assessment, understanding about vulnerability, pre-sentence reporting and prisoner escort reports, and completion of the T1:V and T1:VR forms. The training adopts a very practical approach to the subject matter and majors on techniques that should be adopted to obtain the clearest information from documentation and from the young person through interviews.

12.2.7 If there is any criticism to be made of this scheme is that it more time should be allocated to its delivery. With the changes in the understanding of vulnerability reported by the Operational Review in earlier chapters, more time could be allotted to a discussion of this topic, prior to the application exercises with the T1:V procedures

12.3 Training in Suicide Prevention

12.3.1 The guidance manual **Suicide Prevention Strategies** reinforces the need for suicide prevention training to be developed as an important part of

each YOI's local suicide and self-harm prevention strategy. The Prison Service provides a comprehensive range of suicide prevention training programmes. The programmes assume that all training should reflect the importance of involving and working with different disciplines and recognize that all staff, and not solely health care staff, have an ability to engage with and assist young people at risk of self-harm and suicide. The role of Samaritans and Listeners forms part of such training; it is promoted as good practice to actively involve Samaritans and Listeners themselves in the delivery of the programme. However, the Listener programme is not considered appropriate for juvenile trainees.

12.3.2 At entry to the service, all new officers are given the opportunity to undertake suicide prevention training and so acquire the values and attitudes required in this important area of work. In this training the emphasis is on the 'duty of care' owed to all prisoners, underpinned by the service's core values and the importance of the officer/prisoner relationship in generating a supportive culture. The guidance recommends that the core module for the training **'Caring for prisoners at risk of self-harm and suicide'** is delivered by local suicide prevention trainers to all staff, including specialist health professionals and contract staff such as teachers, who have a direct contact with young trainees. The guidance also emphasises the need for night duty staff to be included in all training initiatives in this area of work.

12.3.3 The training also includes practical advice about the response to, and management of, suicide attempts. This action is detailed at Annex C of PSO 2700. Staff are provided with specific training in First Aid that encompasses this advice including training in the cutting down of those who have attempted suicide and are suspended by a ligature. These training arrangements are of vital importance and the guidance **Suicide Prevention Strategy** advises that establishments also consider the institution of refresher training in suicide prevention and relate these more closely to the experience and incidence of self-harm and suicide at the individual YOI.

Safer Custody and Self-Harm Toolkit

12.3.4 As noted earlier [at paragraph 10.12], the Self-Harm Toolkit provides comprehensive guidance on self-harm and suicide. Published by the Safer Custody Group in September 2004, the Toolkit is available in CD Rom format and on the Prison Service intranet. The Self-Harm Tool kit brings together all relevant information and guidance on best practice and also includes a training package **'Understanding Self-Harm'** that can be delivered by non-specialist trainers or used by individuals. This is an excellent new resource that will assist understanding of this complex area of practice.

CHAPTER 13

TOWARDS GREATER EFFECTIVENESS

Quality Assurance in the Secure Estate

13.1 This Operational Review has looked in considerable detail at the operational procedures and practices that have developed within the secure juvenile estate, with a particular focus on YOIs, to ensure that the quality of life for young people is the best that it can be given in the abnormal circumstances represented by detention in custody. In particular, the review has examined closely the arrangements for safeguarding children and young people, and for their special protection and care when they threaten to indulge in very risky behaviour and self-harm. But how do we know whether any of this will work or prove as effective or safe in actual practice as the procedures might suggest?

13.2 In the course of this examination, attention has been drawn to the checks that have been built into the operational procedures and the line management arrangements; and to the balances that are provided by reporting and monitoring arrangements. Where there is full compliance with these requirements in both management and practice, these arrangements should be adequate to secure optimum performance given the availability of adequate and appropriate resources. But we know that in everyday practice such an ideal world is difficult to achieve, particularly in such a demanding field as youth justice and in such complex settings as YOIs and the rest of the secure juvenile estate. It is therefore important to develop mechanisms for assessing how effective performance really is, or not, and how far there is to travel before full confidence in the quality of performance can be assured.

13.3 The development of an active programme of quality assurance within the secure juvenile estate is essential if progress towards the achievement of the YJB's aspirations and targets for the estate is to be achieved. It is very encouraging to see the amount of work that has already been developed in this area, particularly in the past year or so. Good quality assurance programmes are not just about counting numbers or assessing indicators, but should be interactive and provide material with which the organisation can learn about itself and how it might perform better and more effectively.

13.4 The outputs from quality assurance programmes should impact on any cultural obstacles and non-compliance issues that appear to be inhibiting change and improvement. Quality assurance outputs can also inform arguments about resources and the impact that an assessed resource shortfall can have on the quality of work, in both the short and long term. Quality assurance has also a great deal to contribute to ensuring the welfare of individual young people, by setting goals for their achievements, dealing with their complaints, monitoring their periods of stress and seeking their views, for instance, about their feelings of safety.

13.5 This Chapter of the Operational review reports on two major aspects of the Quality Assurance arrangements for the secure juvenile estate. Both provide an invaluable range of material for organisational learning and development.

- The YJB **Effective Regimes Monitoring Framework**
- The YJB **Serious Incident reporting arrangements**

Effective Regimes

13.6 Over the past year the YJB has sought to develop and introduce an overarching scheme for monitoring and performance managing the secure juvenile estate. This work has resulted in the establishment of the **Effective Regimes** monitoring framework. After some piloting in the latter part of 2003, the framework has been fully operational since July 2004. The framework is designed to monitor all three sectors of the secure juvenile estate and has considerable potential not only for measuring and describing how the secure estate is functioning, but also, by investing in appropriate means for feedback and interaction between commissioners and providers, for bringing about improvements in the quality and effectiveness of the services provided to young people.

13.7 The **Effective Regimes** framework brings together a range of monitoring and performance measures already present in the secure estate. The framework is underpinned by sets of published standards including the National Standards for Youth Justice Service, the National Specification for Learning and Skills and the National Specification for Substance Misuse, together with provision-based standards such as those promulgated by the Prison Service and national minimum standards for Children's Homes. These standards are also enshrined in contracts or service level agreements with providers.

13.8 The **Effective Regimes** framework also incorporates pointers to best practice provided by the **Key Elements of Effective Practice** set of guidance booklets that create their own quality assurance framework.

Secure Estate Performance Measures

13.9 The YJB, in exercising its statutory responsibility for advising the Home Secretary on the operation of the youth justice system, has put in place a performance management framework that both shapes the work of the youth justice system and measures its effectiveness in preventing and reducing offending by children and young people. It is noted that these performance management arrangements have been commended by the Audit Commission in their report **"Youth Justice, 2004".** There are 14 performance measures for Youth Offending Teams and there are eight performance measures for the secure estate.[see Annex 5].

13.10 The YJB reports that the performance measurement approach has taken longer to bed into the practice of secure estate service providers and it has only been since 2003 that regular reporting against the measures commenced. New contractual arrangements with local authorities and the service level agreement with the Prison Service have ensured that arrangements are now firmly in place for consistent reporting and for practice to be driven by performance measures. The YJB report that more has yet to be done to ensure a similar level of embedding within the STCs.

