Investigation into the death of a boy in January 2012 while in the custody of HMYOI Cookham Wood

Report by the Prisons and Probation Ombudsman for England and Wales

August 2013
This is the report of the investigation into the circumstances surrounding the death of a boy who was found hanging in his cell at HMYOI Cookham Wood in January 2012 and who died in hospital the next day. He was only 15 years old when he died. I offer my sincere condolences to his family and his foster parents.

The investigation was led by an Assistant Ombudsman. The local PCT appointed a reviewer to review the clinical care the boy received in custody. HMYOI Cookham Wood and Medway Youth Offending Team (YOT) cooperated fully with our enquiries. This was a long and involved investigation and it has taken some months to complete. I therefore apologise for the length of time it has taken to issue this report.

Like many children in custody, the boy had had a troubled childhood. He was taken into care when he was five years old and, although he had had a settled home with foster carers, as he got older he began to get into trouble. By August 2011, he had been convicted of a number of offences, had breached various court orders and faced custody. His YOT worker recommended that, given his vulnerability, he should go to a secure training centre rather than a less well resourced young offender institution. Unfortunately, this recommendation was not put to the court and he was remanded to Cookham Wood. He was bailed shortly afterwards, but, in October, was sentenced to ten months in custody and returned to Cookham Wood without sufficient reconsideration of whether such a vulnerable 15 year old should be allocated to a young offender institution rather than a secure training centre.

The boy had attention deficit hyperactivity disorder (ADHD) and regularly saw a child psychiatrist and the mental health team. During his time in custody, he began to withdraw from participation in the regime, his behaviour became difficult to manage and he mixed less with other young people. Because of concern about him, he was monitored under suicide and self-harm prevention procedures briefly in October, later in December and then almost constantly from the beginning of January.

The boy’s behaviour continued to deteriorate. YOI staff often imposed punishments under the rewards and sanctions scheme and he was also subject to a number of formal disciplinary charges for being abusive to staff or covering the observation panel in his cell door. While many staff clearly cared for him, the management of his behaviour was inconsistent and lacked co-ordination at a senior level. This meant that underlying issues were left unresolved.

Shortly before his death, the boy told his long-term foster parents he did not want to return to live with them after his release as he did not want to cause them further hurt. On several occasions he was also found with nooses made of laces and made spoken and written threats that he would kill himself in this way. On the night of his fatal act of self-harm, he discussed with an officer, for the first time, the sexual abuse he had suffered as a young child. He was evidently very upset and the frequency of his suicide and self-harm monitoring was increased to five observations an hour, although it does not appear that the full range of options to protect him was considered.

A short time later, the boy was found hanging in his cell. There was an initial delay before officers went into his cell which should have been avoided, but we cannot
know whether this would have affected the outcome. Following emergency intervention, paramedics managed to obtain a pulse but, sadly, he died the next day in hospital.

Even though I have concerns about the boy’s location in a young offender institution in the first place, the investigation illustrates that many of the staff at Cookham Wood did their best to help and protect him. Indeed, his foster parents, with whom he had lived for ten years, told my investigators that many of the staff knew and understood him well.

Nevertheless, the investigation has identified a number of areas where things could have been done better and I expect lessons to be learnt as a result. Moreover, this is one of three tragic cases of deaths of young people in custody my office has investigated this year. As in the other cases, I have been concerned that too many of the systems in young offender institutions holding children merely replicate those in adult prisons and can be poorly suited to addressing the needs of a child in crisis. Accordingly, as well as recommendations to address the specific issues identified in the boy’s case, I make a broader recommendation to the National Offender Management Service and the Youth Justice Board calling for a more holistic and child focused approach to managing and safeguarding children at risk of suicide and self-harm.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

August 2013
CONTENTS

Summary
The investigation process
HMYOI Cookham Wood
Key events
Issues
Conclusion
Recommendations
SUMMARY

1. The boy was born in 1996. In June 2002, he was placed in the care of his local authority, the London Borough of Tower Hamlets, after saying that he had been sexually abused. He went to live with foster carers in the Medway area of Kent.

2. After a period of apparent stability, the boy’s behaviour began to change. He became increasingly difficult at school and was excluded many times. He first came into contact with the criminal justice system in 2008. By 2011, he had been convicted of a number of offences and had breached the conditions of previous court orders. In August 2011, he was remanded into custody at HM Cookham Wood Young Offender Institution (YOI). His Youth Offending Team (YOT) officer had recommended a Secure Training Centre, but this was not put to the court. After a week at Cookham Wood, he was bailed and then, in October 2011, he was sentenced to ten months’ custody and returned to Cookham Wood. There was little apparent further consideration of whether this was an appropriate placement.

3. Initially, the boy appeared to settle well. He engaged well with YOI staff, attended education and socialised with other young people. He also saw a child psychiatrist, as he had a diagnosis of attention deficit hyperactivity disorder (ADHD). He was seen regularly by the mental health in-reach team. In October 2011, self-harm monitoring procedures were begun after a workshop tutor thought he had been cutting himself. He assured staff that he had not, and the monitoring ended the same day.

4. Over the next two months, the boy began to withdraw from participation in the regime and became more difficult to manage. He mixed with other young people less and often refused the opportunity to go outside to spend time in the open air. An officer became concerned about the boy and began self-harm monitoring procedures again on 23 December 2011.

5. Officers monitored the boy closely, but his behaviour became increasingly challenging. He regularly blocked the observation panel in his cell door, so that officers were unable to check on him properly. He frequently used abusive language to YOI staff and began to tattoo himself. However, on 3 January, following a review, the self-harm monitoring procedures were closed as it was considered that he was unlikely to harm himself.

6. Three days later, the monitoring procedures were re-opened. The boy was again blocking his observation panel, was not engaging with staff (he had refused to attend a meeting to discuss his future) and had tattooed himself.

7. On 8 January, the boy had a visit from his foster parents, with whom he had lived for nearly ten years. He told them that he did not want to return to live with them once he completed his sentence as he did not want to hurt them further. He went back to his cell and refused to engage with officers who went to see how he was.
8. The boy's behaviour continued to deteriorate and he became increasingly difficult to manage. He was charged with several disciplinary offences against YOI rules which led to him having his television removed and not being allowed to spend social time and eat his meals with other young people. The punishments appeared to have taken no account of the fact that part of the target to reduce his risk of self-harm was to encourage him to mix more with others. This further isolated him. On several occasions, the boy left notes for YOI staff, either pushed through his door or in the observation panel, threatening to hang himself. Staff continued to review him under the suicide and self-harm monitoring procedures, although he often did not engage with them.

9. Three days before he was found hanging, the boy was found to have tied a noose in his cell made of a shoelace. During this period he referred to having shoelaces several times, yet there was no review as part of the suicide and self-harm monitoring procedures about whether he should be allowed to have them or any other items which he could have used for self-harm. In the weeks leading up to his death he frequently did not collect the medication that he was taking for ADHD.

10. On 23 January, the boy began the day cleaning the wing with a group of other young people. The officer in charge noted that he was in high spirits, as he also appeared later that afternoon during an education session. A senior officer (SO) held a self-harm monitoring review that day and noted a small improvement but many of the same concerns applied. His risk to himself was still regarded as raised.

11. The next day, the boy again helped to clean the wing. One of the young people he cleaned with told investigators that the boy seemed well and did not mention any problems. He was asked to take part in a session for trainee social workers from the Medway area later that morning. When asked what he missed in prison, he replied “family” and said that an ideal social worker was “someone who listens”. He attended an education session that afternoon, and showed the teacher some shoelaces that he had in his pocket. The teacher checked with an officer that he was allowed them.

12. On the evening of 24 January, the boy had a conversation with an officer, in which he probed her about how much she knew about the abuse that he had suffered as a child. He then made a telephone call to his foster parents, after which he briefly cried in front of another officer. The officers discussed what to do with the wing SO who agreed that they should hold a review the next morning and in the meantime, increase the frequency that he was monitored to five times every hour.

13. After night staff came on duty, the boy asked for a toothbrush, which he was given. When he was next checked, less than ten minutes later, he did not respond and officers could not see into his cell as he had blocked the observation panel. Officers did not use their emergency keys to open the cell but asked the officer in charge to attend so they could go into the cell. However, an officer, who was still in the YOI writing up a note of her earlier
conversation with him, arrived with keys and went straight into the cell. She found him hanging and cut him down.

14. YOI staff tried to resuscitate the boy before emergency services staff arrived and took over. After they obtained a pulse, he was taken to hospital, but sadly he died the following day.

15. Too little consideration appears to have been given to whether Cookham Wood was the appropriate place for the boy and whether a secure training centre would have met his needs better. Nevertheless, it is apparent that many members of staff at Cookham Wood knew him well and used a variety of methods to try and get him to engage with the regime. However, these attempts lacked co-ordination and were sometimes at odds with each other, with punishments given that directly contradicted the plans made in the self-harm monitoring procedures. We are concerned that he frequently did not take his medication, which his psychiatrist said might have led to increased impulsivity, and that this information was not shared with the staff who had to manage him. This was in contravention of Cookham Wood’s own policy. Before the boy hanged himself YOI staff recognised he was at increased risk, but it is not apparent that all the options that might have protected him were fully considered. We do not consider that the Prison Service suicide and self-harm monitoring procedures are suitable to manage the complex vulnerabilities of children and a more high level and holistic approach is needed.
THE INVESTIGATION PROCESS

16. This office was informed that the boy had seriously harmed himself on the morning after the incident. We were informed of his death later that day. An Assistant Ombudsman and a Senior Investigator led the investigation.

17. The Assistant Ombudsman and Senior Investigator visited Cookham Wood on 30 January, accompanied by the Ombudsman. While there, they visited the boy’s cell and spoke to the Governor, the Head of Safeguarding, the Head of Faith and a family liaison officer. They also spoke to the Chair of the Independent Monitoring Board, two representatives from the Prison Officers’ Association and two representatives from Kent Police. They were provided with copies of the boy’s prison documents and medical record.

18. The local PCT commissioned a clinical review of the boy’s healthcare while he was at Cookham Wood.

19. The Assistant Ombudsman and Senior Investigator returned to Cookham Wood on 27 February to interview staff and young people. On 1 March, the investigators were joined by the clinical reviewer for four interviews. Two of the interviews were not recorded but notes were made. Feedback was given verbally to the Head of Safeguarding on 1 March. The Assistant Ombudsman followed this with an email to the Governor on 2 March, and a letter confirming the feedback on 6 March.

20. On 7 March, the Assistant Ombudsman attended a meeting with the Serious Case Review (SCR) panel at Tower Hamlets Town Hall. The purpose of the SCR was to

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

21. At the meeting, it was agreed that the Prisons and Probation Ombudsman (PPO), while not a member of the SCR, would share information with the panel. Copies of PPO interview transcripts were sent to the SCR panel on 18 May.

22. Further interviews took place at Cookham Wood on 19 and 20 March. These were conducted by the Senior Investigator, Assistant Ombudsman and clinical reviewer.

23. One of our family liaison officers contacted the boy’s mother, father and foster parents and outlined the purpose of the investigation and gave them the opportunity to raise any concerns or questions they wished to be considered.
24. On 22 March, the family liaison officer and Senior Investigator visited the boy’s father, who wished the following concerns to be taken into account by the investigators:

- Why his son was placed at Cookham Wood and what the procedures and protocol were for placing him in a young offender institution. Why was he not given information about his son’s placement?
- Cookham Wood was not a suitable place as it was purpose built for women and not fit to be used for young offenders.
- He wanted to know the reasons why, when his son had been in a good mood in the afternoon before his death, he was emotionally upset by the evening. He wanted to know what happened during that period and why he had been in tears.
- He asked what procedures were put in place to safeguard his son’s safety, given his mental and emotional state, particularly as an officer had spoken to him to try and console him that evening. He wanted to know if the officer’s report and information were passed onto the night staff and if there was sufficient communication between staff.
- He was concerned that, as his son had expressed intentions of self-harm, nothing was done to safeguard him. He was concerned about the suitability of his cell, in particular that there was a broken mirror and electrical cables.
- Did the CCTV footage show staff checking him regularly?
- He had been informed by the Governor that his son’s observations had been increased but that this was by checking through the observation hatch and not entering the cell. He wanted to know why officers did not enter the cell to check thoroughly, as he understood that his son covered up his observation panel. He also understood that his son had written graffiti on his cell door with a picture of a man hanging himself.
- What procedures were taken once his son was found and was there any delay in administering emergency medical treatment?
- He explained that he was unhappy with the way he was contacted and told of his son’s condition and that there were then problems over responsibility and arrangements for his funeral.
- He understood there were concerns over where his son would be placed once he was released from Cookham Wood and he wanted to know what arrangements were made for him and whether he had been assigned a social worker in the YOI. He wanted to know if anyone from the local authority visited him while he was at Cookham Wood.
- He was concerned that he was not contacted about what was happening with his son or his self-harm.

25. The Assistant Ombudsman and Senior Investigator returned to Cookham Wood on 16 May. They conducted further interviews and gave full feedback to the Governor.
26. On 18 and 19 June, the Senior Investigator and a colleague visited Medway Youth Offending Team (YOT). They interviewed four members of staff, and interviewed another member of staff at their home.

27. On 3 July, the Assistant Ombudsman and Senior Investigator met the clinical reviewer to discuss various issues surrounding the clinical review process. The next day, the Assistant Ombudsman met members of the SCR panel to inform them of progress in this investigation. The clinical review was received on 15 August.

28. The family liaison officer and Senior Investigator met the boy’s foster parents, on 11 July. They asked for the following matters to be taken into account as part of the investigation:

- They explained that the boy had been placed with them when he was five years old and at that time had limited social skills and physical interaction. He had some early contact with his brother and grandmother but this stopped. He also had some contact with his father.
- When the boy became a teenager he began to get into trouble with the police and his foster parents felt that the times he was in court were confusing and difficult for them all.
- The boy’s foster mother explained that her last phone call with him was distressing. He said he could not come back to her home as he did not want to hurt her any more, but she tried to reassure him and persuade him to come home.
- The foster parents were contacted by phone and told that the boy had been taken to hospital; they were unaware at the time of the seriousness of his condition. As he was in foster care this meant that the local authority was legally responsible for him and would make any decisions relating to his medical care. His father was contacted and attended the hospital.
- Following his death his foster parents explained that the situation became difficult and they felt excluded. Although they had looked after the boy for ten years they had no legal status and could not keep any of his belongings or arrange his funeral.
- They both considered that while he was at Cookham Wood staff had taken the time to get to know him and they found this very reassuring.

29. The Assistant Ombudsman and Senior Investigator returned to Cookham Wood on 2 October to complete a further interview.
HMYOI COOKHAM WOOD

30. HMYOI Cookham Wood is a young offender institution in Kent, for boys between 15 and 18. Cookham Wood is next to HMYOI Rochester, which holds young men between the ages of 18 and 21 and Medway Secure Training Centre\(^1\) for boys between 12 and 17. Before 2008, Cookham Wood was a women’s prison.