13.11 The YJB aspires to use the set of performance measures in order to drive up the quality of outcomes for the lives of the young people. It does not want them to be seen just as a set of percentage indicators. This requires a high level of interaction between providers and the YJB as commissioners. Independent mechanisms including research and inspection also need to be utilised to provide more detailed qualitative information about reported performance. It is, for instance, very interesting and important to note that **Performance Measure 8: Safety** is assessed on an annual basis by a questionnaire-based survey conducted by HM Inspectorate of Prisons.

Monitoring and compliance

13.12 As noted in earlier chapters of this Operational Review the secure estate has established a wide range of monitoring obligations, especially with respect to safeguarding and the management of risk. These monitoring responsibilities are now encompassed within the **Effective Regimes** monitoring framework and this should, over time, provide a more comprehensive and more fully informed view of the performance of individual YOIs or other secure establishments, or the estate as a whole.

13.13 The **Child Protection and Safeguards Review 2003** recommended that the Prison Service develop a juvenile-specific Child Protection and Safeguards monitoring framework, gathering together data that is mostly already collected, but in a more integrated format that can be interrogated for improved practice purposes. This would provide a very useful tool in the hands of YOI Safeguards Managers. The review proposed that the set of monitored items should include:

- Reports of self-harm, attempted suicides and suicides
- Incidents of harm sustained from another young person
- Incidents of racial harassment
- Incidents of harm from staff or other adults
- Number and analysis of child protection referrals to local authorities
- Incidents of control and restraint

This set of monitored indicators is now included in the **Effective Regimes** framework.

13.14 Ensuring compliance is an issue for all complex businesses and the development of the **Effective Regimes** framework should offer a new

opportunity to address this issue in circumstances where a consistent pattern of monitoring and reporting suggests some under-performance. The monitoring framework provides an opportunity to ask questions and seek reasons for performance issues and to identify remedies. The **Effective Regimes** framework requires monthly reporting, with serious matters being specifically identified by exception reporting. The scheme provides feedback in the form of a monthly report to regional YJB management and this operates on the basis of the 'traffic lights' approach to assessment of individual item and overall performance.

13.15 As has been noted, the **Effective Regimes** monitoring framework is still in the very early stages of implementation. The assessment of its own effectiveness and potency to achieve its intended goals of raising quality standards in provision, and by so doing raise the quality of life and improve the safeguarding of young people, will only be judged in future years. But the approach clearly has great potential, and as long as the incipient threat of over-bureaucratisation of such a complex framework can be resisted, the management of the secure juvenile estate should benefit.

Learning from Serious Incidents

13.16 As the investigations into the circumstances of the death of Joseph Scholes and this consequent Operational Review of effectiveness and safeguarding exemplifies, it is helpful to examine in some depth these serious incidents so that lessons can be learnt, both for the present and for future practice. These lessons can have impact at both local and national level. They are an important element in the frame-work for keeping the system under close scrutiny, although the circumstances in which Serious Incident Reviews become necessary are challenging and often demand skilled management and handling.

13.17 Since its inception, the YJB has always had in place arrangements for undertaking Serious Incident Reviews (SIRs). The original guidance was issued in 2001 and this was the procedure by which the death of Joseph Scholes was reviewed (see paragraph 2.2). That guidance has now been revised in the light of changes to both the manner in which serious incidents are investigated and the need to align the YJB's procedures with other case review mechanisms. A revised version of the guidance was published in July 2005.

13.18 The YJB categorises serious incidents that are subject to the SIR process as follows:

- the death of a young person who is in a secure facility placement commissioned by the YJB;

- the attempted suicide of a young person who is under community supervision by a Youth Offending Team or other YJB-supported project, where the event is assessed as life-threatening;

- a grave allegation of, or conviction for: murder, attempted murder or serious sexual assault by a young person either in a secure facility or in the community while subject to a criminal court order.

13.19 These are by their nature rare occurrences, but they raise important issues of public confidence in the capacity of the youth justice system to protect young people and the community. In the period March 2003 until early April 2004 there were 26 Local Management Reviews completed, including one death in custody and nine in the community, due in some cases to drug overdose or fatal motor vehicle accidents. About half of the SIRs related to young people who were alleged to have committed, or had committed, very serious offences against people, including 12 young people charged with murder or assault and three with rape.

13.20 On 1 April 2004 the responsibility for the investigation of deaths involving young people in YOI custody became the responsibility of the Prison and Probation Ombudsman. In the near future the Prison and Probation Ombudsman's remit is to be extended to encompass fatal incidents in STCs. The revised SIR procedural guidance recognises this and also sets out to coordinate investigations carried out under these auspices with those established for Child Protection under Chapter 8 of *Working Together to Safeguard Children, 1999* and the Commission for Social Care Inspection (CSCI).

13.21 The revised SIR process retains the two-tiered approach with Local Management Reports (LMRs) being required on all incidents and Serious Incident Reviews being commissioned, where the death of a young person occurs in custody or, at the discretion of the YJB Chief Executive, where a young person commits a particularly serious offence whilst on an Intensive Surveillance and Supervision Programme (ISSP). These SIRs will also be prepared to inform any parallel ACPC Chapter 8 case review, CSCI inspection or Prisons and Probation Service Ombudsman's enquiry.

13.22 The Serious Incident Review manager based at YJB Headquarters oversees the SIR process for the YJB. The SIR process is supported by clear procedural and good practice guidance that spells out how and when investigations are to be conducted and how they are to be handled within the YJB line management arrangements. Strict timescales have been inserted into the process and these reflect the urgency and importance of the investigations. Local Yot managers have 20 days in which to complete an LMR and submit it to the YJB regional manager and the YJB's Serious Incident Review manager. A further 20 days is allowed for the completion of an SIR if the incident falls into the respective category. In the event of a death in custody, this timescale does not apply. At the end of this process a final report with recommendations is presented to the YJB.

13.23 The revised SIR process includes a model format for the preparation of reports based on experience of the former process. The procedures are also posted as the **Serious Incident Management Pack** on the YJB website. This practice is commended. The decision to align the SIR processes with other

review frameworks is a sound and welcome move. In respect of alignment with Chapter 8 procedures, whereby the LMR or SIR can be treated as an individual agency management review, it may be helpful to directly draw the YJB reviewer's attention to the model analytical framework for such reviews as set out in the guidance. This would facilitate the preparation of the Chapter 8 Overview report. (see ***Working Together to Safeguard Children, 1999***, paragraphs 8.20 to 8.24).

CHAPTER 14

SUMMARY OF KEY ISSUES

CONCLUSIONS AND RECOMMENDATIONS

Preamble

This Operational Review has provided an opportunity to look in some detail at matters of safeguarding and the management of risk as highlighted by the Investigations into the death of Joseph Scholes at Stoke Heath YOI in March 2002. Since that time the YJB and the Prison Service have actively sought to address those issues within a much broader programme of work aimed at bringing greater effectiveness and safety to the treatment of young people in the YOI sector of the secure juvenile estate. That work, particularly that related to the care and protection of vulnerable children and young people who may self-harm or threaten suicide, has been described and assessed by this Operational Review.

Overall, the primary conclusion of the Operational Review is that the YJB and the Prison Service, through the work of the Safer Custody Group and the Juvenile Group, have developed a set of policies and procedures that focus directly on the issues and have the potential capacity to deliver a more effective and, most importantly, a safer service. Clearly the manner in which these policies and procedures are implemented and resourced will remain at the core of concerns about the safety, or otherwise, of the YOI experience for young people. The policies and procedures examined would appear to support the drive towards safer YOI communities and more satisfactory outcomes for the young people as a result of their experience, but it is also clear that many adverse factors, both cultural and operational, still retain the capacity to thwart best intentions and inhibit best practice.

So it is important to again stress the key part that both quality control, through compliance and active management, and quality assurance - through inspection, monitoring and active learning, must play in ensuring that the safeguarding framework is fully implemented and embedded in the work of the Yot and the YOI. Procedures of themselves do not take you very far. It is also important to develop a workforce that is dedicated to their underlying philosophy of care in custody and committed to the task of ensuring that the welfare of the young person is paramount. It was very encouraging to note such a level of commitment by staff at the two YOIs visited as part of this Operational Review. This offers the possibility of eventually securing the safeguarding objectives for the YOI estate expressed by the YJB and the Prison Service.

The following summaries of the various issues examined by the Operational Review are referenced back to the main themes that arose from the investigations into the death of Joseph Scholes, as set out in Chapter 3, and to other aspects of the terms of reference of this Review. In the course of the

Operational Review a broader approach was taken to some matters and these are also summarized here. [Recommendations for future development and improvement have been underlined].

14.1 Appropriateness of Placement

All of the Investigations into the circumstances of the death in custody of Joseph Scholes concluded that young men who presented his level of risk are not appropriately placed in YOIs and that every effort should be made to secure their placement in a Local Authority Children's Home. There should be consideration of the development of discrete facilities within the YOI sector for young people demonstrably at risk of self-harm or suicide.

- The YJB has drafted an overall strategy that emphasises the importance of reducing reliance on custody and reducing the number of secure places commissioned, by the development of more intensive and effective punishments in the community.

- There are marked differences between the three types of provision - YOI, STC and LASCH - that comprise the secure juvenile estate and an understanding of these differences is key to determining a placement policy.

- A contemporary assessment of the level of demand for places for those children and young people identified as 'vulnerable' still indicates that there are, and will continue to be for the foreseeable future, insufficient places for such children outside the YOI sector. **This remains a situation of concern.**

- 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.

- The YJB is committed to placing children and young people in a secure establishment that can most effectively manage their identified needs and risk factors identified by Yots and make decisions based on the best 'fit' between the vulnerability of the young person, the availability of places within the three sectors and the needs of other young people already placed. The YJB is committed to placing all boys under 15 and girls under 17 in the LASCH and STC sectors.

- The YJB has recently published for consultation its strategic vision for the secure juvenile estate for the next three years. The YJB accepts that it will take some time to achieve this vision and much will depend on sentencing trends and the level of funding available to the juvenile offender sector.

- 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'.

- The YJB is also exploring alternatives to full security, including the possibility of extending the quantity of open YOI accommodation (currently and the provision of units with a secure perimeter only.

- The YJB has restated its commitment to maintaining a strategic safeguarding policy for the YOI estate.

14.2 Quality of Assessment Work and the Management of Risk

All the Investigations concluded that, by one means or another, the court considering Joseph's sentence had received explicit advice about his vulnerability, his history of self-harm and attempted suicide. Comparison was drawn between the quality of the pre-sentence report and the Asset assessment, the latter being considered incomplete and lacking in supporting evidence.

The effective use of *Asset*

- This Operational Review strongly supports the YJB's belief that planning action and services to meet the needs of children and young people can only proceed on the basis of a comprehensive assessment that takes into account the full extent of the young person's personal circumstances, attitudes and beliefs.

- The ***Asset*** assessment tool provides a structure for recording and analysing a wide range of relevant information. The assessment instrument is designed to look at the young person's offending behaviour and identify the multiple factors or circumstances that may have contributed to that behaviour.

- Whilst there is no doubt that ***Asset*** provides a valuable, well designed and validated assessment framework, as with any instrument of this nature its effectiveness relies heavily on the quality of and relevance of information gathered to inform the assessment, either by interview, case history work or reports sought from other agencies relevant to the young person's life and family, and the skill and judgement of the assessor.

- Although the ***Asset*** assessment tool allows for 'don't know' responses, in all instances information about why there is an information or judgement gap needs to be provided. Unless this is the case then degrees of uncertainly will remain in the minds of those who have cause to utilise the ***Asset*** report to inform their own decisions.

- ❖ Users of ***Asset*** must ensure that judgements are clearly and substantially informed by evidence. This is a matter that needs to be strengthened, perhaps by management action to reinforce the notes of guidance and through professional supervision.

- ❖ The strength of the ***Asset*** approach is that it provides a standardised framework, supported by preparation and training tailored to the approach. At Yot level, different professional disciplines drawn from a balanced agency mix should bring strength to the various components in the assessment process. Sharing expertise and experience across teams should lead to better informed assessments.

- ❖ The Government's proposal under *Every Child Matters* to develop a common assessment framework for children in need provides a further opportunity to enhance aspects of the ***Asset*** assessment in collaboration with other agencies.

- ❖ Communicating with children and young people is an area of practice where experience and expertise play an important part and Yot workers should be encouraged to develop their skills. This is especially necessary when working with vulnerable, disadvantaged or disabled children or young people.

Identification and Management of risk

- ❖ New draft YJB guidance *'Managing Risk in the Community'* offers a detailed examination of the management of risk in both a policy and practice context. The guidance is comprehensive in its coverage of matters related to the assessment and management of risk and the preparation and support of Yot staff. The guidance provides sound advice.

- ❖ This Operational Review endorses the approach set out in *'Managing Risk in the Community'* and considers that the publication, implementation and integration of this guidance into Yot practice should represent a major step towards improving the understanding and management of this challenging area of work.

- ❖ The availability of specialised guidance to Yots on the issue of 'vulnerability' would be beneficial. *'Managing Risk in the Community'* suggests a graduated approach to defining different levels of vulnerability.

- ❖ This Operational Review considers that the suggested categorisation has merit. It helps to 'unpack' the concept of risk and allows differential approaches and interventions to be thought about and adopted.

- ❖ *'Managing Risk in the Community'* builds on the current guidance on vulnerability in the ***Asset*** framework and provides well-informed advice

geared directly to the various judicial and practice processes undertaken by Yot Teams.

- In recent years much progress has been made in enjoining agencies, particularly in the field of safeguarding children and young people, to share information on an open and confident basis. The Yot has played a full part in this. It is appreciated, however, that some obstacles still remain, particularly with respect to the interface with mental health services and psychiatry and how information from those sources is handled within Yots.

- The Government, through the Children Act 2004, is committed to the creation of an integrated set of services for children and young people and an important part of that resolve is to engineer a shared information base about children. This resolve should provide leverage to assist the YJB and Yots overcome any residual problems with Information exchange.

14.3 Placement of children and young people at High Risk in the Secure Estate

All the Investigations closely examined the operations of the YJB Placements Team. There was a generally agreed conclusion that, accepting the complexity of the team's task and the difficulties inherent in managing three sectors with differential levels of availability, more clarity needed to be introduced into the placement arrangements. Issues concerning the quality and transmission of information, and the arrangements for transfer between placements were also highlighted.