HM Inspectorate of Prisons (HMIP)

31. Since Cookham Wood changed its role to hold young people under 18, the Inspectorate of Prisons has conducted three inspections. The first inspection, held in February 2009, found that the prison was “a frightening and unsafe place”, with young people hiding in their cells, afraid of coming out. Inspectors also found that the physical environment was very poor, with broken windows and damaged fittings. However, inspectors considered that a reasonable start had been made in providing education, training and resettlement activities.

32. A follow up inspection, conducted in October 2010, found that there had been improvements, but that Cookham Wood was still “not sufficiently safe”. In particular, inspectors felt that there was an over-reliance on formal disciplinary procedures, which many young people did not think were being applied fairly. Inspectors noted that the personal officer scheme was not functioning in any meaningful way and, while commending the improvements made in ACCT process (see the section on ACCT below), noted that not all staff had been trained in suicide and self-harm monitoring procedures. Inspectors found that there was a good level of mental health care, with a full time mental health in-reach team and a visiting child psychiatrist.

33. The next inspection was conducted in November 2011 (shortly after the boy had arrived for the second time). In what he called “an encouraging report”, the Chief Inspector of Prisons said in his introduction that Cookham Wood was making good progress and that outcomes for young people were now reasonably good across HMIP’s four tests of a healthy prison. Detailed findings from this inspection are discussed later in this section of the report and, when relevant, in the issues section.

Independent Monitoring Board (IMB report)

34. The Independent Monitoring Board (IMB) is made up of unpaid volunteers from the local community who monitor the day-to-day life in the young offender institution to help ensure that proper standards of care and decency are maintained. The IMB at Cookham Wood most recently published an annual report for the period August 2010 – July 2011. The Board said in their report that significant and rapid improvement had taken place during this

\(^{1}\) Secure Training Centres (STCs) house vulnerable young people who are sentenced or remanded to secure accommodation. There are four STCs in England and Wales, and one of these, Medway STC, is next to Cookham Wood. STCs are significantly better resourced that YOIs and the ratio of staff to young people is much higher at an STC than a YOI.
reporting period. Detailed comments from the IMB report are covered later in this section.

**Accommodation at Cookham Wood**

35. Residential accommodation is on three wings, known as Ash, Beech and Cedar Houses. Accommodation on Ash and Beech is on three floors (known as landings – the ground floor is known as the “1s”). Cedar has just 17 rooms and usually holds young people who have just arrived or are about to leave Cookham Wood. All cells are single occupancy. There is a further separate unit, the Phoenix Unit, described below.

36. During the 2011 inspection, inspectors found that cells were adequately furnished, although some needed a deep clean and others contained small amounts of graffiti. They noted that all cells had kettles, but that electricity was turned off at 10.00pm. Cell call bells (which allow young people to alert staff to concerns when they are locked in their cells) were answered promptly, and the majority were answered within five minutes.

37. The IMB noted that significant investment was planned in new accommodation at Cookham Wood in “belated recognition of the unsuitable physical environment”. Work on the new accommodation was in progress during this investigation.

**Phoenix Unit**

38. The Phoenix Unit has 12 beds, and houses young people with complex needs or who need intensive support and also those who are segregated under the provisions of the YOI Rules. Young people there for disciplinary reasons are kept apart from those who are more vulnerable with complex needs, or who need intensive support.

39. Inspectors found that young people in the Phoenix Unit had individual care plans, with multidisciplinary reviews held once a week (in addition to any reviews at Safer Custody meetings). For those young people with complex needs, a psychological assessment informed the care plan, and the plan also included a section on how the young person could be reintegrated to the main part of the YOI.

40. The IMB said that care plans were used for all young people in the Phoenix Unit, but noted that although there had been improvements, young people there spent less time out of their cells than those on other wings.

**Healthcare provision at Cookham Wood**

41. Healthcare services at Cookham Wood are commissioned by the local Primary Care Trust (PCT), and general services are provided by the Prison Service. Mental health services are contracted to a private company. Inspectors found that, for primary physical healthcare, young people had
access to a good range of health services, with short waiting lists and a good level of attendance.

42. With regard to mental health, inspectors said that the team comprised three mental health nurses and a forensic psychologist, with a visiting psychiatrist (who specialised in ADHD) visiting two days each week. Inspectors also noted that the mental health team were closely involved with many departments across the establishment and there was good multidisciplinary working in the care of patients. Mental health awareness training for staff was regarded as very well managed, with induction and first night staff (as well as other officers) trained in mental health assessment.

Education provision

43. The learning programme at Cookham Wood includes both academic subjects, such as literacy and numeracy, and vocational subjects, such as motor vehicle engineering and construction. For those with special educational needs (which included the boy)\(^2\), a coordinator (known as the SENCO) is supported by a team of learning support assistants. Inspectors found that the quality of educational provision at Cookham Wood was “good overall, but significantly better in the vocational workshops”. Relatively few young people were returned to the residential units because of poor behaviour.

44. The IMB noted that there had been an overall improvement in the range, outcomes, quality and experience in learning and skills in the previous year. They also said that behaviour in classes had improved, with the final say on when a young person should be removed from class being given to the teacher.

Previous PPO investigations at HMYOI Cookham Wood

45. The boy was the first young person to die at Cookham Wood since it became a juvenile establishment in 2008.

\(^2\) A “statement of special needs” is a formal document detailing a child’s learning difficulties and the help that will be given. A statement is only necessary if the school is unable to meet a child’s needs on its own. Approximately two per cent of children need a statement.
KEY EVENTS

46. The boy was born in June 1996. In 2002, he was made subject of a care order under section 31 of the Children Act 1989 after he indicated that his eldest brother had sexually assaulted him.

47. The boy was placed in the care of the London Borough of Tower Hamlets. He was placed with foster parents in the Medway area, with whom he remained until he was sent to Cookham Wood in 2011. His biological father was granted parental responsibility in 2002 and he had contact with him while he was in foster care.

Education history

48. After being placed in foster care, the boy enrolled at a primary school in Gillingham, where he initially struggled to settle. In 2007, he moved to a secondary school in Rainham. Although he met many of his educational targets, his behaviour was problematic, although not seriously so. Incidents included low level bullying, talking out of turn, and using inappropriate language. Between November 2007 and November 2010, he was excluded from school for 51 days, spent 45 days in the school’s “impact room” (which is effectively internal exclusion) and 85 days in the inclusion unit.

49. The boy started to attend a catering course run by Nacro (a charity aimed at reducing crime), but was excluded on two occasions for smoking cannabis and threatening the centre manager. A meeting was held on 13 June 2011, following which he was allowed back to Nacro one day a week. In the next six weeks he did not attend on two occasions.

Offending history and interaction with Medway YOT

50. The boy first came into contact with the criminal justice system on 29 July 2008 when he was 12. He was arrested for shoplifting and having an article with intent to damage property. He was given a reprimand.

51. On 19 May 2010, the boy again came to the attention of Kent Police. He was given a warning for damaging property and handling stolen goods.

52. The boy appeared at a Youth Court on 14 September 2010, when he was 14, charged with destroying or damaging property on 1 September. He pleaded guilty and was given a three month referral order\(^3\). This meant he came to the attention of Medway YOT for the first time.

---

\(^3\) Since 2002, most first time young offenders pleading guilty at court have been given a referral order (unless the offence is so serious that it warrants a custodial sentence) for a period between three and 12 months. The order is to a Youth Offending Panel made up from at least two community panel members and a member of the local YOT. The young person is asked to sign a contract with the panel, which is based on the principle of “restorative justice”. The young person is asked to take responsibility for their actions, to make reparation for the offence (either to the victim or the community) and to engage in interventions to address their offending behaviour. Should they fail to comply with the referral order, they can be returned to court for re-sentencing.
53. On 14 December, the boy appeared in front of the court again, this time on a charge of damaging property on 24 September (this was a toilet block at his school). He pleaded guilty and his referral order was extended by a further three months.

54. As part of the referral order process, the boy’s YOT worker contacted the school to ask for their opinion about the offence. The Vice-Principal described his behaviour as “irrational” and said that care should be taken before putting him in a public place “because he uses any opportunity to draw attention to himself”.

55. On 29 December 2010, Kent Police were called to a stretch of the A2 after glass was found on the carriageway. The boy had smashed bottles along the road and was charged with endangering life.

56. The YOT worker completed a Reparation Referral assessment on 6 January 2011. As part of the assessment, she noted the following:

   “Although there is no evidence to suggest that he may harm himself or others, the Asset⁴ did indicate some vulnerability … there are some concerns regarding his esteem and identity issues.”

57. On 10 January 2011, the boy made a complaint to the police that he had been assaulted by a security guard in a shop in Chatham. The next day, police visited him at home and he said that he wanted to press charges, although he also said that he had been winding the security guard up and had sworn at him several times. The police told him that he might be charged with using racist language. His foster parents were concerned about him and asked their local doctor to come and conduct a psychiatric assessment. Instead, the next day, the supervising social worker from the foster placement agency e-mailed Tower Hamlets Council and asked whether someone from Tower Hamlets could conduct this assessment.

58. As part of the referral order, the boy was also due to attend a catering course organised by the charity Nacro. He did not attend on 11 January, which was the day the police saw him at home. He had a meeting with his YOT worker on 12 January and agreed to attend Nacro the next day. He seemed keen to make more constructive use of his time and suggested working with young children in an educational setting. While she had reservations about this, given his behaviour, she agreed to explore ways of achieving this.

---

⁴ Asset is a structured assessment tool used by Youth Offending Teams. It is designed to look at the young person’s offence or offences and identify any factors or circumstances – ranging from lack of educational attainment to mental health problems – which might have contributed to such behaviour. The information gathered from Asset can be used to inform court reports so that appropriate intervention programmes can be drawn up and highlights any particular needs or difficulties the young person has, so that these can be addressed.
The YOT worker e-mailed the supervising social worker on 14 January confirming that the boy had attended Nacro and had received “glowing reports” from the tutor.

The boy was required to attend six victim awareness sessions on consecutive Mondays throughout January and February. He failed to attend the session on 17 January, and was given an initial warning by his case manager.

The boy appeared at Juvenile Court on 27 January 2011, where he pleaded guilty to causing a dangerous occurrence on or over a road. Sentencing was postponed pending the resolution of other charges.

In the meantime, the boy was charged with common assault following an incident at a shopping centre on 16 January 2011. He told his YOT worker that his friends had encouraged him to “happy slap” a man, who he later found out had learning difficulties. He described his own behaviour as “pretty out of order”. For this offence, he appeared in front of a Juvenile Court on 10 February. Again, sentencing was postponed.

At this court appearance, the boy also pleaded guilty to two counts of burglary. On 31 January, he had been charged with burglary and theft from two garden sheds. He told his YOT worker that he and some friends had taken some beer from one shed and a chainsaw and petrol from the other, to “saw some trees down”.

On 14 February, the boy met his YOT worker for a review of his interventions. They considered what had gone well. He had attended individual meetings with her and started with Nacro, but had also re-offended and had not started his reparation hours. They agreed a three month intervention plan, which included meeting her weekly, sticking to his bail conditions and considering the effect of his behaviour on others.

The boy was charged with possession of a bladed article on 19 February 2011. Police had been called to a pub in Gillingham after reports that he was there with a concealed knife. He was searched, but said that he had thrown the knife in a bush. He later told his YOT worker that he had received a text message saying another boy wanted to fight him, and he went out with the knife to protect himself. He said he would not have used it but would have displayed it to anyone who thought of attacking him in order to put them off. He was on bail at the time of this offence. He appeared at Youth Court three days later and pleaded guilty to having an article with a blade in a public place.

On 24 February, the boy attended the YOT and completed a “What do YOU think” form with a YOT social worker. This form asked him to assess which statements best described him. He said the following statements were “just like me”:

- Stay away from home without asking
- Have lost someone special from their life
• Need to get more training or qualifications
• Often stay (or stayed) away from school when they should be there
• Live in places where it is easy to get drugs
• Have lots of friends who get into trouble
• Have choices about what to do in my life
• Live in areas where there is not much to do
• Do things they know are dangerous
• Have friends who often use drugs
• Rush into things without thinking
• Get into trouble because it is exciting
• Damage their own things or property belonging to others

Asked “what would you like to be different about your life in three months’ time?”, the boy answered “everything apart from foster placement and friends”.

67. Before his next appearance at court, the Intensive Support and Supervision (ISS) coordinator at Medway YOT completed an assessment of whether ISS would be suitable for him. She met him both at the YOT and at home, and attended a group work session with him. She was concerned whether he would be able to comply with the conditions that would be attached to an ISS programme, and thought that he might be vulnerable if exposed to a larger group (she had observed him exaggerating his own criminal behaviour in the group session). She concluded that ISS might give him more structure which would help him address his offending behaviour. However, she also thought that a multi-disciplinary youth rehabilitation order (YRO)\(^5\) without ISS could also provide this structure without making him vulnerable to other young people.

68. On 29 March 2011, the boy was sentenced for the offences he had committed in 2011. He was given a YRO with a 12 month supervision requirement, and a curfew requirement of four months with electronic tagging (the curfew was between the hours of 7.00pm and 7.00am). He was also given an activity requirement of 80 days, a programme requirement and a prohibited activity requirement.

69. The same day, the YOT social worker completed a “Risk of Serious Harm” form (he had prepared the pre-sentence report for the court, as well as a

---

\(^5\) Youth Rehabilitation Orders are the standard community sentence used for young people who offend and are designed to encourage a more risk-based approach to sentencing for young people. It provides a “menu” of interventions which are aimed at addressing offending behaviour, such as curfew, activity or drug testing requirements. Requirements can include Intensive Support and Supervision (ISS) or Intensive Fostering.

ISS is a mixture of punishment and positive opportunities and provides courts with an alternative to custody. Curfew and electronic tagging requirements are mandatory if an ISS is used.

The threshold for a YRO with ISS is that the offence must be so serious that if the YRO with ISS was not available, imprisonment would be the likely outcome. The YRO with ISS must be for a minimum of six months, and the ISS part of that sentence must be for between 90 and 180 days.
Vulnerability Management Plan). He concluded that the boy presented a medium risk to others because of his offending behaviour, which he said sometimes led to “reckless and dangerous behaviour”. He noted that the boy had mentioned thoughts of killing his brother and did not take his medication or cooperate with CAMHS (the Child and Adolescent Mental Health Services, to which he had been referred). He added that his behaviour sometimes meant that he was at risk of harming himself.

70. The YOT worker saw the boy for a review on 12 April. They again discussed what had gone well and not so well. He said that he had met her every time as arranged, and had stuck to his bail conditions. He had also started to think about how his behaviour affected others, but admitted he did not understand how it made his foster parents feel. He had also found it difficult to stay away from one of his friends, who was often present when he offended.

71. The following day, they completed the next intervention plan. They agreed targets including continuing with YOT and Nacro sessions, looking at how his behaviour affected others and talking more about his feelings. The YOT worker also asked him to bring examples of him saying “no” to bad behaviour when with his friends.

72. The boy did not attend a session at the YOT on 27 April (and had also not attended a health assessment the day before, as agreed). The YOT worker issued him with a warning letter, in which she said that she was frustrated with him as he had been making really good progress. The next day, she issued a final warning after he missed another session. She had telephoned him in advance of the session to remind him to attend. He was told that he would be returned to court if he missed another appointment.

73. The boy’s next conviction was for damaging property. On 31 May 2011, he appeared at Youth Court and was given a curfew requirement of 63 days.

74. The boy’s 15th birthday was in June. At the start of June, he failed to attend sessions on four consecutive days. The YOT worker completed a breach report for a court appearance on 21 June. She noted that he had agreed to undergo a mental health assessment, which she thought might have a significant impact on him. She proposed that the YRO should be maintained. The court agreed. (In preparation for this hearing, she prepared a placement alert form in case he received a custodial placement6. She recommended that the most appropriate location for him would be a Secure Training Centre (STC). She indicated on the form that he was not at risk of potential self-harm or suicide.)

75. The boy further breached his YRO on 18 June (failure to comply with his curfew), on 27 June (failure to attend a supervisory session), on 28 June (failure to comply with curfew) and on 5 July (failure to attend a statutory pre-breach meeting).

6 The placement alert form is sent electronically by the YOT team to the YJB placement service who are responsible for making placement decisions when a young person is remanded into custody.
76. On both 18 and 28 June, the boy stayed out overnight with friends, despite being told by his foster parents that this would be a breach of his conditions. On 18 June, he had been found by the police in a disused garage with another boy and a girl. On 28 June, he had missed an appointment at the YOT but had gone to meet his YOT worker after being told to do so when he arrived home. Later that evening, he left with some friends and did not return. On both occasions, she completed a “Missing Child: Return Interview”, and Tower Hamlets were informed.

77. The boy’s foster parents became concerned that their house had been broken into several times by the boy and his friends. On 2 July, a neighbour saw him outside the house while a friend went through the window. The following day after putting locks on the windows, his foster parents found that someone had entered through a small open window. On 5 July, he failed to attend a meeting at the YOT and was not seen for several days. Tower Hamlets were informed. He returned home on 8 July. He told his YOT worker that he had been staying with friends and fairground workers.

78. The boy was arrested at home on 18 July, accused of assaulting a friend after lending him some money. On 22 and 23 July, he did not arrive home before his curfew. On 23 July, he did not return home before midnight: he arrived home in the early hours of 24 July. His foster parents later found that £50 was missing from their safe.

79. The YOT worker completed an Asset Core Profile report on 25 July 2011. In the section “Offence Analysis”, she asked the boy about reports of him playing “chicken” on parts of the A2. He said that he still did that sometimes although he was aware of the risks both to him and other road users. She wrote that he “has many unresolved emotional issues from his early childhood, that he is a psychologically damaged young person, struggling with his own self-identity”. She noted that he had agreed to undergo a mental health assessment, but had then returned to court on 21 June, for breaching his YRO conditions and was due to return again the next day (26 July) for another breach.

80. The YOT worker further noted that the boy had continued to stay away from home in breach of his electronic tag and curfew conditions. His foster parents had reported several incidents of theft from the family home (which he denied even though he had been seen by neighbours), but were reluctant to pursue formal charges in case he received a custodial sentence. Finally, she noted that he was due in court on 1 August, on a further assault charge.

81. In her Breach Report form for court, the YOT worker said that the boy’s non-compliance with his YRO was now persistent. She recommended that the YRO be revoked, a pre-sentence report ordered, and that the matter be adjourned pending the hearing for assault which would be heard on 2 August. At the hearing on 26 July, the court agreed to this approach.
The YOT worker also completed a placement alert form, in advance of the breach hearing the next day in case of a custodial sentence. Again, she recommended a placement at Medway STC. She also noted that the boy was not at risk of suicide or self-harm.

Following the breach hearing on 26 July, the YOT worker completed a range of forms. Among these was a vulnerability management plan. In the section, “Managing vulnerability: external and internal controls”, she noted that the boy had expressed concerns about coping in a custodial environment. She noted that, in custody, he would need to be put on an ACCT\(^7\) to ensure that he was properly monitored.

**The boy’s period of remand at Cookham Wood: August 2011**

The boy appeared at Youth Court on 1 August 2011. He was charged with the following offences:

- 16 July 2011 - Battery
- 21 July 2011 - Theft x2
- 27 July 2011 - Attempted theft
- 29 July 2011 - Theft by finding
- 30 July 2011 - Possession of an offensive weapon
- 30 July 2011 - Disorderly behaviour

In advance of this hearing, the YOT worker completed another placement alert form. She again recommended a placement at an STC should custody be used. She noted as risk factors, that it would be his first time in custody, that he had a history of abuse and some mental health issues. The key risk factors, however, were noted as “reckless behaviour and highly influenced by peers”. At interview, she mentioned that she thought that an STC would be more appropriate for him because of his vulnerabilities. He was remanded to custody by the magistrates.

Following this hearing, a project manager at Medway YOT, who was the court officer that day, faxed a post-court report to the Youth Justice Board (YJB), who co-ordinate custodial placements in the youth justice system. On the form, she noted that the boy had expressed some concerns about the amount of time he might spend on remand. However, he had not expressed any thoughts of suicide or self-harm. At interview, she said that she had not seen the placement alert form which recommended an STC for him. She also said

---

\(^7\) ACCT (Assessment, Care in Custody and Teamwork) is the Prison Service process for supporting and monitoring those thought to be at risk of harming themselves. An ACCT plan can be opened by anyone working in the YOI if they have any concerns that a young person might have tried, or, in the future, might try to harm himself. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the young person. Levels of observations (where staff must check the young person) and interactions (where staff must have a conversation with the young person) are flexible and are set according to the perceived risk of harm. If staff perceive the risk of harm to be very high, the young person can be constantly supervised, with a member of staff positioned outside their cell at all times. Where the perceived risk is lower, the level of observations may be several times an hour or day. Observations also take place during the night.
that she spoke to the YJB by telephone but did not recall discussing whether a placement to Cookham Wood was appropriate.

86. That evening, the YJB placed the boy at HMYOI Cookham Wood, although there were two spaces available at Medway STC. Because the project manager did not put forward the YOT worker’s recommendation to the court that he should go to a secure training centre, he was remanded into custody rather than given a court ordered secure remand. This meant the YJB had no option but to hold him in a YOI.

87. When the boy arrived at Cookham Wood, he was seen by a nurse for a reception health screen. The nurse described him as “a healthy young person”. He said that he had stopped taking medication for ADHD a year earlier. The nurse noted a history of aggressive behaviour, but thought that his mood was stable and that he appeared logical and organised. While he did not have any thoughts of suicide or self-harm, the nurse noted that he was anxious about the unknown and had never been in prison before. He also told him that he had scars over his body, although there is no record that these were checked. Following another appearance at court the next day, when he was again remanded to custody, the nurse saw him again. There were no new healthcare concerns.

88. For his first four days in Cookham Wood, the boy was monitored regularly, three times during the day, and hourly through the night. On the first night, he played table tennis and watched television with other young people. An officer spoke to him. He said that he was okay but missing his mum and dad (his foster parents). He was given an induction to Cookham Wood, which included a session with the advocacy service, Voice\(^8\).

89. On 3 August, a nurse conducted a secondary health screen. The boy said he smoked cannabis and tobacco regularly but used alcohol rarely. He declined any vaccinations, as he had a fear of needles.

90. The boy’s foster parents visited him in Cookham Wood on 6 August. In an e-mail to the YOT worker, his foster mother said that he admitted that he did not want to stay, or go back, to Cookham Wood. However, he said that he thought he was safe. His foster mother noted that she was not sure if this was bravado.

91. The boy appeared again at Youth Court on 9 August. He was granted bail and ordered to reside with his foster parents, to observe a curfew between 5.00pm and 5.00am, to stay away from two listed properties and to reappear at court on 30 August. He was also charged with further offences:

- 13 July - Burglary with intent to steal
- 17 July - Burglary and theft
- 30 July - Burglary with intent to steal

\(^8\) Voice is an advocacy service which works with young people in the community as well as YOIs. They help young people to explain themselves to those making decisions about them, to prepare for meetings and to help young people understand what people are saying.
On 12 August, a psychologist at Cookham Wood made a retrospective entry in the boy’s medical record for an assessment made on 9 August. This followed the standard mental health assessment for all new arrivals at Cookham Wood. The results of his screening showed that there was some evidence of ADHD, and that he was suitable for referral to the psychology team.

The psychologist forwarded this information to the YOT worker at Medway YOT on 18 August, when he realised that the boy had been bailed. He suggested that, if he agreed, he should be referred to the local CAMHS.

**Court appearance, sentencing and the boy’s return to Cookham Wood – October 2011**

The boy was arrested by Kent Police on 9 October. He appeared at Youth Court the next day, charged with various offences including burglary, aggravated taking of a vehicle, driving without a valid licence or insurance and breaching the terms of a YRO.

The senior practitioner at Medway YOT who had taken over the boy’s case completed a breach report before his court appearance. She listed the occasions on which he had breached the terms of his YRO, and noted that while he had been on the YRO with ISS his engagement had been inconsistent. He had sometimes been hard working and mature but at other times had been disrespectful and disruptive. As he had continued to offend and had been remanded into custody for not complying with police bail, she felt that custody was likely to be the only viable option for the court. On a placement alert form sent to the YJB, she noted that the suggested most appropriate placement was a YOI and named Cookham Wood as the preferred unit.

The boy was remanded in custody to appear back at court the following day. There was no recommendation for a secure training centre and a place was arranged for him at Cookham Wood, where he arrived at 5.10pm.

That evening, the boy was seen by a nurse, who explained when interviewed that she did not do a full health screen for him as he had not been away from Cookham Wood for very long. She noted that he appeared fit and well, although his behaviour was slightly hyperactive, and that he had no thoughts of self-harm or suicide. He said that he smoked cannabis regularly. She told him that he would be referred to the mental health in-reach team so they could assess his ADHD, as had been planned during his previous stay at Cookham Wood. She noted that he was fit to be accommodated on a standard residential wing, and that he could attend education and the gym. As with all new arrivals he was again regularly monitored throughout the night.

On 11 October, the boy returned to court and was given a ten month custodial sentence. The project manager spoke to him following the hearing and completed a post-court report. She noted that he was okay going to
Cookham Wood as he had been there before and that it was “not a problem for him”. She made no recommendation for a secure training centre. She also noted that he did not present an immediate risk of harm to himself. The YJB allocated him to Cookham Wood. While they noted that he was “quite young”, they placed him at Cookham Wood in line with the placement alert form and the project manager’s comments on the post-court report.

99. When the boy returned to Cookham Wood after being sentenced, he again went through the routine reception process. At 7.35pm, he received a yellow card under the rewards and sanctions scheme\(^9\) from an officer, who noted his “disrespectful and disruptive attitude in reception”. He refused to accept this yellow card.

100. A “looked after child”\(^10\) meeting was held at Cookham Wood on 13 October, attended by staff from both the YOT and Cookham Wood. During the meeting, the boy said that he wanted to stay at Cookham Wood for ten months, but did not want to go back to his foster parents or remain in the Medway area. It was noted that a referral had been made to the mental health in-reach team.

101. On 14 October, the boy completed an SDQ (strengths and difficulties questionnaire), part of a mental health assessment. That morning, his mother telephoned the Child Protection Officer and told her that the boy had not used the showers when he was on remand, possibly because of the alleged sexual abuse he suffered when he was younger. The Child Protection Officer raised a STIIR\(^11\), and discussed this with the first officer (who was a temporary senior officer on Ash wing at the time). She arranged for the boy to shower separately from other young people.

\(^9\)At Cookham Wood, a rewards and sanctions scheme operates to encourage good behaviour. There are three levels, gold, silver and bronze. Young people earn or lose privileges based on their conduct or attitude. The scheme is described as “the main method of keeping good order”, and reviews take place before a young person is moved to a different level of the scheme. Every young person on the bronze level of the scheme is reviewed each week or earlier if their behaviour is thought to have improved.

There is a set of expected behaviours in place for a young person to maintain silver level. These include treating staff and other young people with respect, treating the establishment with care and working constructively with YOT workers and case managers. Young people earn stamps (which can be redeemed each week at the prison shop) for complying with the regime or for good behaviour. They can also be awarded green cards for very good behaviour, which can lead to promotion under the scheme. Yellow cards are given for behaviour below the expected standard and, if a young person is given three yellow cards, their level under the scheme is reviewed. A range of sanctions is used for poor behaviour.

\(^10\) The term ‘looked after children and young people’ is generally used to mean those looked after by the state, according to relevant national legislation. This includes those who are subject to a care order or temporarily classed as looked after on a planned basis for short breaks or respite care.

\(^11\) The STIIR (Safeguarding Team Integrated Information Report) form is used by staff at Cookham Wood to alert the Safeguarding team to incidents of bullying, child protection issues, vulnerability concerns or self-harm or suicide information.
102. Four days later, on 18 October, the boy saw a nurse (the first nurse) for a full mental health assessment. That morning, a tutor in education completed a STIIR after being concerned that he was withdrawn from the rest of the group. The Child Protection Officer followed this up the same day, and spoke to him. He said he was not being bullied and that he had no issues with any other boys. She also spoke to one of the other young people mentioned in the STIIR, who said that he was just joking with the boy.

103. A Safer Regimes meeting was held the same day. As part of the meeting, attendees (who include senior managers and representatives from each wing, mental health in-reach teams, child protection and casework teams) discuss any young person who they consider might be at risk of harming themselves. As he had recently been assessed, the boy was mentioned at this meeting. The notes of the meeting record only that “his screening does not show anything but in-reach will take a closer look at him”. Later the same day, the boy was issued another yellow card, this time from an officer, after he had refused to help clean the wing when it was his turn. He refused to accept the card.

104. On 21 October, an educational instructor issued the boy with a third yellow card, this time for not following instructions during an exam. He again refused to accept the card and threatened to “smack up” the teacher. He was charged for this offence, under YOI Rule 55 paragraph 22 (using threatening words or behaviour), and on 24 October, he attended a hearing held by the Head of Children’s Integrated Services. He pleaded guilty to the charge and received a punishment of seven days’ loss of canteen. (Canteen is the YOI shop through which young people are able to buy additional items such as confectionary and toiletries.)