Review of the YJB Placement function

- In December 2003 the YJB commissioned an Independent Review of the placement function and work of the Placements Team. The aim of the independent review was to assess the robustness of placement procedures and practice, so as to ensure that decisions made by the Placements Team maximised the safeguarding of young people at highest risk.

- The Independent Review recognised the difficulty of the team's work and concluded that, although the team were able to demonstrate some considerable achievements, a range of operational factors remained that inhibited maximum effectiveness. These factors included processes for the transfer of information, an under-developed computer based information retention and retrieval system, and the continued use of unreliable Fax.

- The Independent reviewer was unable to affirm confidence in the ability of the Placements Team to make effective and informed judgements

about placement decisions, due primarily to the lack of information of an acceptable quality supporting requests for placements. The system of Vulnerability Alerts operating at that time also captured too many children and young people; the system failed to sufficiently discriminate and identify those children most at risk.

- Positive action has now been taken by the YJB to address issues raised by the Independent Review and the investigations into the death of Joseph Scholes.

- This Operational Review is pleased to conclude that the YJB Placements Team has demonstrated a very responsive approach to the need to create a service environment that protects both the young people and the public interest. The Placements Team deals with a high volume of work on a daily basis in terms of the numbers of placements that need to be negotiated. These also present qualitative challenges in terms of the complexity of judgements and the management of a constantly moving and changing balance between demand and supply.

Current Placement arrangements

- The YJB has now revised the **YJB Placements Protocol.** This gives prominence to issues of vulnerability and risk. The protocol now provides clearer guidance on the placement process and the information required to make a well-informed placement decision. The revised protocol has strong child-focus and safeguarding threads running through it.

- The **Placements Protocol** clearly sets out arrangements and requirements for the safeguarding of vulnerable young people on their admission to a YOI and the processes by which transfers of young people between establishments can be achieved.

- Applications for places now use the new **YJB Placement Alert Form**. This form travels with very clear and informative guide-notes that set out procedures to be followed for the different categories of young person. The new application form is a marked improvement on the earlier format and should provide Placements Team caseworkers with better quality and fuller information about the young person and their placement needs.

- As a consequence of the Joseph Scholes investigations, both the new form and supporting guidance notes ask the Yot to specify their preferred sector for the young person's placement and provide information about placement policy in the three sectors. There is also now added emphasis on the provision of quality information by the Yot concerning vulnerability and the assessment of risk.

Priority Setting

- ❖ Whilst the full completion of the ***Asset*** documentation remains at the heart of the assessment process, the Placements Team need as much supporting evidence as possible if they are to undertake with maximum confidence the task of prioritization of placement of those young people at greatest risk.

- ❖ 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'*. This will bring some congruence to the assessment of risk and facilitate even-playingfield discussions about prioritization between Yot officers and the Placements Team case workers.

- o 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, as described in the body of this review report.

- ❖ 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. This will help overcome tensions on the part of some Yot staff about the nature and impact of placement in custody for young people and concerns about regimes at some YOIs. It is important that Yot staff are provided with good quality and contemporary information about positive developments within the YOI estate.

Review and transfer between placements

- ❖ The **Placement Protocol** now requires the Placements Team caseworker to review, within three working days, all placements where an alert has been sent. If sufficient concerns about suitability of placement are identified a move of placement would be considered. In all cases the placement caseworker will continue to monitor all placements of young people considered to be at most risk when placed in a YOI.

- ❖ Lessons from the Investigations of Joseph Scholes' death point to the necessity of Yots making it clear at the earliest possible stage that, following what they may consider an inappropriate placement of a young person in a YOI, they will be seeking an alternative bed in a LASCH and preparing a case for transfer immediately post sentence.

- The **Placements Protocol** confirms that it is possible for young people to be transferred across the secure estate depending on their circumstances and, in some instances, the needs of the estate.

- In the case of planned transfers, emergency transfers and transfers following placement review, 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.

- 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.

14.4 Reception of young people into YOIs

The Investigations into Joseph Scholes' death concluded that at his admission all reception procedures in force at that time were carried out satisfactorily and that Joseph received a high level of care and attention. However, all four Investigations expressed reservation and uncertainty about the robustness of the transmission of information between the Yot and the YOI; in particular the timely availability of his psychiatric history.

Revised framework for reception into a YOI

- As a result of the developmental work that has taken place within the YJB and Prison Service over the past two years, a revised **Prison Service Order PSO 4950** was issued in September 2004. The revised PSO seeks to promote improved practices and procedures in the field of reception into custody and initial assessment.

- The procedural framework and best practice guidance examined in the course of this Operational Review in respect to the provision of safe and responsive reception arrangements would appear generally satisfactory and appropriate to the task. The YJB and the Prison Service have clearly recognised that the experience of admission is a crucial one for young people and that all should be done to make that a safe and supportive experience. There remain, however, some

features of the current arrangements that work to inhibit best performance.

Collection and handling of Information

- PSO 4950 now requires Governors to ensure that they have a system in place for recording the receipt of key documents related to the reception of the young person.

- Each YOI is required to put in place arrangements for informing the YJB of any missing documentation and for ensuring that this is received as soon as possible. The YJB/Prison Service service level agreement sets a one-hour time limit (or 9.a.m. next working day if out of hours) for alerting the local Yot to missing ***Asset*** or Pre-Sentence Reports. If these reports have not been received within 24 hours then the YJB is to be informed.

- 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.

- For those young people whose documentation is missing or is so incomplete that it gives rise to well-placed uncertainty about the level of risk of a young person, then PSO 4950 requires that the young person be managed as 'vulnerable'.

- Decisions about the most appropriate first night placement of young people in this situation are based on what limited information might be available, a health care screening, the completion of form **T1:V, Initial Custodial Reception Assessment** and the cell-sharing risk assessment. The PSO guidance notes also advise, wisely, that all staff should be made aware of this status and be asked to give increased supervision and support to the young person, particularly in the first few days.

- The Investigations into the death of Joseph Scholes suggested that, at that time, there were variations in the quality and extent of information available to staff at YOIs on reception. and that it is important to obtain as full a picture as necessary at the earliest possible point. If the proposal to require Yots to support their completion of the ***Asset*** assessment with contributing evidence is followed then it makes sense that this material should also travel with the young person.

- Within the limits imposed on the remit of this Operational Review to directly examine practice on the ground, it would appear that the 'fail-safe' arrangements are working in a satisfactory way and that information is now being received more consistently. But there remains much room for improvement.

- In future, the introduction of secure email for the transfer of information should ensure that relevant information, if available, is accessible. Suitable flagging arrangements might be included in the system that could quickly signal non-receipt. However, there will still remain quality and interpretation issues and these will only be addressed through improved skills and awareness on the part of Yot staff.

Initial health Assessments and Screening for Risk

- PSO 4950 requires that every young person is screened on the day of arrival to ensure their safety and to identify any immediate health needs. This screening must include an assessment by a member of the YOI health care team of the likelihood that the young person would harm themselves and a further in-depth assessment of the young person's physical, mental health and substance-misuse history. For young women the screening must also include consideration of any sanitary, child care or pregnancy issues.

- PSO 4950 requires the provision of 24 hour health care facilities at all YOIs that receive young people directly from court. All young people must be medically examined and assessed by a qualified nurse or doctor within 24 hours of their reception and this assessment must include an assessment of mental health needs and substance abuse.