105. The boy saw a consultant psychiatrist on 25 October. The psychiatrist is a specialist in child psychiatry and recorded in the boy’s medical record that:

“He is a 15 year old young man who presents with features suggestive of ADHD in the context of late onset Conduct Disorder and substance misuse. The above difficulties arose in the context of early traumatic experiences such as neglect, abuse and sexual abuse, being a looked after child, possible specific learning difficulties and influence of a delinquent peer group …

“He feels overwhelmed by the struggle ahead and has little aspirations for the future. “I don’t want to make plans for the future, because nothing will come true.” He is good at cooking and would like to join a course when he leaves the prison. He was keen to take the medication [the psychiatrist prescribed atomoxetine, a drug used to treat ADHD, and aripiprazole, an anti-psychotic also used for ADHD and to reduce impulsivity] and was keen to engage in psychological therapies.”

106. The first entry in the boy’s case note history (which is held on the Prison Service computer system, P-NOMIS) was made by an officer on 26 October, more than two weeks after his arrival. The officer noted that his behaviour
had deteriorated slightly over the previous few days, and that he had received several yellow cards and a proven adjudication. The officer concluded that “he needs to improve behaviour or he will end up on basic [under the rewards and sanctions scheme]”.

107. On 28 October, at 8.45am, a tutor in the workshops opened an ACCT document after noticing that the boy had some cuts on his left wrist. He discussed his concerns with an officer, and they agreed an immediate action plan, which included hourly observations when he was locked in his cell.

108. A nurse was called to examine the boy. He noted in the medical record that he had self-tattooed names of family members on his left arm, but that the cuts appeared clean and to be healing effectively. He declined pain killers or plasters for the wounds.

109. During the day, staff made regular entries in the ACCT document. At 9.40am, the boy was in the gym and seemed to have low motivation. He was asked about this and told the PE instructor that he was not really interested in gym activity. Later that morning, the Child Protection Officer spoke to him. She noted that he seemed quite low. He mentioned that he was concerned about his grandmother, who he was not allowed to have direct contact with. He also said that he had a new social worker through whom he could have contact with his grandmother, but was yet to meet him or her. Throughout the afternoon, entries in the ACCT reflect that his mood seemed to have improved.

110. At 6.10pm, an officer conducted an assessment interview with the boy, who told him that he had previously cut his name into his left bicep with a razor. He did not think there was anything wrong with this. He said that he did not have any negative feelings or thoughts of self-harm or suicide. He did say that he missed his grandmother, who he had not seen for five years.

111. Later that evening, at 7.50pm, a temporary senior officer (T/ SO) held a case review, which was also attended by the boy and a nurse. The boy said that he had scratched the names of his family as tattoos as he missed them. He reiterated that he was not tattooing as a form of self-harm and said that staff did not need to worry about him. The T/SO agreed to close the ACCT, but reminded him that self-tattooing was against the YOI rules and any future incidents would mean that he would be placed on report.

112. The next day, a Healthcare Assistant (HCA) saw the boy during the medication round. She noted in the medical record that there were no problems.

113. The boy received a visit from his foster parents on 30 October. The first nurse saw him on 1 November, to monitor his compliance with his medication, and to assess him for any side effects. He said he was taking his medication, and the prescription chart confirmed this. He reported that his sleep and appetite were normal. The first nurse noted that the boy did not seem to be losing weight, but he reminded the primary healthcare team to monitor him weekly.
114. An ACCT post-closure review meeting was held on 6 November. No concerns were identified by staff or the boy. The meeting agreed that the ACCT should remain closed.

115. The boy attended healthcare on 9 November, and saw a GP. The boy said he had injured his finger several weeks before, and it was now painful with a discharge. The GP diagnosed an infected finger and prescribed an antibiotic. The next day, the boy did not collect his medication.

116. A YOT assessment and planning review meeting was held at Cookham Wood on 10 November, chaired by the YOT caseworker at Cookham Wood, and attended by the boy, his foster mother, staff and someone who is described in the minutes as representing “resettlement”. The boy said that he was getting on well at Cookham Wood. He was taking exercise, and was on the painting and decorating course, which he enjoyed. He said that he was taking his medication and eating okay. The YOT caseworker noted that “he will soon be able to apply for enhanced status [under the rewards scheme] if his behaviour continues”. She also noted that the first nurse should be invited to the next review meeting.

117. The boy’s weight was monitored on 13 and 20 November, and was 76.4kg on both occasions. On 18 November, he again did not take his medication.

118. On 21 November, at 4.40pm, an officer issued the boy with a yellow card, for “imitating my accent”. When challenged, he continued his behaviour, but accepted the yellow card. On 23 November, at 11.15am, the second officer gave him a yellow card for refusing to attend the gym. He accepted the card.

119. That afternoon, the boy saw the psychiatrist again. The psychiatrist noted that he was doing well on the wing and was not getting into as much trouble as he used to. However, he also noted that he was “somewhat dissociated” and that his previous experiences had made it difficult for him to trust anyone. The boy had said that he would like to speak to his younger siblings but did not know if this would be allowed. The psychiatrist kept him on the same medication, and asked the first nurse to talk to his foster parents and the caseworker to see if he could speak to his siblings.

120. On 26 November, an officer raised a STIIR after witnessing an encounter between the boy and two other young people. The officer recorded that, from the boy’s facial expression and body language, it appeared that he did not welcome the interaction. (We understand that the two young people had been pressuring others for canteen items and that he had not been specifically targeted.) The officer noted on the STIIR that he did not feel threatened by this. As a result, one of the young people was moved to the Phoenix Unit and the other placed on a CABS\textsuperscript{12} document.

\textsuperscript{12} The Cookham Wood Anti-Social Behaviour Support Strategy is commonly known as CABS. The document should be raised when there is clear evidence that a young person is subject to bullying and needs additional support outside the ACCT process.
121. On 27 November, at 10.20am, the boy received a green card from the first officer for helping her with the bins and some dirty kit. An hour later he received another green card, this time from an officer, for helping to clean Ash Wing. On 29 November, he received a yellow card from the second officer after passing a CD to another young person, which was against the rules. He accepted the card. The next day, he failed to collect his medication.

122. Officers in the YOI routinely conduct checks on the fabric and fixtures of cells, known as accommodation and fabric checks. During a check on 7 December, staff found three unauthorised items (a large screw, a fuse and a sharpened plastic knife) in the boy’s cell. The boy was charged under YOI rule 55 paragraph 13a (possession of unauthorised articles), and pleaded guilty at a hearing on 8 December before the Head of Young People. He said that he did not intend to use the knife as a weapon and that he was not scared. His punishment included 14 days’ loss of canteen and ten days’ loss of association and television. A punishment of seven days’ removal from the wing was suspended for three months.

123. On 12 December, at 2.20pm, a member of education staff issued the boy with a yellow card after he became “rude and uncooperative”, refusing to comply with instructions. He refused to accept the card.

124. That morning, the YOT caseworker chaired another Assessment and Planning Review meeting. She noted that the boy still did not have an allocated social worker in Tower Hamlets. The panel discussed the adjudication held on 8 December and how serious this was. They reminded him that this could affect his chances of early release.

125. On 18 December at 4.00pm, an officer issued the boy with another yellow card. She had marked him with a score of four (out of ten) during a room inspection, noting that this was unacceptable. He refused to accept this card.

126. At 2.35pm the next day, the boy received a yellow card for refusing to attend education. He accepted the card. Later that afternoon, at 5.50pm, he received another yellow card for misusing his cell bell. He also accepted this yellow card. He did not collect his medication that evening.

127. The boy attended a review under the rewards and sanctions scheme that day and was given a final written warning (which is given before being downgraded to bronze status) following the two yellow cards. He was advised not to get any further yellow cards or disciplinary charges, to follow the rules, not misuse his cell bell and to be polite to staff. He signed the review sheet.

128. On 20 December, at 2.20pm, an officer issued a yellow card to the boy, which he accepted, after he refused to attend education.

129. The boy collected his medication on 22 December shortly after 6.00pm. It was noted that he had enlarged a pierced hole in his earlobe with an object (it is not clear what this object was). He was given an anti-inflammatory steroid cream by a nurse.
The opening of the second ACCT document: 23 December

130. On 23 December, an officer opened a CABS document (when interviewed, she had mistakenly thought that this was a BIP\textsuperscript{13}). She was concerned that the boy had become withdrawn, was blocking off his cell observation panel, refusing to come out of his cell and was being sent out of class.

131. Later that evening, at approximately 7.30pm, the third officer overheard another young person talking about the boy. She noted in the CABS document that they said that he “had the white thing in his ear again … urghhh!” She became concerned that he might be being bullied. However, when she spoke to him, he refused to speak about his issues, saying only that he was not close to his family and was estranged from his mother. He said that if he started to talk he would not stop, so it was best if he stayed in his room.

132. Shortly afterwards, another officer spoke to the boy again. Although he said that he was relieved to be on the CABS document, he said that he would not tell her if he was going to harm himself as he would then be put on an ACCT and would be unable to do anything to himself because of the checks. At 8.52pm, she opened an ACCT document because of her concerns, and the CABS document was closed.

133. The officer referred the ACCT to an SO (the first SO) and they agreed an Immediate Action Plan to ensure the boy’s safety. The plan included three recorded observations per hour, access to a telephone and a possible move of landing if bullying was thought to be a factor. Later that evening, he told an office that he was unhappy about being on an ACCT, but was otherwise okay.

134. The following day, 24 December, at 8.55am, an officer went to the boy’s cell to conduct an ACCT assessment interview. He refused to engage, got into bed and pulled the covers over him. (It was noted on the ACCT co-ordinator’s check list that the assessment had not been done within the required 24 hours after the ACCT was opened.)

135. The first officer saw the boy several times over the course of the morning. At 9.10am, she went into his cell to clear his blocked observation panel. (He usually used paper to block the panel, although he sometimes used other items such as teabags.) He said that he would continue to cover it. At 11.10am, he told the first officer that he was unhappy that he was on an ACCT, that he did not intend to harm himself, but could not account for his

\textsuperscript{13} Behaviour improvement plans (BIPs) are drawn up when a young person’s behaviour repeatedly falls below the standard expected. Under the plans, the young person is given specific objectives to achieve. The aim is to promote good behaviour, but sanctions are also used which can include exclusion from association, eating meals communally, education of loss of television.

During the last HMIP inspection, inspectors found that these objectives were “too basic, and did not always address the specific changes the young person needs to make”. The boy was placed on a BIP on 6 January 2012, and this was still in operation when he died.
recent change in behaviour. He said he was not being bullied, but that he would not tell staff if he was. An hour later, he refused to go to lunch.

136. In the early afternoon, the boy repeatedly blocked his observation panel. At 12.30pm, an officer completed the lunchtime roll check. When she checked his cell, he was hiding and refused to answer her before eventually jumping out and saying “boo” to her. Later, the first officer had to go into his cell again to uncover the observation panel. She told him that she would turn the power off, but he said he was “cool” about this.

137. In place of the ACCT assessment, a T/So and an officer held a case review, at 3.25pm, which the boy refused to attend. In the record of the review, the T/So noted another officer’s conversations with him earlier that morning. She decided that the ACCT should remain open, with the same level of observations, three an hour. His level of risk was recorded as raised.

138. That afternoon, the boy had a visit from his foster parents. When asked by the first officer on his return to the wing he said the visit had been good. He also told her that he did not want to go to dinner that evening.

139. An officer working night shifts spoke to the boy several times that evening. At 9.10pm, they spoke about the ACCT when the officer told him that the ACCT would not be closed, or observations reduced, until he attended a review and satisfied staff that he would not harm himself. The boy said that he was not in the mood, but would try again for the next review.

140. The following day, Christmas Day, the first SO completed a CAREMAP for the boy. (A CAREMAP is designed to ensure that there is an action plan in place to address the issues that have caused the ACCT to be opened). The issues that she recorded on 25 December were:

- Food refusal
- Refusal to associate/attend activities
- Refusal to discuss possible problems

141. The first SO also noted the following warning signs on the inside cover of the ACCT document:

- Blocking off view panel; refusing association
- Refusing to attend education or not engage in discussing reasons for behaviour with display of very low mood – which is out of character
- Food refusal – also out of character

142. The boy refused to sign either the CAREMAP or the list of warning signs. He accepted his Christmas lunch from an officer, but later refused his evening meal. The officer then spoke to him and he agreed to take it. When another officer returned for his night shift, the boy asked him several times when his next ACCT review would be held. Later that evening, the boy complained of a headache and was given some paracetamol.
143. The next day, the second officer gave the boy his breakfast pack at 8.40am. He declined her offer of going to the gym. Shortly afterwards, she had a longer conversation with him. She told him that there would be an ACCT review later that day. She said he shrugged in response. He told her that he would be going home in 47 days, to live with his foster parents and to return to his catering placement at Nacro, which he enjoyed. He said that he was not anxious about returning home, and missed his family and friends. She asked if he was feeling low, and he said that he was not, but that he would not say even if he was. She noted in the ACCT record that he was very difficult to engage with.

144. An officer spoke to the boy at 9.45am. The boy again shrugged when asked why he refused to engage. The officer explained that he needed to engage if he wanted to come off the ACCT, but the boy said that it was fun being on it as he got to speak to people. The officer told him that he would be able to do that even if he was not on the ACCT. At interview, the officer described the boy as a “very stubborn young man – once something was in his head you’re not shifting it … if he chose not to do something he wouldn’t do it, simple as that”.

145. At 10.00am, another SO went to the boy’s cell as he refused to go to the wing office for an ACCT review. She was accompanied by a nurse. She noted that he seemed quite low in mood, although he said that he was eating and sleeping okay. He agreed that he was low because it was Christmas. She noted that she thought he would return to normal once the Christmas period was over, but that in the meantime the level of observations and conversations should remain the same. He said that he had no thoughts of harming himself. His level of risk was now recorded as low, but the level of observations remained the same, at three an hour.

146. The nurse noted in his medical record that he had scored himself four out of ten in terms of his mood. She had told him that it was difficult to assess how he felt as he always smiled and he had said that this was for his own protection. When interviewed, she said that she was surprised at the score he had given himself as this was not the way he presented to her. She said that he “was always quite jovial, bouncy”.

147. The boy refused to leave his cell for lunch, after spending the rest of the morning doing a painting by numbers. He then declined the opportunity to come out of his cell and spend a period socialising with others on the wing (which is known as association). At 4.10pm, the second officer had another chat with him. The boy said he could not be bothered to go on association and there were no other reasons why he did not go. She offered him the opportunity to use the telephone, but he said he did not want to call anyone. They also discussed his eating. He told her that he was quite used to only eating breakfast and he did not want prison food. She noted that his eye contact had improved and he smiled a lot while talking to her. However, he subsequently refused to come out of his cell for dinner. She took some food (in a “grab bag”) to his cell. Later that evening, he wrote a letter to a friend.
148. The next day, 27 December, the boy declined to go out and spend some time in the open air (known as exercise). An officer asked if he would like to help with the cleaning, to which he agreed. The officer noted that his mood was good. She recorded that he kept repeating how many days he had left to serve, and told her about his foster family. He said that he would go back and live with them when he was released, and that he would “sleep his way to the end of his sentence”. She gave him a green card (under the rewards and sanctions scheme) for his efforts.

149. The boy again refused his lunch and to go on association that afternoon. An officer noted that he was doing a painting by numbers. They later had a conversation, and he mentioned that a friend might be coming to visit him. The officer noted that he was bubbly and joking with him. He later came out to collect his grab bag for dinner.

150. On 28 December, on several occasions, the second officer offered the boy the opportunity to go to the gym later that morning. He declined and, later, also refused a shower. At 10.00am, an SO conducted an ACCT review, which was attended by the boy and the first nurse from the mental health in-reach team. He was noted to be jovial but repeated that if he intended to harm himself he would not tell anyone. He said that he “couldn’t be bothered” to attend education, the gym or association. He said that he missed his grandmother, but was not allowed to contact her as his eldest brother lived with her. The first nurse agreed to spend some time with the boy that afternoon to discuss issues in more depth. The SO noted that the boy appeared “to be attempting to hide his feelings by smiling and putting on a façade” but agreed to reduce the level of observations to one an hour, with three decent conversations per day. His level of risk was still assessed as low.

151. The first nurse saw the boy later that afternoon. In the medical record, he noted that they discussed self-harm. The boy said that he did not think that he had harmed himself while in prison, but that he tattooed himself and “if that is classed as self-harm then yes [he had]”. The boy also mentioned not having a social worker, and the first nurse said that he would follow this up. The boy said that he did not like going to the gym, that he was not being bullied, had no plans to harm himself and that he thought it was pointless going to association. He refused dinner that evening.

152. The next day, 29 December, the third officer offered the boy a shower and his breakfast pack, both of which he accepted. He turned down the chance to go outside for exercise. The third officer noted that he had blocked his observation panel and went into his cell to check on him. He smiled at her and said he was fine. He was in bed and had the television on, playing a music channel.

153. That afternoon, the boy refused to go out to lunch, but accepted it when it was taken to him by the third officer. At 2.10pm, another officer noted in the ACCT document that he had “instructed the boy repeatedly to stop blocking his obs panel, but he fails to see why he should”. He issued a yellow card, which the
boy accepted. (The officer did not note this in the ACCT.) At 5.00pm, he told the officer that he did not want his dinner. The officer noted that the boy was “smirking” as he did so.

154. Forty minutes later, an officer went to the boy’s cell after he called him. He asked for his power to be turned back on. (At interview, the officer recalled that another officer had turned the power off but could not recall why.) The boy also threatened to stab this officer. The officer reported him for this remark.

155. On 30 December, the boy received a social visit from members of his foster family. The Roman Catholic chaplain visited him in the afternoon and noted that the boy was happy to engage in conversation and that he enjoyed painting. The second officer arranged for him to do some cleaning that afternoon. She noted that he appeared relaxed and calm. She twice offered him a shower, which he declined.

156. At 5.30pm, an officer went to check on the boy and found he had blocked his observation panel with paper. Two officers went into the cell and removed the paper. A few minutes later the boy pressed his cell bell and an officer returned to find the panel blocked again. On the paper he had written some abusive language.

157. Shortly afterwards, the boy asked an officer to put his power back on (it is not clear when the power was turned off). He was told that it would be turned back on if he unblocked his observation panel. He later helped the officer to arrange a kit change. At 7.20pm, he was back in his cell and rang his bell to ask for some toilet roll. The second officer responded and asked him to unblock his observation panel. He swore at her.

158. An hour later, the second officer issued the boy with a disciplinary charge for threatening an officer the previous day. He threw the paperwork in the bin.

159. On 31 December, the boy again refused to go to the gym. At 9.20am, the fourth officer tried to talk to the boy about his situation. The fourth officer described the boy as being “immature” in his answers and attitude, saying that he would not open up. The boy did, however, talk about his release in 41 days and said he was looking forward to taking cookery classes again.

160. The boy attended his adjudication hearing (for threatening to stab an officer on 29 December) at 10.35am. The adjudicator was an operational manager. The boy pleaded guilty and was given seven days loss of canteen, association and television. An officer took him his meal that evening and asked him how he felt about the punishment but he said he did not care and would carry on not engaging with staff. Nevertheless, the officer noted that the boy spoke positively and had good body language. Several times during the rest of the evening, he refused to unblock his observation panel.

161. The next day, an officer again tried to stress to the boy that he should keep his observation panel clear. The boy said that he was not interested in
complying with the regime. He later refused his dinner but had a shower. At 4.00pm, he asked the officer whether he would be in trouble if he tattooed himself. The officer told him that he would as he would have changed his appearance which was against the rules. The officer noticed that the boy was holding his wrist. When asked, he reluctantly showed his wrist and the officer, saw that he had drawn a cross in ink. The officer told him to wash it off and said that he would check that he had done so.

162. During the evening, the boy continued to block his observation panel. At 8.27pm, the second officer could not obtain a response from him and, as the prison was in night state, called the Night Orderly Officer. After obtaining permission to enter the cell, she went in and removed the blockage, again reminding him why it was important to keep the panel clear.

163. On 2 January, the boy had a shower but told an officer that he would not comply with the regime. During the afternoon, he was taken for a telephone call but was not able to connect the call. On the way back to his cell, he asked the officer how many observations he was on every hour. An officer answered his cell bell several times in the afternoon, and noted that he had blocked his observation panel. At 4.15pm, the first SO took him a toilet roll and a painting by numbers. Another officer noted that his mood had improved. That evening, the boy jumped out and surprised an officer when she was doing the roll count. She noted that he seemed in good spirits.

The closure of the second ACCT document: 3 January 2012

164. The following morning, the boy worked cleaning on the wing with the second officer. She noted that he was in very good spirits and that he worked very hard, interacting well with another young person. After he had a shower, she asked him about his behaviour and why it had been so bad recently. He did not really answer her, but instead asked about ROTL (release on temporary licence). She said that he had reached the time in his sentence that he could apply for ROTL, but that he needed to be on the enhanced level of the rewards scheme.

165. Shortly afterwards, the boy attended a Dreamwork session (a mental health tool which helps people look at their aspirations for the future) with two nurses (including the first nurse). When asked where he thought he would be in 30 years’ time, the boy said that he thought he would be in catering and hoped to have a chain of restaurants. He said that, on a scale of 0-10, he was at level 5 in terms of wanting to stop using cannabis.

166. At 11.00am, the boy attended an ACCT review chaired by the first SO and also attended by the Roman Catholic chaplain, the YOT caseworker, the Child Protection Officer and two nurses (including the first nurse). They noted the boy’s improved mood and that he had been communicating better with staff and other young people. He said that he didn’t have any thoughts of self-harm, but could not predict how his mood might change. He said he knew who to turn to for support. He also said that he did not block his observation panel so often, which he usually did for fun just to annoy staff.
167. The review team discussed some outstanding issues. The YOT caseworker said that she was trying to arrange, through the social services, a visit from his grandmother. The boy said that he planned to attend education and activities. They discussed his release and resettlement plan. The panel did not explicitly record in the minutes of the meeting that they were satisfied that the issues on the CAREMAP had been addressed, although it was noted that he was eating properly, interacting more with staff and other young people, and said that he knew who he could get support from if he needed to. The review panel agreed that the ACCT should be closed, with a post-closure review to be held one week later.

168. The boy was discussed at the Safer Regimes meeting that day (this was the first time he had been discussed at this meeting since October). It was noted that an ACCT review had been held that morning, and he seemed to be improving after Christmas. It was also noted that the mental health in-reach team was working with the caseworker to try and resolve his issues.

169. In the evening, a nurse was asked to see the boy as he had tried to cut a tattoo on the back of his left hand. The nurse described this as a name, and noted that he had also picked at the wound of a previous tattoo. Neither wound was bleeding or infected. The nurse reminded the boy that he risked infection, but also noted that he seemed very positive and cheerful. However, the nurse said that he was disappointed when an officer (presumably the fourth officer although he is not named) said that he would place him on report. The nurse completed a report of injury form (F213SH), a form completed when a young person injuries himself.

170. On 5 January, the boy attended a disciplinary hearing. The adjudicator was the Security Operations Manager. The boy had been assessed as being fit for the hearing by a nurse. He had been helped to prepare for the adjudication by an advocate from Voice, although no one from Voice attended. He had been charged with two offences under YOI rule 55 paragraph 26. The first charge stated that “at approx.19.30 [it is not clear on which day] you showed a tattoo on your upper left arm which had been done in prison to an officer”. The second charge related to a tattoo on his left hand which he had showed the officer on 3 January. He pleaded guilty to the charges and received a punishment of five days’ loss of association and television. No action was taken with regard to the suspended punishment from the adjudication on 8 December.

The reopening of the second ACCT document: 6 January 2012

171. On 6 January at 8.30am, an officer issued the boy a yellow card as he had refused to attend education. He refused to accept the card.

172. Later that morning, a casework review meeting was scheduled. The YOT caseworker told the investigators that the purpose of this meeting was to discuss issues around the boy’s release, such as the terms of his licence. He refused to attend, and would not tell the first nurse his reasons. The meeting
was not to review the boy’s risk of self-harm but it became clear that his mood had deteriorated, and he was displaying the warning signs that had led to the ACCT being opened on 23 December. The first SO decided to re-open the ACCT. A review meeting was held with the first nurse, the YOT caseworker and the members of the casework review team, which included a police officer, an officer from Medway YOT, the boy’s foster mother and the Supervising Social Worker. The first SO noted her reasons for re-opening the ACCT as follows:

- “He refused to attend the casework review which was in keeping with his behaviour from 5/1/12
- His added complete non emotion or care for anything was a great concern
- Today he has taken to not looking after himself or his cell
- He has continuously blocked off his view panel in the cell door
- He has made marks/superficial scars in shape of letters/shapes as an attempt to tattoo himself. He was referred to healthcare who consulted/treated. He was due to see the Doctor today as a follow up but refused the appointment. Healthcare will continue to monitor this issue (no concerns at this stage)
- In general his mood is withdrawn – not taking part in any education/activities today.”

173. The boy said that he had no thoughts of self-harm. His foster mother told the meeting that his behaviour was not unusual and he had behaved like that at home in the past. The first nurse reported that they had carried out the Dreamwork session on 3 January, but that he still needed to collect some more information. The review panel agreed that observations should be set at two each hour at times when he was locked in his cell, with three quality conversations each day. His level of risk was noted to be raised. The CAREMAP was updated with the following issues (although it is not clear whether all these issues were added on the same day, as they are not dated):

- Non engagement with regime
- Constant behaviour problems
- Contact with grandmother
- Sever ties with current carer

174. The officer from Medway YOT noted in her review of this meeting on Asset that the boy had asked her for a ROTL (release on temporary licence) form. However, when she discussed this with staff on the wing, they thought that he would not get ROTL because of his behaviour. She noted that her colleague would visit him at Cookham Wood the following week. She also suggested that a social worker should be allocated from Tower Hamlets so that they could start to build a relationship. She concluded that he should be released at the mid-point of his sentence, which was on 11 March 2012, but also commented that “he has been struggling at Cookham Wood. Lots of support has been put in place for him and will continue to be put in place”.

35
175. On 6 January, a review under the rewards and sanctions scheme was held by the wing manager (the review is initialled, most likely by the first SO). The review was held because of the boy’s increasingly poor behaviour and was to discuss whether he should be moved from silver to bronze on the scheme. However, as the ACCT had been reopened, it was decided that the best avenue to help him was through the BIP and that a downgrade to bronze was not in his best interests.

176. That evening, the first SO spoke to staff and the boy about his situation. She made a comprehensive minute in the ACCT record, in which she noted that a BIP would be opened to support the boy. She also noted that “it was decided to waive the lawful placing on report for attempts to tattoo himself as this was an incident that related to his current problems and further adjudication awards would exacerbate his problems, heightening the risk of self-harm”. (This appears to refer to how future episodes of tattooing would be dealt with.) She believed that any future disciplinary charges at that time would have a negative effect on the boy and might increase his likelihood of harming himself.

177. Not long after the first SO had finished discussing the BIP with the boy, he pressed his cell bell. It was answered by the first officer who noticed that he had gouged a cross in the top of his arm. She contacted healthcare and a nurse attended to apply a dressing. The nurse did not see any new bleeding or new tattoos. At 8.30pm, an officer returned his television.

178. The next morning, 7 January, when the first officer woke the boy and told him what the regime was for the day he swore at her and would not comply. A nurse saw him at lunchtime and did not see any new tattoos. He noted that the boy was cheerful and said he would not cut any more tattoos.

179. During the day, the boy frequently blocked his observation panel, although the third officer noted that he engaged with staff, had good eye contact, and was being cheeky. In the afternoon, the first officer warned him that she would turn off his power unless he unblocked his observation panel. The next time she checked, he had left a big enough gap for her to be able to see into the cell. Although he continued to block the panel in the evening, he took it down when asked.

180. On 8 January, the boy declined offers to go to the gym or exercise. He continued to block his observation panel, laughing at an officer before being told by another officer that it was unacceptable. He asked for a change in dressing for his arm, which was arranged. At 1.30pm, the first officer found his panel blocked again. She asked him to remove it, but he only moved it enough so that she could see his eyes. Believing that this had gone on for long enough, she placed him on a disciplinary charge.

181. At 3.05pm the first officer went to the boy’s cell to ask him to get dressed as he had a social visit from his foster parents. He initially refused to go, but she reminded him that his visitors cared about him, they had made the effort to
come and see him and were the people who would support him on release. He relented and agreed to go to the visit.

182. The officer in the visit hall recorded in the ACCT that the boy appeared reluctant at first, but then started talking. After 45 minutes, he asked for the visit to be ended. The officer noted that the boy then sat on a different table from his foster parents, who were visibly upset.

183. Another officer in the visits hall spoke to the boy’s foster parents after he had left as they appeared distressed. They explained that he had told them that he did not want to have anything to do with them and never had. They said that he had told them that he did not want to be released early and would make sure, through his behaviour, that this did not happen. They also thought that he was concerned that he might be arrested for other offences when he was released. The officer asked if there was anything staff could do and his foster parents said that the boy had said that he would harm himself.

184. Two officers went to see the boy in his cell, and found him in darkness with the observation panel blocked. One officer later recalled that the boy jumped out from the toilet area when they went into the cell “as if it was a game”. When she told him that his foster parents had mentioned he was concerned about being arrested, he told her he had just said this to “get them off [his] back”. He refused to talk to the officers and repeatedly asked them to leave the cell.