- Following this assessment a Health Care Plan for each young person must be prepared and arrangements made to provide appropriate treatment and medical services. This as an important part of the young person's overall sentence plan.

- The YJB is strongly committed to the provision of this service and has selected this as one of the eight Secure Estate Performance Targets in 2004/5.

- All young people must be interviewed by reception unit staff within one hour of their arrival (two hours in exceptional circumstances) to start the assessment-of-needs process and judge level of vulnerability. At this point, the reception unit or other relevant staff complete the T1:V form.

- <u>Form T1:V is a valuable assessment instrument. Although in some circumstances, where information is missing the judgements made may need to err on the side of caution, the format asks the right type of question with respect to vulnerability and potential victimisation or risk to others.</u>

- The joint **Review of Child Protection and Safeguarding, 2003** recommended that staff receive specific training in the completion of T1;Vs, as well as in broader techniques of assessment. This Operational Review would strongly support that proposal.

- Where a risk of self-harm is identified then appropriate action has to be taken in accordance with **PSO 2700, Suicide and Self-harm Prevention**, to minimise that risk. Reception unit staff are then required to open a form **F2052SH** on the young person. Reception staff should be trained and competent to do this in discussion with health care staff.

- As a consequence of the completion of a F2052SH form, a decision is made as to whether the young person should be located for their first night in the YOI Health Care Centre or on a normal residential unit. This is clearly a matter of professional judgement, but in some circumstances this judgement may be conditioned by the availability of vacant beds in the Health Care Centre.

First night and initial support arrangements

- The YJB has recognised that this initial experience and particularly the first night of a young person's time in custody, is critical to gaining some sense of safety and have taken steps to alleviate as much as possible any feelings of anxiety and uncertainty.

- The YJB has introduced 'first night' packs for all new admissions. This is a very sensible and supportive innovation. The revised PSO 4950 reinforces the advice that night duty staff need to be clearly informed about new young people where there are concerns about vulnerability or the possibility of self-harm. As part of their first night pack, young people are also provided with information about the rules, timetables and facilities at the YOI.

- The revised PSO 4950 provides fuller advice about the approach that needs to be adopted when meeting the mandatory requirements to provide telephone contact, to help young people resolve any immediate problems and to put in place arrangements to make contact with next of kin in respect to visiting and other matters. The advice as drafted is supportive and respects situations where the young people may be in some distress, particularly in relation to their families, including the possibility of concern as young parents about their own children.

Security screening

- The revised PSO 4950 stresses that a full body search remains an essential and important part of the reception procedure, but it must be conducted with consideration and courtesy, and should not be experienced by the young person as undignified or stressful. The advice reinforces this approach by reference to the significance of the

age and level of risk of the young people and the likelihood of them having experienced physical or sexual abuse earlier in their lives.

- For many people, full body searching of young people presents a contentious issue. Yet it has to be recognised that there are genuine security issues to deal with here, including the illicit concealment of drugs or potential weapons, all informed by wider issues of trainee safety and security. The conclusion of this Operational Review is that if the PSO advice is closely and faithfully followed, and full body searching is conducted with due sensitivity, then young people should not experience the practice as unnecessarily abusive or invasive.

Achieving best practice in Reception

- Some YOIs still have to deal with both juvenile and adult admissions to the YOI in the same reception suites. This makes for difficulties in management and inhibits the fullest achievement of the objective of a reception regime dedicated to the needs and interests of juveniles. The YJB should continue with the drive to provide such dedicated facilities.

- It is reported that there are circumstances where young people will arrive late at reception having experienced a long day in court followed by a long journey, both in time and distance, under escort to an unfamiliar destination and YOI. The additional stress for the young person induced by this situation is not difficult to appreciate and requires great sensitivity on the part of reception unit staff if a satisfactory reception process is to be experienced.

- Some of this additional stress would appear to derive from the difficulty in achieving placement of the young person within the 50 miles from home target set by the YJB. Some of it derives from the transport arrangements. Both negative factors will continue to operate whilst the secure estate is under conditions of heavy demand for both remand and DTO places.

- It is noted that for some time now the YJB has sought, with some success, to develop separate arrangements for the escorting of juvenile offenders from court to YOI. This move is welcome and this initiative should continue and lead to the abolition of the conditions reported above.

- The reception at YOI reception units of batches of young people at any one time clearly makes the objective of arranging an ordered and sensitive reception experience for the individual trainee more difficult to achieve. This might also be compounded by having a mix of juvenile and adult trainees to process at the same time. It is appreciated that this situation can only be more effectively managed by the availability of adequate staffing and better arrangements for programming arrivals.

- Reception suites at YOIs experience heavy usage and by young people who are, on occasion, under some considerable stress. It is therefore important that attention is paid to environmental aspects, including the condition of secure rooms and holding cells, and the ambience of the unit. Otherwise the accommodation can give out a message that this is an unsafe place for young people and bodes poorly for their capacity to settle constructively to their period of training.

- 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.

14.5 Care and Sentence Planning

One of the key issues identified by the various investigations into the death of Joseph Scholes related to the arrangements to plan for his stay at the YOI. There were concerns about the organisational arrangements for the planning meeting and its optimum timeliness. Some the investigations recommended that a much shorter time than the YJB National Standard [NSF 10.10] of within 10 working days of admission should now be adopted. The Investigations also expressed concern about arrangements for recording at YOIs

- The revised PSO 4950 reinforces the requirements set out in the earlier 1999 version and place a responsibility on Governors and Yot managers to ensure that each young person's sentence plan, including an Individual Learning Plan, is drawn up within the 10 working days following reception at the YOI. Plans should set specific, measurable, achievable, realistic and time-bounded objectives for each young person and these should inform their daily programme of activity at the YOI. The plan should also look ahead to the young person's resettlement in the community.

- PSO 4950 sets out an appropriate framework for care and sentence planning, and review. Quality issues in respect to the availability of information and assessments about the young person, the quality of recording, and the commitment and presence of relevant people in the process, including the young person and possibly their family, will continue to impact on the effectiveness of the plan and will demand ongoing management attention.

- All of the Investigations recommend that care planning for young people deemed to be at greatest risk should be well within the 10 day maximum limit set by the YJB National Standard. This Operational Review has considered the case for introducing a shorter, say 3-5 day, timescale that would apply to those young people who are adjudged to

be seriously at risk at admission (defined as being subject to F 2052SH status). This should not preclude the proposal that a full initial assessment that focuses on issues of vulnerability takes place within 24 hours as suggested by both the Prison Service Investigation and the YJB Serious Incident Report. This Operational Review supports and recommends such an amendment.

- PSO 4950 requires Governors to establish and develop a personal officer or caseworker system that provides every young person with an advisor with whom they have frequent, purposeful contact that offers opportunities to establish good personal and supportive relationships. Personal officer status carries important responsibilities and arrangements have to be made to ensure that these are achieved.

- The role and function of the personal officer system can be seen to provide a cornerstone to the safeguarding arrangements and the development of the role is vital if more effective and safer regimes are to be delivered.

- Experience of key worker systems elsewhere suggests that there is always merit in one person being given prime responsibility for this role. However, complementing arrangements, including arrangements for working conditioned hours, shift working and holiday absence cover, militate against this in all types of residential provision offering care or custody**.** This Operational Review has considered various solutions to these manning issues, including team-working and various arrangements for deputisation.