185. The first nurse went to the boy’s cell to talk to him. He found that the observation panel was blocked and that the boy was not communicating. He went into the cell with an SO, but the boy continued to refuse to talk. The SO arranged for observations to be increased to five every hour while he was in his cell, and two per hour at other times. A review was scheduled for the following day, 9 January.

186. The first nurse made a note in the medical record that the ACCT had been reopened. He also noted that he had advised officers to put the boy on report for the tattoo, that he would be reviewed by the in-reach team the next Monday and that a referral form for the Phoenix Unit had been completed. Shortly afterwards, another nurse noted that the boy’s weight was 80.2kg.

187. At 5.15pm, the first officer and a colleague found that the boy had blocked his observation panel again. They went into the cell and found him in darkness in the toilet. They reminded him why it was important that he did not block the panel. The first officer said she asked the boy about his visit, but he said that she knew that he would not tell her about it. She said she had told him that she would continue to offer him the chance to talk. He asked them to leave.

188. The boy continued to block the observation panel. He was verbally abusive to an officer and told him he did not want to unblock it as he was tattooing himself. Staff continued to check on him throughout the evening, and he asked if his stored property could be checked for a CD he was looking for. An officer said that she would check as long as he kept his panel unblocked. He
later asked a member of the night shift (the signature is illegible) how many
times he was being checked every hour. He said that he thought she had
been joking when she said they had been raised to five per hour. The fourth
officer later explained the reasons for this decision, and he agreed that he
found it difficult to talk to people.

189. That evening at 4.52pm, the boy’s personal officer\textsuperscript{14} made a comprehensive
entry in his P-NOMIS case notes (the Prison Service’s electronic record
system). He noted that, because of the boy’s deteriorating behaviour, he had
referred him to the Phoenix Unit in order to get extra support and care. The
personal officer noted that his social skills were poor, that he did not interact
with others on the wing and that his cell was full of rubbish.

190. At 7.45am on 9 January, the third officer and a colleague issued the boy with
two notices of disciplinary charges. The charges referred to the day before,
when the first officer reported that the boy had shown her a new tattoo on the
lower part of his left arm. (He was charged under YOI Rule 55 paragraph 26,
a failure to comply with any rule or regulation.) This was not noted in the
ACCT record. The second charge related to him blocking his observation
panel and refusing to take it down.

191. The third officer noted that the boy was verbally rude but otherwise quite
passive. He accepted the charge sheets, but said he would not comply with
the regime that day. At 9.00am, he told another officer he would attend the
adjudication. Before an adjudication hearing, young people need to be
assessed by a member of healthcare staff to ensure they are fit to take part.
At 9.45am, a nurse saw him in his room and did not consider him fit to attend
the adjudication.

192. Because of this, the first nurse went to see the boy and did not find any
deterioration in his mental state. The first nurse noted that the boy did not
seem to have any motivation and was not concerned about sanctions such as
loss of television or association. The first nurse also discussed with him the
possibility of moving to the Phoenix Unit, but he said that he not want to go
there. (The first nurse noted in the medical record that the first officer had
referred the boy to the Phoenix Unit.) The first nurse decided that he was fit
to attend the adjudication.

193. Before the hearing, an advocate with Voice spoke to the boy after wing staff
told her that he had been non-committal about whether he wanted advocacy
support. He decided that he did not want their help, but said that he knew that
they would support him if he changed his mind.

\textsuperscript{14} Each young person at Cookham Wood is allocated a personal officer whose role is set out in a
policy document (issued in July 2011) which describes the objective of the scheme as follows:

“To establish, develop and offer a support system which provides every young person with
an advisor with whom they have frequent, purposeful contact and with whom they can
establish a good relationship. The personal officer will work closely with the young person,
his resettlement Caseworker, his family and other relevant professionals with the aim of
reducing the risk of re-offending. Personal officers will be allocated from the Residential
officer team within each young person’s home wing.”
194. During the morning, the YOT caseworker contacted a worker at Tower Hamlets Social Services to inform her that the ACCT had been reopened and that the boy continued blocking his observation panel and had tattooed himself. The YOT caseworker also said that the boy wanted to speak to his grandmother, which she thought would need to be arranged by social services, and that another placement would need to be arranged for him.

195. At the adjudication hearing, the boy pleaded guilty to the charges. The adjudicator imposed a punishment of seven days loss of television, canteen, association and eating his meals in association (the opportunity to eat his meals together with other young people rather than in his cell). Following the hearing, an SO spoke to the boy to see if he would attend the planned ACCT review that afternoon. He said that he was not interested. He also told the SO that he did not want to go to the Phoenix Unit to serve his punishment there.

196. The boy spent the afternoon in his cell. Staff frequently had to go in to the cell to unblock his observation panel. At 4.15pm, he attended the ACCT review, which was chaired by the first SO and attended by the first nurse and the Child Protection Officer. The review found the boy to be in good spirits, but the first SO described what he had to say as “poignant”. This was partly to do with his tattoos, one of which was “clearly of his grandmother’s name” and “which can be seen as harming himself as they are … disfiguring”. He talked briefly about the visit the day before. He said that the unhappiness at home was “not new” as his foster mother often cried because of the stress he caused. He refused to go to the Phoenix Unit. He said that he was having thoughts of self-harm, and had thought of ways to do it, but he insisted that he blocked his observation panel to annoy staff. The first SO noted that the boy had lost his television as a result of adjudications, but that he would be provided with other things to occupy him in his cell as long as they did not give him the opportunity to self-tattoo. The ACCT remained open, his risk level remained raised and observations were kept at five an hour while he was in his cell. Another review was arranged for the following day.

197. That evening, the boy had a shower and asked for some new plasters, which he was given by healthcare staff. He asked the third officer for a comb, but she would not give him one because of his previous self-harm. He told her that he “had things on his mind”. She offered to talk to him further, but said he replied “what’s the point, it doesn’t make any difference”.

198. The next morning, 10 January, the boy asked if his day’s activity could be changed to wing cleaning. He refused to go to a planned creative media session. He had a visit in the morning from the Tower Hamlets duty social worker (he did not have his own allocated social worker at this time).

199. The next Safer Regimes meeting was also held on 10 January. It was noted that he
“does not communicate with staff. He is now on an open ACCT for self-harming and is also on a BIP. He is negative about everything and has stated with only 2 weeks [left to serve until his earliest possible release date] will cause the Prison a lot of problems. He has already said he does not want to return to his carers [foster parents], who he has been with for 10 years”.

(Below that paragraph, the minute from the previous meeting about him was repeated.)

200. Early in the afternoon, the boy spoke to the Child Protection Officer and a chaplain. The chaplain reported that the boy was happy to stay in his room all day. She asked him what he might do to improve himself in terms of his education, but he merely drew attention to his recent self-harm scars, “almost to the point of bragging”.

201. The boy refused to go to education at 2.30pm, but attended an ACCT review, which was chaired by an SO and was attended by the first nurse, the YOT caseworker, the Child Protection Officer, a member of the safeguarding team, the advocate who had been asked to attend by the YOT caseworker, and an officer from Medway YOT. The SO noted that he did not really engage with the review and was “not taking it seriously”. He said he had no thoughts of harming himself, did not want early release as he thought he would be back in custody soon, and that he did not trust people. He repeated that he was happy to remain in his cell. The SO recorded that the boy had offered to help young people who felt vulnerable when they first came to Cookham Wood, which was seen as a positive. The review panel decided that the level of observations should be reduced to two observations an hour, with three quality conversations each day. His level of risk was reduced to low.

202. At interview, the SO recalled that the boy did not give the panel any information about himself at this review. The panel offered to vary his activities in an effort to engage him, by getting him cleaning in the morning and to go to education in the afternoon. He agreed.

203. Later that afternoon, at 5.45pm, the boy was given a yellow card by an officer after apparently misusing his cell bell when he had been told not to. Although he accepted the card, he was abusive to the officer. Ten minutes later, the officer gave him another yellow card after he continued to be abusive.

204. The next day, 11 January, the second officer told the boy that he was now on the wing cleaning team. He told her “I don’t care”.

205. Later that morning, the boy had an appointment with the psychiatrist. The psychiatrist recorded the details of this meeting in both the medical record and the ACCT. He found no signs of depression or psychosis. The boy said that he had not been feeling well and had been cutting, but could not explain the reasons for the deterioration in his behaviour. He admitted that he had missed several doses of medication but agreed to start taking his medication again. The psychiatrist increased the dosage of atomoxetine to 40mg, and
continued aripiprazole 2.5mg each night. He arranged to see the boy two weeks later.

206. After he returned to Ash wing, the boy continued to block his observation panel, although he moved the blockage slightly when asked. That afternoon, an education link worker visited the boy in his cell to discuss why he was refusing to engage with education. The first SO recorded that he was initially uncommunicative, but the link worker decided to try one-to-one teaching. He said that he did not want it. The first SO described his mood as “playfully obstructive”.

207. At 7.45pm, the second officer, with a colleague, went into the boy’s cell as they thought he might be tattooing himself. She noted that he responded by asking “why do you think I’m cutting myself, I’ll show you cutting myself, I’ll put something round my neck if you want”. The first SO then went to speak to him.

12 January

208. Another SO spoke to the boy the next morning, 12 January. She asked him about his self-tattooing and explained the hazards to him. However, he did not appear to want to talk to her. She noted that he seemed a “very unhappy young man, with emotional problems – certainly keeping people at bay and not opening up”.

209. The boy spent the morning cleaning with an officer, who noted that he worked well and was laughing and joking. During the afternoon, he blocked his observation panel repeatedly. At one point, he ripped up his education work, which he was doing in his cell, and threw it under his door. The first SO spoke to him. He then painted over his observation panel. The first officer noted that the boy was lying on his bed, “looking quite proud of himself”. That evening, he was taken for his medication, allowed to make a phone call and returned to his cell at 8.00pm.

210. At 8.35pm, the boy showed an officer some superficial cuts to his arms. The officer called healthcare and a nurse attended and dressed the wound. The nurse noted that he had used ink to highlight a tattoo with the name of his grandmother. The officer completed a report of injury form (F213).

13 January

211. The third officer saw the boy at 8.50am on 13 January. He declined to go to one-to-one education and refused her offer to get some education work for him to do in his cell. He spent the morning cleaning. He refused to attend his next ACCT review that afternoon, which was called as a result of the superficial cuts he had made the night before.

212. This ACCT review was chaired by a T/SO and attended by the fourth officer and the first nurse. The T/SO went to the boy’s cell to get him for the review, and explained that it was because of his self-harm the previous evening. The
boy said that he had not harmed himself and declined to attend. As he had
denied making the cuts, the panel decided to keep the observation level the
same. His level of risk remained assessed as low.

213. After the review, the fourth officer went to speak to the boy, but said he was
“unprepared to listen to what advice I try to give him” and that he found him
quite disrespectful.

214. A nurse noted that the boy had not taken his morning medication for both 12
and 13 January. He recorded in the medical record that “he must be carefully
observed when taking tablets [and] should he continue to miss the morning
dosages, in-reach must be informed Monday morning”. It does not appear
from the medical record that this was done.

215. Later that evening, the boy helped an officer with kit change for the wing, and
then had a shower and made a phone call. The officer described him as
being “a brilliant help” and “in a very good mood”. He asked the officer for a
green card. However, the officer issued adjudication papers for a disciplinary
charge of repeatedly blocking his observation panel (this charge related to
events the day before, 12 January). The boy ripped up the papers, saying it
was “stupid”. After he refused to unblock his observation panel later that
night, another officer turned the power off in his cell.

14 January

216. The boy continued not to engage with staff and to block his observation panel
the following morning (14 January). He also did not attend to collect his
medication.

217. At 11.00am, the boy was taken for an adjudication with the Head of Young
People. He pleaded guilty. He was punished by 14 days loss of canteen and
television (both suspended for three months) and seven days loss of dining in
association.

218. After returning from the hearing, the boy pressed his cell bell. He asked the
second officer if he could get some plasters to cover the tattoo of his
grandmother’s name. She said that she would call healthcare for them to
attend when they could (there is no mention in his medical record that they
did). She noted that he had blocked his observation panel with a piece of
paper which said “You are the devil”, a phrase he repeated to her as she
walked away from his cell.

219. At some point during the day, an SO conducted an assessment under the
rewards and sanctions scheme. He issued a final written warning as the boy
was not engaging with the regime, even though he had been allocated
cleaning responsibilities. The SO noted in his review decision that “it is hoped
that by allowing him a second chance he can improve his behaviour and
prove that he should remain on standard/silver regime”.

42
At 1.00pm, he asked the fourth officer for a pen so that he could write to his solicitor. The fourth officer later took him to make a telephone call (it is not clear who this call was to), but he could not get through. He was reported to be in good spirits. At 5.30pm, he refused to unblock his observation panel, so the further officer and a colleague went into the cell. He seemed to be fine.

Twenty minutes later, the boy asked another officer when he would get “things” (such as his television) back. The officer said that this would depend on his attitude with staff and if he stopped blocking his observation panel. The boy said he would do whatever he liked. At 6.45pm, he rang his cell bell. He told the officer that he had tried to cut himself with a knife but had failed to make a mark. He also said that he would try and “string up” that night as he had “had enough of life”. As a result of this conversation, an SO took a plastic knife from him and increased the level of observations to four an hour. He also arranged for a review to be conducted the following day. (Two days later, he told another officer that he had spent some time in a safer cell (one which is designed to be free of ligature points) that evening. There is no record of this in the ACCT record. There are also no safer cells at Cookham Wood.)

Shortly afterwards, at 6.50pm, the fourth officer noted that the boy had said that his grandmother was the cause of his issues. He said that he would hang himself in five minutes. Ten minutes later, he asked another officer for a pen. She asked him to clear his blocked observation panel. He replied by saying he would “string up” in 20 minutes, but then moved the obstruction in the observation panel so that she could see him.

Within a quarter of an hour officers could not obtain a response from the boy. An officer and a SO went into the cell. They found him leaning on his toilet, laughing. He was abusive to them. At 7.25pm, he passed a note under his cell door which said “I am going to string up and I am being serious”. At the next check, 7.45pm, the boy could not see him, as he was in the toilet. After a few knocks on the door, he gave a verbal response to fourth officer.

He continued to make it difficult for officers to see him. An officer noted that he was using tea bags to block the observation panel. At 8.48pm, he told the officer that he would do it (kill himself) that night. However, by 9.45pm, he had moved the block sufficiently for officers to see him.

15 January

The next morning, 15 January, an officer noted that the boy was “so aggressive” whereas he was normally quite polite to her. He refused to clean his room, even though she offered to help. Later that morning, he asked her why she cared. She told him that she did not like to see him like this when he had once been so chirpy. He did not attend for his medication that morning.