- On balance, the strengths of the single responsible officer approach suggest that this policy should be implemented wherever possible. Given the pivotal role of the personal officer in the sentence plan, it should be managerially possible to resolve these matters through forward timetabling and some arrangements for deputisation or pairing where one partner has the lead and the other provides support and cover. This would seem to offer a pragmatic solution to the very real practical problems associated with the one-on-one option.

- Most reviews and enquiries into the quality of public services have identified deficiencies in case-recording and disciplined record-keeping as an aspect of practice that inevitably contributes to less than satisfactory outcomes for service users. This need to bring improvement to the quality of recording is a matter that is recognised by the YJB and Prison Service and calls for management to make arrangements for the provision of suitable ongoing staff training and development programmes.

14.6 Provision of Health Care

Each of the four Investigations into the death of Joseph Scholes concluded that the care and attention given to Joseph by the medical, nursing and YOI staff at the YOI Health Care Centre was of good quality and appropriate to his level of need. There was unanimous criticism of the physical state of the Health Care Centre.

- This Operational Review is pleased to report that the situation in 2004 has been greatly improved with the provision of a new, purpose designed and equipped Health Care Centre. The Health Care Centre now provides first class facilities for health care, including suites for medical and dental examination and consultation and a range of suitable in-patient accommodation (12 beds) for the medical care and treatment of the young people. This accommodation includes suitably designed and equipped cells for the care of very distressed young people.

- The YJB has committed itself to a major enhancement of the quality of health care available to the young people. This has included the provision of funding for 24-hour health care in all YOIs that take children and young people straight from court, and screening arrangements for both physical and mental health. The YJB has also moved to integrate YOI health services into mainstream NHS management arrangements by agreeing the transfer of responsibility for YOI health provision to local Primary Care Trusts (PCTs).

- It is hoped that through these developments young people will experience a high quality of support for their health needs. It is recognised that the population of young people in YOI present higher risk factors in mental health and substance misuse than the general population of their age group. The overall approach to the provision of health care services is one based on multi-disciplinary working.

- Where young people are identified as having significant health needs and are receiving support, either as in-patients or on an out-patient basis, they should have in place a health care plan that is reviewed and discussed weekly by the multi-disciplinary team. Depending on the young person's needs, care planning may include support from specialist medical, mental health or substance misuse staff.

- The Operational Review fully supports the appropriateness of this approach to health care and promotion and, given improved management and resourcing at individual YOIs, considers that the policy should deliver improved services and benefits to the young people.

Mental health

- The current situation gives cause for considerable concern as the number of adolescents in the community who present serious mental health challenges would appear to be increasing and a substantial

proportion of those young people are sent to YOIs. As a greater number of more challenging young people are accommodated, the task of maintaining a safe environment for other young people becomes that much more difficult. The issue is one that bears down on both the level of mental health support that can be appropriately provided by a YOI Health Care Centre and the facilitation of alternative treatment options.

- 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.

14.7 Management of self-harm and suicide in YOIs

Overall, the Investigations into the death of Joseph Scholes concluded that the YOIs suicide awareness strategy was sound and that it was applied with care and attention. The Prison Service Investigation recommended that some tightening of procedures would improve effectiveness.

- PSO 2700 **Suicide and Self-Harm Prevention** provides detailed guidance to Governors at the strategic, managerial and practice levels.

- Although suicide and self-harm policies at YOIs are generally clear and up-to-date, and respond to the requirements of PSO 2700, they are not juvenile-specific. YOIs need to take action to achieve this goal. Such policies and local guidance need to strike a balance between the provision of an overall environment that recognizes and safeguards the potential vulnerability of all young people accommodated and the special needs of those young people identified as most vulnerable.

- Staff at YOIs are reported to have a good basic understanding of the vulnerability of young people, but articulate a need for more training in the assessment and understanding of risk. Most YOIs placed the support role for young people on front-line staff and these staff required a clear support structure and the development of enhanced support and supervision arrangements for staff working with self-harm and suicide.

- In general, the F2052SH Self-Harm procedures are being followed satisfactorily, but there is a recognized need to bring the quality of recording within the format up to a standard that more accurately represents the level of work and support offered to the vulnerable young people.

- Experience suggests that more still needs to be done to highlight issues of good practice in the management of self-harm specific to young people.

- There is some concern that as the number of young people who might be assessed as having some level of vulnerability grows within the juvenile offender population, then the additional obligations imposed on staff by virtue of F2052SH status will become increasingly difficult to meet at a satisfactory level.

- In these circumstances prioritization of staff resources to meet the challenges posed by the most seriously vulnerable young people will almost inevitably weaken the network of care provided for the still not insignificant number of young people who would appear to present less serious concerns.

- This issue can be seriously exacerbated where the YOIs are faced with having to manage one or more extremely seriously disturbed or disruptive young people. The management of these young people is extremely consuming of staff resources, time, energy and emotional commitment.

- Working with young people who are serious self-harmers, staff need to feel that as well as being equipped with as much knowledge and understanding as they need, they are going to receive support and assistance from their colleagues and from specialists. In most cases this will mean access to medical, and especially psychiatric, resources that will help them care for the young people who have health needs with greater confidence.

- It is important that young people who are at risk of self-harm or suicide have easy recourse to confidential support, counselling and advocacy services. This is fully recognised by the Prison Service and, through the Safer Custody Group developmental initiatives, a great deal has been achieved to bring such schemes and facilities into establishments.

- Currently the YJB is working with 13 voluntary agencies who are involved with the development of helplines, to provide an advocacy service to individual YOIs. This development is commended by this Operational Review.

- The Operational review welcomes the phased introduction of ACCT to replace the F2052SH system.

14.8 Accommodation of young people at risk in 'safer' cells

When in the Health Care Centre at Stoke Heath YOI, Joseph Scholes was subject to a prescribed 30 minute observation regime. As Joseph died within 20 minutes of the last recorded observation, the Trafford ACPC Chapter 8 Review recommended that YOIs adopt a 15 minute observation interval where young people are assessed as at serious risk of self-harm and are accommodated in a 'safer' cell. The Chapter 8 Review recommended continuous, direct observation in all other circumstances. The Prison Service Investigation recommended that telephone conversations of trainees under 'at risk' supervision be monitored.

- The Prison Service has set out in **Suicide Prevention Strategies** the policy and good practice guidance in respect to the provision of both unfurnished and 'safer' accommodation. This guidance is clear and supportive, and underwritten by good practice. The guidance concludes that the use of unfurnished cells alone is wholly inappropriate for use with prisoners identified as at risk of suicide or self-harm.

- The management of some very seriously disturbed prisoners can be facilitated by their accommodation in a 'safer' physical setting to enable short term intervention at times of greatest crisis. The 'safer' accommodation is provided to complement a protective and care regime that is directed at understanding and helping the young person. The aim is to provide an environment that reduces stress in the individual and so allows the staff working with them to more fully address their needs and not just the manifestation of their self-harming behaviour.

- It is important to note that no cell can ever be considered entirely 'safe'.