A chaplain saw the boy at 12.00pm. She noted that he missed his family and “seemed very sad in himself”. Soon after she left his cell, he shouted abuse to an officer through his door.
227. In the early evening, the boy asked about getting his television back. An officer told him that he would not get the television back that night and his behaviour would need to improve (he was due to get his television back the next day). He threatened to “smash a Gov’s face in” when he next came out of his room. Shortly afterwards, the boy blocked his observation panel again. When the officer eventually obtained a response, he swore at her. She told him that staff just wanted to help, but he said something under his breath that he would not repeat.

228. Over the next hour, he spoke to an officer several times. After asking him for the time, he was then rude and abusive to him, and told him to go back to his own country. Later, he asked the officer if he was on the medication list. When told that he was, he was verbally abusive to the officer.

229. At 7.45pm, the second officer noticed that the boy had blocked his observation panel again, although she could see him in the gap at the side of the door. At 8.23pm, however, she could not see him and went into the cell. The boy was standing in the toilet area.

16 January

230. The boy spent the morning of 16 January cleaning the wing with an officer. The advocate saw him that morning and recalled that he was smiling. They talked briefly about his accommodation when he was released, and she reminded him to come and talk to her once he had decided what he wanted to do. At 12.00pm, the second and third officers went to return his television. As he had again blocked his observation panel and refused to take it down, the officers did not return the television.

231. An officer spoke to the boy at 1.00pm. He said that he was okay but had been held in a safer cell for a while on 14 January. The officer noted that the boy seemed jovial and was laughing and joking.

232. The boy attended a one-to-one education session at 3.35pm. The tutor noted that the boy engaged well and used a dictionary, although he said that he did not know the alphabet. He also said that he had difficulty adding up his canteen sheet. She agreed that this was something they would work on.

233. At 5.30pm, the boy asked an officer to speak to the wing SO about getting his television back. Fifteen minutes later, he told another officer, who was making a check on him, that he was okay. When the officer next returned to the cell, at 6.15pm, he found that the boy had blocked the observation panel, this time with a note that said “I am string up right now!!!”. The officer called for assistance as he could not get a response. He noted in the ACCT that the boy “found it very funny when we entered the cell”.

234. There were no records made in the ACCT document between 6.15pm and 8.30pm. The boy had been on association and had caused no problems. However, as soon as he returned to his cell, he blocked the observation panel
and became abusive to staff. The fourth officer, who was working night shifts, spoke to him at 9.05pm. The boy said he was happy as he had now got his television back (this was not recorded in the ACCT document). The fourth officer reminded him that he should be good so that he did not lose it again.

17 January

235. The following morning, 17 January, the boy refused his medication and exercise, and also did not attend an appointment with the first nurse. He did some wing cleaning with an officer, who noted that he “worked really well and seemed in good spirits”, and had been quite chatty with another young person.

236. At 11.00am, the Roman Catholic chaplain spoke to the boy. He said that he did not receive any replies to the letters he sent out, and did not manage to make contact with family members by telephone. She asked if he sent visiting orders to them, and he said that he had not done so recently as he did not want them to visit. She noted that “he is still reluctant to say much though with a bit of gentle probing he will communicate more”. He collected his lunch shortly afterwards.

237. After lunch, the boy blocked his observation panel but, during a check, asked an officer for a plaster. The officer asked him if he had cut himself again. He said that he had not and, although he could not see him, the officer recorded that he did not seem to be in pain or otherwise distressed.

238. An ACCT review was held that afternoon at 3.20pm. The boy refused to attend the review which was chaired by the first SO and attended by the first nurse, the YOT caseworker, the Roman Catholic chaplain and a YOT worker. The first SO noted that he had made some progress, but that his level of risk was now assessed as raised. She noted the following positive factors:

- He had started cleaning on 12/1/12 and had been consistent with this
- He had attended association on 16/1/12 with no reported problems
- He had started to engage (on 16/1/12) with one-to-one education with a tutor
- He had begun to block less of his observation panel so that staff could observe him – as a result, he had got his television back (although this was due to be returned after the completion of his adjudication punishment)
- He had been using the showers and keeping himself clean
- He had agreed to continue to work with the in-reach team

239. However, the first SO also noted that some concerns remained:

- He was not looking after his cell. The first SO noted that “he has continued to graffiti his blinds and bedding with words like “devil” and random abusive language” (this had not been mentioned in his ACCT document up to this point).
• He was unlikely to get early release in February because of his behaviour, and would therefore be in Cookham Wood until the mid point of his sentence in March.
• Work with social services to arrange a care placement was described as “slow”; neither the YOT caseworker nor the YOT worker were sure about the progress in a change of [foster] carers.
• There had been no progress on enabling him to contact his grandmother.
• He was talking about self-harming, and had discussed various methods he knew. He had also started putting up notes about “stringing up”. His behaviour reflected a raised level of risk.

240. The first SO kept the ACCT document open, with the same level of observations – two times per hour when in his cell, with three quality conversations per day.

241. The boy attended an education session while the review was taking place. He told the tutor that he might try and get placed in a safer cell that night “to waste people’s time”. He said he knew how to make a ligature and that he thought it was “funny to waste officer’s time”.

242. After he returned to his cell, the second officer went to check on him at 5.05pm. He had left a note in his observation panel which said “I am cutting my arms”. She went into the cell and checked his arms. She did not find any new cuts or scratches. She asked him to unblock his observation panel and he smiled at her.

243. He went to association that evening and was noted as being “quite okay [and] chatty with staff”. He told another officer that he would continue to block his observation panel. He was given adjudication paperwork for a hearing the following day. He had been charged under YOI rule 55 paragraph 22 for allegedly verbally abusing an officer at 8.48pm on 16 January, and then using further abusive language. He accepted the paperwork and then ripped it up. (There is no mention of this incident in the ACCT record.)

18 January

244. On 18 January, the boy refused exercise and did not attend for his medication. At 8.10am, the first officer went to his cell for a routine check. He was hiding behind the side panel and, when she called him, he stood up with his middle finger raised. At 8.45am, she returned and found the observation panel blocked with a message saying “I’m going to cut up and so leave me alone”. She went into the cell with a colleague and found the boy in bed. He asked what they wanted. The first officer pointed out that if he did not block his observation panel, they would not have to disturb him. He replied that he wanted to. The officers removed all the paper and glue from his room. The boy said that he wanted his glue back. The first officer said that she would keep it until he stopped blocking the panel. She described him as “rude and abusive”.

46
245. Another officer spoke to the boy a few minutes later and told the first officer that the boy had said that he would “do something today – either cut my arms or string up”. He had also put a note up saying he would string up. He refused to go to cleaning. He kept his observation panel blocked, although the first officer could still see him in his cell.

246. At 10.15am, he was taken to the Phoenix Unit for the adjudication hearing in relation to the charge of being abusive to an officer. The adjudicator, an operational manager, found him guilty and gave him seven days’ loss of association.

247. After he returned to Ash wing at 10.55am, the boy pressed his cell bell and spoke to the first officer. He asked her to post a complaint form for him (the complaint related to her removing his glue). He also asked why his power had been turned off. She told him that this was because he had refused to go to activities, and that it would be turned back on once those at education had returned. He had, once again, blocked his observation panel.

248. Twenty minutes later, he called another officer to his door to ask her what the time was. When she opened the flap, she saw a note in the observation panel asking staff to “leave me alone as I am cutting my arms”. Two officers went into the cell and he showed them some superficial scratches and said “told you I would do it”. A nurse was called to see him, but he refused to show her the marks. She completed a report of injury form (a F213SH), and noted in the medical record that she had not seen the injuries.

249. The first officer turned the power back on at 11.50am. She also removed some Velcro, which the boy had used to block his observation panel. At lunch, he apologised to a different officer for his earlier behaviour.

250. At 3.30pm, the first officer returned to the boy’s cell and found his observation panel blocked. She went into the cell, but he put his foot on the door and laughed. She asked him to remove it, which he did. He refused to attend one-to-one education because he said “he couldn’t be bothered”. The tutor gave him a yellow card for refusing to attend education. He accepted the yellow card.

251. Later, he asked for some writing paper. An officer said he would give him some if he cleared his blocked observation panel. He refused. At 6.15pm, the first officer removed his television as a sanction for the earlier yellow card. She told him that it would be returned the next morning, and he said “well, if I don’t kill myself first”. She noted that the boy smiled as he said this.

252. He next rang his cell bell at 6.40pm. He asked an officer for some paper. However, when she said that she would give him some when he showed some manners, he called her a “dumb bitch”. A few minutes later, he used his cell bell again, and this time he asked her politely. She gave him two pieces of paper.
253. During the next half an hour, an SO went to see the boy as she was concerned about him. His observation panel was still blocked and he refused to let her open the door, putting his foot against it. She described him as rude and abusive and noted that “he is making life very difficult for himself by not accepting any interaction”.

254. The boy continued to block the observation panel, and verbally abused two officers when they checked on him. At 9.00pm, an Officer Support Grade (OSG) noticed water coming from the boy’s room into the corridor and turned the water off. At 10.38pm, the boy asked for the water to be turned back on. The OSG said he would ask. (There is no record of when the water was turned back on.) By midnight, he had lowered the block of his observation panel enough so staff could see him. He did not attend to collect his medication that evening.

19 January

255. On 19 January, at 8.35am, an officer issued a yellow card to the boy after he refused to go to work. He also did not collect his medication that morning. Another officer tried to speak to him at 10.40am, but he was abusive and refused to talk to him. An hour later, the boy asked for his television. The officer said that the sanction for the yellow card that morning was the loss of the television. He swore at the officer.

256. That afternoon, the boy went to his education session. He engaged better with numeracy work than writing. The tutor noted that the boy had brought a pen with him, which he then broke. He refused to give the ink part back, saying that he would tattoo himself later that night. She informed officers on the wing. While the boy was with her, an officer conducted a check on his cell. He found a piece of broken mirror which he thought the boy might use to harm himself.

257. At 5.25pm, after he returned from education, the boy pressed his cell bell and told an officer that he had harmed himself. She asked if she could go into the cell, and he agreed. He showed her a scratch on his forearm which he said he made with a yoghurt lid. She informed healthcare, and a nurse attended. The boy refused to let the nurse examine the arm. The nurse noted in the medical record that the boy had verbally abused staff, but that he appeared “bright and positive”. The boy did not collect his medication again that evening.

258. He later blocked his observation panel again. At 8.20pm, an officer issued him with a disciplinary charge for an adjudication relating to him blocking his observation panel and squirting water through his door the day before.

20 January
259. The next morning, 20 January, the boy joined in cleaning on the wing, supervised by an officer, but did not go to collect his medication. After being passed fit by a nurse, he attended the adjudication hearing which was held by the Security Operations Manager. He was found guilty, and received seven days loss of association.

260. The boy attended a meeting with the psychiatrist that afternoon. The psychiatrist noted that he was not complying with his medication regime and appeared to be distressed. However, he refused to talk about the reasons why. The psychiatrist noted that the boy continued to be disruptive and often behaved in “a childish manner”, but did not see any signs of major depression or psychosis. The boy agreed to talk to the wing staff he trusted, to discuss his difficulties in interacting with them, and to take his medication regularly. The psychiatrist also made a note of this meeting in the ACCT record.

261. Shortly after this meeting, at 12.15pm, an officer went to see the boy as she noticed that he had made a noose made out of shoelaces and tied it to his locker. He told her that he was not going to use it and it was just a joke. She asked him to remove it. She noted that she thought that he would do this again. Ten minutes later, the first officer went into the boy’s cell after he had blocked the observation panel, and he called her a bitch.

262. The officer told the investigators that the noose was very well made and not like any others that she had ever seen. When the boy took it down he said they could not stop him doing it again. She had told him that if necessary they would take all his shoelaces from him if they thought he might use them as a noose. He then told her that he would not put up another noose and that he was only joking. She said that she told an SO about it, but the boy turned it into a joke and said he was only messing.

263. At 1.15pm, the first officer returned to find the boy had again blocked his observation panel. They spoke through the door. The boy asked why he had been placed on report for blocking the panel without being told. The first officer told him that she had told him again and again about this, that his BIP was not working and that in future he would just be placed on report.

264. An ACCT review was held at 3.00pm, which had been arranged following his self-harm the day before. (The record of this review was erroneously dated 19 January 2012.) The boy chose not to attend. The review was chaired by the first SO, who was joined by two nurses (including the first nurse) and the YOT caseworker. The review team were concerned about the way in which the boy made self-harm and blocking his observation panel seem like “child-like play” when they were, in fact, inherently dangerous. They felt that he used abusive language as a way of disengaging with conversation, and were concerned about the number of adjudications he had (although they did not comment on the effect of the punishments and how this impacted on his care). The record of the review does not mention the noose that an officer had found a few hours earlier.
265. The review noted that on the positive side he had attended four out of five education classes and cleaning sessions that week. He had also agreed to take his medication, and to continue to work with the in-reach team. The meeting agreed that the level of observations should be changed to three per hour while he was in his cell. His level of risk remained the same, raised.

266. The boy attended his one-to-one education session. The tutor noted that the boy banged on the wall which connected to the wing office, which he found funny. He did some good maths work, but also put “bullshit” down for several answers, which she thought was done for attention. He told her that officers were annoying him, especially for taking items such as his glue, and that “he would string up” if they continued to annoy him. However, he left the session in apparent high spirits.

267. At 5.15pm, the boy asked the fourth officer for a visiting order and a PIN phone form after pressing his cell bell. The fourth officer reminded him that he had been talking to him all afternoon and could have asked him without pressing the cell bell. After going for a shower, the boy returned to his cell shortly after 8.00pm. He blocked his observation panel. During a check, an OSG noticed that the boy had shoelaces in his hand. The first SO entered the cell, took the laces and removed the blockage.

21 January

268. The next day, 21 January, the boy did not come out of his cell during the morning and missed his medication. Although he had covered his observation panel, he had left a gap so that staff could see him. He asked an SO if he could get a haircut, which the first officer arranged for him. When they returned to his cell at 4.15pm, the first officer noticed a noose made from a shoelace hanging from his locker (which was just inside the door to the right). She cut it from the locker, and he told her that he would cut her next time he saw her. He also demanded his other shoelaces back.

269. Throughout the evening, the boy continued to block his observation panel. The first officer threatened to put him on report. At 6.45pm, he asked the first officer for his shoelaces back and then asked her for a pen. After speaking to another officer, the first officer returned the boy’s shoelaces at 7.45pm, but did not give him a pen as the officers thought that he would use this to tattoo himself. (At 7.20pm, an officer had seen the boy trying to tattoo his arm, for which he placed him on report.)

22 January

270. The following morning, 22 January, the boy went for a shower but did not collect his medication. At 11.20am, he rang his cell bell and asked the first officer for a pen. She could not find one and said that she would check other wings when she had a chance. She noted that his observation panel was not blocked at the time. She gave him a pen shortly afterwards and told him that this would be the last she would give him if he tattooed himself.
271. At 12.20pm, the boy was placed on report by the first officer as he refused to uncover his observation panel. At 12.35pm the third officer gave him lunch. They spoke briefly about his past and his family, but he said he wanted to live, and be, on his own. He said he was usually happy to speak to her. She told him that she would talk to him soon.