Observation, Supervision and monitoring

- The parameters for **Intermittent observation** set by PSO 2700 already allow for observation at the level suggested by the Trafford ACPC Chapter 8 Review. This specifies that prisoners subject to intermittent supervision should be observed at least five times each hour at irregular intervals. Experience has indicated that deaths have occurred when a prisoner has been aware that checking will be taking place at a regular and predictable interval. <u>This Operational Review supports the retention of current requirements.</u>

- Constant observation is viewed by the Prison Service and the PSO guidance as a measure to be used only in extreme circumstances and with prisoners who present the most acute and critical challenges to their satisfactory care.

- This Operational Review accepts that this is a very difficult policy and practice area. The availability of constant observation for all young people demonstrating acute at-risk behaviour is not feasible beyond its use as a very short term crisis-intervention tool. Without additional resources, the impact on individual staff and on staffing resources and deployment steers away from endorsing the Trafford ACPC proposal. The answer must lie, as with other matters noted elsewhere in this Review, with the development of more imaginative care planning and a wider range of more positive interventions.

- CCTV can be a useful additional tool and, while it has some limitations, its use should be further explored and developed by YOIs. The Safeguards Review recommended that CCTV should be installed in all juvenile YOIs and that a standard set of stringent and consistent protocols should be in place covering its use and the storage of recorded data for evidential purposes. That advice is endorsed by this Operational Review.

- It has not been possible for this Operational Review to come to a clear view about the recommendation that telephone conversations of at-risk young people be monitored. Whilst there is general acceptance that the practice could provide additional and vital information that might better safeguard the young person and assist with their support, there are substantial issues of resourcing and practicability to consider. The proposal may take on more manageable proportions if limited to those young people at-risk and housed in the Health Care Centre and this solution is therefore suggested as a feasible compromise recommendation.

14.9 Use of Protective Clothing

At the Coroner's Inquest into the death of Joseph Scholes the Jury were concerned to learn about the use of protective clothing and recommended a review of the practice.

- The Prison Service accepts that depriving vulnerable prisoners and trainees of items of clothing, and by so doing drawing the attention of others to them in the process, can worsen their distress. It accepts that such practice may make them feel degraded and punished.

- The current policy is that normal clothing, or individual items of clothing or possessions, must not be removed from at-risk prisoners or trainees as a matter of course. Decisions should be taken on a case-by-case basis as a last resort and as necessary for the immediate safety of the trainee, and then only for the shortest time possible.

- When the trainee's normal clothing has been removed, Governors are required to provide the trainee with protective clothing so that they can

be decently dressed [PSO 1600 paragraph. 4.5.1]. This decision has to be made in consultation with a health professional.

- Where it is considered that the young person is at acute risk of taking their own life when wearing normal clothing, then they are required to dress in a 'protective gown'. This is a loose fitting, 'dressing-gown' type of garment worn without underclothing and made from heavy duty flame retardant material.

- The term 'protective clothing' is now considered most appropriate to describe the alternative wear to normal clothing in these circumstances. It is important to note that no garments have yet been found that represent a completely safe and decent alternative to normal clothing. It is understood that the search for a suitable garment continues.

- The protective garment currently in use is not 100% safe. YOI staff demonstrated how the garment could be unpicked at the hem and also exhibited a potential ligature that had been made from a strip of the 'protective' material.

- Accepting that the use of protective clothing is not meant to provide a long-term solution, and noting that operational guidance reinforces its use for the shortest possible time, this Operational Review notes that wearing the clothing is still a mark of 'difference'. Although in many cases the clothing is required to ensure the young person's safety or even survival, it is potentially stigmatising and can add to their distress and poor self-image.

- In these difficult circumstances, staff will require good practice guidance and support to help them assess the situation and more confidently explore alternative management strategies and approaches. The Operational Review commends the Prison Service for developing new draft guidance on this important subject.

- The draft guidance is due for publication in 2005, subject to the satisfactory completion of consultation, in the form of a revised version of PSO 2700. This Operational Review has concluded that the new guidance provides very sound and sensitive advice and should prove very valuable in assisting staff with the management of very vulnerable young people. The draft guidance demonstrates good practice and reinforces what appears to be the resolve in the Prison Service to ensure that the dignity and welfare of young prisoners is safeguarded wherever and whenever possible.

- The draft guidance presents a range of strategies that the care planners may wish to consider that alleviate the need to remove normal clothing. In essence, these proposals are based on ideas that actively engage the young person in the management of their own self-harming

behaviour or allow for an environment that will be experienced as supportive and 'therapeutic' rather than demeaning.

- A strong theme that runs through the draft guidance relates to the acceptance that the removal of normal clothing is a last option within any self-harm management plan. The draft guidance encourages staff to consider how the activities of the trainee can be normalised. The draft guidance sets out the requirement for the circumstances to be reviewed at highly frequent and regular intervals. This requirement aims to protect the welfare of the individual prisoner and to have this exceptional mode of protective intervention in place for the minimum time possible.

- 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.

14.10 Anti-Bullying Strategies

The Investigations into the death of Joseph Scholes all agreed that one aspect of YOI life that he feared or that fed his apprehension about his sentence was the threat or belief that he would be subject to bullying should he move from the Health Care Centre to a residential unit.

- The joint **Child Protection and Safeguards Review 2003** concluded that anti-bullying policy and practice was an area where there were serious service deficits. The Review recommended a robust programme of improvement.

- The joint Review found that although there were anti-bullying policies at YOIs these were generally of a reactive rather than proactive nature. There was a lack of clarity and consistency.

- The joint Review was particularly concerned about what appeared to be a complete lack of training for staff with regard to managing bullying and anti-social behaviour by adolescents. This situation was compounded by the limited availability of support services for young victims and limited intervention programmes for both perpetrators and victims of bullying.

- Following the recommendations of the joint Review, the Prison Service established a much stronger and more determined framework for developing anti-bullying practice.

- ❖ Whilst much remains to be achieved, the Review had also identified some positive developments and imaginative ideas to combat bullying and make regimes safer. Most YOIs have now instituted an Anti-Bullying Committee and there is no doubt that staff at all levels appreciate the serious effect that bullying can have on the regime of the YOI and the lives of individual young people who reside there.

- ❖ <u>This Operational Review endorses the approach to anti-bullying articulated by the joint review framework. Anti-bullying policy and practice should be more closely integrated with other aspects of safeguarding, in collaboration with other local agencies charged with similar responsibilities.</u>

14.10 Wider Safeguarding of Young People in YOIs

- ❖ This Operational Review strongly supports the regenerated approach to child protection and safeguarding enshrined within revised PSO 4950. The appointment of Safeguards Managers and the establishment of the Safeguards Committee at each YOI should enable the delivery of more effective and improved safeguarding arrangements across the range of relevant policy and practice areas.

- ❖ The suggested integration of these arrangements at individual YOIs with similar ones already in place to drive forward programmes directed at self-harm, anti-bullying and substance misuse is also strongly supported. The close inter-relationship between these areas of work and concern is well-understood.

- ❖ This Operational Review welcomes the prominence that the revised PSO 4950 gives to YOI Governors' child protection and safeguarding responsibilities. These responsibilities will in future be strengthened by the Children Act 2004 (section 13.3) that establishes Governors of YOIs and Directors of STCs as statutory members of the new Local Safeguarding Childrens Boards and thus, alongside other agencies, responsible for the operation of the Board and the effective discharge of its functions. The Act also places on Governors direct responsibility for safeguarding the welfare of children within their custody.

- ❖ To achieve this each YOI must put in place a child protection framework that relies on three key elements: the appointment of a member of the senior management team as Child Protection Coordinator, the establishment of a Child Protection Committee and the development of working relationships with local ACPCs and their constituent agencies.

- ❖ The joint **Child Protection and Safeguards Review, 2003** recommended that dedicated senior **Safeguards Manager** posts should be developed with ring-fenced funding. At the present time not all YOI have the resources to situate the Safeguards Manager post at

senior management team level. The Prison Service Safeguards programme is seeking to address this, subject to the availability of funding. This resolve is strongly supported.

- ❖ The issue of the categorisation of incidents that take place within the everyday life and regime of a YOI as 'significant harm' and their investigation is a difficult area. The issuing of LAC (2004) 26 should bring some structure to this process and ensure that YOIs and associated ACPCs and their member agencies work together to set out some protocols on the identification, referral and investigation of significant harm incidents as they occur in YOIs.

- ❖ Greater clarity about what constitutes the significant abuse threshold and its relationship to the residential setting needs to be undertaken and incorporated into staff training and development work.

- ❖ To help achieve maximum effectiveness of the child protection arrangements and safeguarding in YOIs, the YJB has recently agreed to fund the appointment of 25 local authority social worker posts for the sector. These social workers will be located throughout the YOI estate. At individual YOIs they will facilitate the introduction of child protection matters with YOI staff and address the improvements required to ensure that local authority obligations to children and young people in their care are appropriately discharged. This represents a very welcome and significant new safeguarding resource.

14.11 Training

Training for *Asset*

- ❖ This Operational Review welcomes the training initiatives that the YJB has planned and resourced. They are closely linked with the important developmental work on the management of risk instigated by the YJB and the need to respond positively to changes in the external world of children's services with its strong emphasis on even greater and closer inter-agency working.

- ❖ 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 and focus the YJB's training initiatives. It is noted that Module 1 of the Professional Certificate in Effective Practice (Youth Justice) programme is devoted to training in the understanding and completion of the *Asset* framework, with a strong emphasis on working with and managing risk.

- ❖ The YJB has also developed some new shorter skills enhancement programmes know as **Effective Practice In-Service Training** (INSET). The YJB has indicated that it would like to see the INSET on training in *Asset* given some priority and so has, as a condition of

funding, required Regional Human Resources (HR) Consortia to prioritise this programme from April 2004 so as to ensure that all staff can undertake detailed training in ***Asset*** based on local need.

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Training in self-harm and risk in YOIs

- The **Juvenile Awareness Staff Programme** (JASP) is a new development for YOI staff. JASP is a two-week modular training package that has been developed for staff in the secure juvenile YOI estate. This Operational Review is remitted to comment on the JASP training programme for **Vulnerability Assessment**. This is a very focussed course based on 12 sessions that are programmed to be delivered by a trainer over a seven day period.

- This Operational Review strongly supports the commissioning of the training needs analysis and the development of the proposed safeguarding training package. It is anticipated that a positive input to this training development will be provided by the new group of social workers appointed under the safeguarding initiative. These staff should be able to provide an invaluable resource of child protection knowledge and information about local contacts and services.

- The ground covered by the Vulnerability Assessment module appears very appropriate to the task and the curriculum picks up on many of the training and preparation issues highlighted by this Operational Review, namely the importance of understanding the ***Asset*** assessment, understanding about vulnerability, pre-sentence reporting and prisoner escort reports, and completion of the T1:V and T1:VR forms.

- The training adopts a very practical approach to the subject matter and majors on techniques that should be adopted to obtain the clearest information from documentation and from the young person through interviews.

- The Self-Harm Tool kit brings together all relevant information and guidance on best practice and also includes a training package **'Understanding Self-Harm'** that can be delivered by non-specialist trainers or used by individuals. This is an excellent new resource that will assist understanding of this complex area of practice.

- This Operational Review supports the introduction of JASP and the development of training materials related to the better understanding and management of at-risk young people. With the growing awareness

of the complexities of this area of practice within the YJB and the Prison Service as reported in this Operational Review, consideration might be given to whether more time could be allotted to these matters within the JASP curriculum.

- The Prison Service provides a comprehensive range of suicide prevention training programmes. The programmes assume that all training should reflect the importance of involving and working with different disciplines and recognize that all staff, and not solely health care staff, have an ability to engage with and assist young people at risk of self-harm and suicide.

14.12 Quality Assurance in the Secure Estate

Effective Regimes Framework

- The development of an active programme of quality assurance within the secure juvenile estate is essential if progress towards YJB targets and aspirations is to be achieved.

- The Effective Regimes monitoring framework brings together a range of monitoring and performance measures for the secure estate. The framework has great potential for measuring and describing how the estate is functioning and should lead to improvements in the quality and effectiveness of services.

- The YJB has put in place a performance management framework for the youth justice system. This has taken longer to bed into the practice of secure juvenile estate providers, although recent agreements have secured greater commitment.

- The Effective Regimes monitoring framework provides a new opportunity to address issues of compliance and under-performance. Regular reporting provides the opportunity for management oversight and intervention if appropriate.

- Within the Effective Regimes monitoring framework can be housed a subsidiary Child Protection and Safeguards monitoring framework that can assist Safeguards Managers at YOIs to keep track of the achievements of local safeguarding arrangements.

- <u>Over-bureaucratisation of the reporting framework should be avoided.</u>

Investigating Serious Incidents

- The recently-revised Serious Incident Review procedures are a welcome addition to the YJB's quality assurance mechanisms.

- The revised procedures are helpfully aligned with those of other serious incident reviewing agencies.

- The strict timetable for the completion of Local Management Reviews and Serious Incident Reports properly reflects the urgency and importance of the investigations.

- The procedures provide a helpful model framework for the preparation of Local Management Reports. This might be more closely aligned with that for agency management reviews for Chapter 8 case reviews.

OPERATIONAL REVIEW

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OPERATIONAL REVIEW

ACRONYMS used in the text

ACCT	Assessment, Care in Custody and Teamwork
ACPC	Area Child Protection Committee
ASSET	Assessment Tool (Developed by Youth Justice Board)
ADSS	Association of Directors of Social Services
CCTV	Close Circuit TV
DfES	Department for Education and Skills
DH	Department of Health
F2052SH	Prison Service Self-harm management system
Juvenile	Under-18 year old Offender
LASCH	Local Authority Secure Children's Home
LASSRs	Local Authority with Social Services Responsibilities
LGA	Local Government Association
LMR	Local Management Report = first stage of YJB SIR
MAPPA	Multi-Agency Public Protection Arrangements
Nite-San	Night-time Personal Sanitary Arrangements
NOMS	National Offender Management Service
PSR	Pre-Sentence Report
PCR	Post Court Report
PS0 4950	Prison Service Order 4950
SCG	Safer Custody Group

SIR	YJB Serious Incident Review
SSD	Social Services Department
STC	Secure Training Centre
TI :V	Vulnerability Assessment Form (YJB)
YOI	Young Offender Institution
YJB	Youth Justice Board
Yots	Youth Offender Teams