272. The boy continued to be checked regularly throughout the afternoon. At 3.40pm, the first officer looked through the observation panel, which was not blocked. She could not see the boy, as he seemed to be hidden completely under the bed covers. After going into the cell she still did not receive a response, so she pulled the covers back. As she did so, he made a funny face and a noise as if he was trying to make her jump. She said she asked if he was okay, and he said “what do you care?” She said she told him that she liked to know that he was safe.

273. An SO arranged for the boy to get a new lead for his stereo after he complained that his had split and that it might electrocute him. At 6.40pm, an officer asked the boy if he wanted to collect his medication. He declined, but the officer noticed that he had painted, on the side of his locker, the words “I’m going to kill myself”. The first officer touched the paint and noticed it was dry. At that point, his observation panel was not blocked.

274. Half an hour later, at 7.10pm, the boy had blocked the panel again. The first officer went into the cell and he removed the blockage. She noticed marks on his arms and placed him on report for tattooing. He asked her if they looked like tattoos, and she noted in the ACCT document that “they looked like lines and zaggy lines, possible self-harm, not fresh”. She pointed out to him that the marks had black ink in them. She also took a pile of paper from his cell. However, his observation panel remained blocked throughout the evening until he fell asleep.

23 January

275. On 23 January, the boy spent the morning out of his cell with a group of cleaners supervised by an officer. She noted that he was in high spirits, and laughed and joked with her and conversed with two other young people in the shower area. He did not attend to collect his medication. When he returned to his cell, he immediately blocked the panel again and kept it blocked despite requests to uncover it.

276. An adjudication hearing was held at approximately 10.30am on 23 January, following an officer’s report of 21 January about the boy tattooing himself. The adjudicator was a residential manager. The boy pleaded not guilty and the charge was dismissed as the adjudicator regarded this as an act of self-harm.

277. At 2.15pm, the boy attended a scheduled ACCT review, which was chaired by the first SO and attended by two nurses (including the first nurse) and the YOT caseworker. In her note of the review meeting, the first SO noted that, by attending the meeting, the boy had shown a small improvement, but many
of the concerns from the last meeting remained. She noted the following steps that would take place in the next week to help him make progress against the CAREMAP:

- He will continue to work with in-reach.
- His YOT worker had a visit arranged for 26 January.
- There was a social services review for that week to help decide on a new carer placement.
- He had also been allocated a social worker which would help his request to contact his grandmother.

The meeting agreed that the document should remain open, with observations at three per hour. His level of risk remained assessed as raised.

278. Following the review, he returned to his cell and asked the first officer for a bin bag, which he was given at 6.20pm. She noted that he got rid of all the rubbish in his cell.

279. The boy attended an individual education session with his tutor on 23 January, at 4.50pm. She recalled that the boy was in high spirits and quite bouncy. During the session, he told her that he had had sex with a teacher. She challenged this and he repeated his claim with, as she noted in a STIIR, a big grin on his face. She told him that this was illegal, but he said it was not, as he had wanted to do it. She asked if he had reported it and he said that he had not. She explained that teachers had responsibility and should not take advantage. She completed a STIIR and discussed his comment with the first SO and the Head of Education at Cookham Wood. The STIIR was passed to the Child Protection Officer at 5.05pm, and she alerted staff on Ash wing about the allegation.

280. During the meeting with his tutor, he asked for an application form to see the optician, which he completed.

281. At 7.15pm, the boy spoke to the first SO about some faces he had drawn on his stomach and in his room. He also gave her several dirty plates from his cell. The first officer noted that he giggled when the first SO called him a hoarder.

282. During the evening, he partly obscured his observation panel.

24 January 2012 – events until 9.00pm

283. A visit order was sent to the boy’s foster parents on 24 January. It is not clear when he applied for the order to be sent.

284. The boy was issued his breakfast pack at 7.30am by the first officer. Twenty minutes later, the second officer asked if he would like to attend exercise but he chose not to. At 7.55am, he went to collect his medication. The first officer noted that he was laughing and joking with healthcare staff, and told
them that he had only gone because he was already awake. It is not clear who issued the medication. The member of healthcare staff replied that it was nice to see him, and he smiled. (Between 14 and 23 January, he missed 14 doses of medication.)

285. The boy spent the morning cleaning with the second officer. She noted in the ACCT record that he had been very helpful and had worked well with another young person. She noted that his work had been of a high standard and that he had been in good spirits. He had a shower before returning to his cell.

286. The investigators spoke to one of the young people who worked with the boy that morning. He said that he had not known the boy that long, but that they talked when they were cleaning. He said that he had asked the boy why he kept blocking his observation panel, and he said he did it to “give officers hell”. The young person also noticed the scars on the boy’s arms. The boy said that these were tattoos, which he did because it was something to do. The young person told the investigators that he did not think that the boy was being bullied. He said that “there is no bullying at Cookham Wood”. He also said that, on the morning of 24 January, the boy had been happy while out cleaning. He did not think that the boy had intended to kill himself.

287. At 10.00am, a Safer Regimes meeting was held. There was a lengthy discussion about the boy, and the relevant section of the minutes is repeated below:

“He declined to move to Phoenix due to him seeing it as a punishment rather than a support mechanism. He has been seeing [the first nurse] and has also seen the psychiatrist. He appears to be regressing into child-like behaviour in an attempt to undermine wing staff and is telling other young people to behave in the same manner. He had an adjudication yesterday for tattooing himself. He has been found guilty of this on a previous occasion. In future this is to be seen as an act of self-harm. He has made a disclosure of abuse to a teacher yesterday. The Child Protection Officer is to follow this up. He has a YOT review this afternoon to discuss a discharge address. He is partaking in wing cleaning and his one-to-one inclusion programme.

“He has refused a move to Phoenix. He has been making slow progress on Ash wing and is now taking part in wing cleaning and one-to-one inclusion. He has an ACCT review today, is seeing [the first nurse] and will be seen by a psychiatrist if this has not already happened. His early release has not been granted. He does not wish to return to his foster carer. He would like to have contact with his grandmother however his brother (who he was abused by) lives with his grandmother.

“He has no allocated social worker at the local social services and is always seen by a duty worker. He is to be raised weekly at this meeting. [A senior officer] is to talk to him in order to discuss the possibility of a move to Phoenix.”
288. The child protection co-ordinator went to see the boy at 12.20pm, to discuss the allegation he had made the previous day. She noted on the STIIR that he told her that he “was joking, couldn’t she [the tutor] tell, I was laughing”. She noted that he did not seem to think that it was a very serious allegation, but she told him that she would be referring the information to the local authority. They had a conversation about how he was feeling. She told the investigators at interview that he was fine when she left his room.

289. That afternoon, the boy was asked to attend a workshop on Oak wing organised by the YOT team manager at Cookham Wood for a group of trainee social workers. The young people were asked to describe their ideal social worker. She recalled that he said “someone who listens”. (The Head of Children’s Integrated Services, who was also present for part of the meeting, thought that this was “quite a strong statement”. He also said that the boy spent the meeting standing by a window.) He also said that he missed his family, but was otherwise quiet.

290. After returning to his cell, he asked staff when his one-to-one education session would start. The second officer spoke to him. She noticed that he had made himself a hot chocolate and “was very smiley while chatting”.

291. The boy’s education session started shortly afterwards. The tutor said that, on 23 January, the boy had taken an application form to see the optician but that when they spoke about it on 24 January, she did not think he had put the application in properly. She said that she went to the Ash wing office and told the staff that he had agreed to see the optician. She recalled that “everyone’s faces lit up” as they had been trying to get him to go for a while.

292. The first officer went to get some forms. When she returned, the boy was struggling with a maths question and was not listening to the tutor. The first officer showed him how she would do it. The tutor recalled that he seemed to engage much more with the officer, even though the method was the same.

293. The tutor told the first officer that, earlier in the session, the boy had pulled out a pair of laces from his pocket, with a massive grin on his face as he did so. At interview, she described the laces as “a horrendous colour and I just thought what sort of trainers are they going to go with?” She said that he had said “look what I have got”, and she asked him why he had them. He replied “because they are mine, I can have them”. She said that this made her question whether he should have them or not. The first officer spoke to him and, according to the tutor, said to him “well, you’re allowed your laces, you’ve got your trainers in your room”. He said that he had and grinned at her.

294. In the ACCT record, the tutor recorded that the boy had attended the one-to-one session. She said that he initially engaged well with a numeracy test, but then “became silly and ripped his work up. We discussed this was not acceptable”. No reference was made to the shoelaces.

295. At 4.48pm, the second officer took the boy’s dinner to him as he was still not allowed to eat with other young people as part of his previous adjudication
punishment. She noted that he was sitting by his desk, but was holding a photograph, which he turned over when she went into the room.

296. The second officer next checked him at 5.25pm. He had blocked his observation panel and prevented another officer from entering his cell. Eventually, he relented and allowed officers in. By 5.45pm, he had blocked his observation panel again. An officer kicked the door to get a response, and asked him to take the obstruction down. He refused and used abusive and racist language towards the officer.

297. An officer then went to see him at 5.55pm. He still had his observation panel blocked, and was rude to the officer. The first officer was with him, and went into the cell as she could see a wire hanging down. When she realised it was the stereo cable, she left it in place. Twenty minutes later, he again refused to uncover his observation panel. At 6.36pm, he rang his cell bell and asked the first SO for the time. He then became disrespectful and rude, swearing at the first SO.

298. The second officer returned to his room at 7.00pm to take him to collect his medications. She noticed a superficial cut on his left forearm. He refused to talk to her about the cut or to show her his arm, and said he did not know what she was talking about. She said that he then became rude and told her that he did not like talking to her as he did not like her. He named an officer he would only talk to.

299. At 7.20pm, a nurse came to Ash wing to examine his cuts. The second officer thought he had made them worse, but the nurse thought, albeit from a distance as he would not let him look at the cuts, that they were superficial.

300. The first officer checked the boy again at 7.30pm, when his observation panel was blocked. She looked through the gap in the door and saw him sitting at his desk. Ten minutes later, she returned and, as his observation panel was still blocked, she went into his cell. He was still sitting at his desk. She asked him what was wrong, and he said “what do you care?” She told him that she did not like to see him suffer or struggle as he was. He asked her again why she cared, and she said that, even though she wore a uniform, she could have compassion and sympathy with someone who was not feeling so good.

301. He then told the first officer that if she knew his past that she would understand. She told him that she did know some of his background. He asked her what she knew. She told him that the YOT had informed them of as much of his background as staff at Cookham Wood needed to know to help him through his sentence. He pushed her for more detail each time she answered, and she told him that she knew about the abuse that he had suffered as a child. He continued to press her for details. She asked him if he really wanted her to speak about it and he said that he did. She eventually told him that she knew about the sexual abuse that he had suffered from his brother. She said he replied that she was telling the truth and it was good that she was not pretending she did not know.
302. The first officer recalled that the boy told her that the abuse was called rape. She asked if that was the reason he was feeling down. He asked her how she would feel if her brother had done what his had done to him. She said that as she was not in that position, she could not really know. He said that it was all he ever thought of, day and night. She asked if he was working with a counsellor. He said that he had since he was six years old and that it did not help. She asked if they could help him with some of his less serious problems, which might help take the pressure off him, but he said that this would not help him either.

303. He then told her that he wanted contact with his family (definitely his grandmother but perhaps also his mother) and that this was a big issue for him at the time. He said that, when he was released, he would come back to jail as he was going to kill his brother. He then said that he would shoot his brother, then shoot himself, and then that he would disappear after he was released so that nobody would see him again “as if he had vanished”. She asked him if he meant that he would go on the run or kill himself. He said either.

304. He then told her that “there was nothing good in life”. She told him that there could be, and it was up to him to make his choices. She added that he should not let his brother take away the rest of his life and happiness, to which he asked her why he needed to be happy. He told her that he was going to string up from the locker “and there was nothing they could do about it”.

305. The first officer said that they would keep him as safe as they could. He replied that he was only checked three times an hour (as the observations had been reduced at the previous review), which left a lot of time in between. She told him that that could change, to which he replied that if someone wanted to die, they should be allowed to die. She told him that he might not feel that way tomorrow and, in any case, by law people could not just stand by and watch. He said that he did not trust adults, and told her that he had not trusted his foster parents in the ten years he had been with them. He said there were only two officers he would talk to. She asked if he would like to talk to another officer, as she was on duty, and he said he would. She said she would ask this officer to come down when she could. She also reminded him that he could use the Childline telephone if he wanted to, but he was not keen. He asked if he could have a telephone call and she agreed.

306. At 8.00pm, the second officer took the boy for a telephone call. (CCTV footage of his landing on Ash wing and the telephone area confirms that the timings are broadly correct from this point on.) She recalled that he pulled up a chair and sat on the back of it, facing away from her. She remained outside the room, to give him privacy, but could see him “with his head down in his hands quite a lot”. She thought that he was wiping his face a lot, and that this had been an emotional telephone call.

307. The investigators have seen a copy of the transcript of this telephone conversation. He started by talking to his foster father who asked how he was. He replied “Dunno” and, when pressed by his foster father, said that
nothing was the matter, but that he was not keeping out of trouble and would not be released until 9 March. He then spoke to his foster mother. They spoke briefly about some family news. He then asked “Do you know what is happening about me moving? [to a new address on release]”. His foster mother told him that his social worker was coming to see him that week. He replied “cool”. His foster mother said that she hoped that he would keep in touch. He said he would try. They then had a discussion about his property before he said that he had had enough. His foster mother pressed him about this. He said that if he lived with her he would end up getting back into trouble. The call ended quite abruptly while he and his foster mother were discussing an event that had happened several years earlier. It is not clear what (or who) ended the call.

308. When the second officer took him back to his room, she asked him if it had been a good call. He shrugged. She asked who he had called. He said that he had called his mum and said that he had not spoken to her for a while. Another officer noticed that he “almost started to cry”, but quickly stopped himself, “like he realised that he had let his guard down”. She told him that he could talk to any member of staff at any time, and if he did not want to talk to her, she would do her best to get someone he did want to talk to.

309. The second officer recalled that this behaviour was uncharacteristic for him, and she was concerned about him. She went to the wing office to speak to the first officer, who was speaking to an SO about her concerns following her earlier conversation with him. The officer explained her concerns about the telephone call, and the SO agreed to the officers’ proposal that they should raise the level of observations to five an hour, and to hold an ACCT review in the morning. (This conversation was not recorded in the ongoing ACCT record, although it was recorded in the wing observation book.)

310. When interviewed, the SO said that because of the time, it would have been impossible to hold a multi-disciplinary review that evening and that he thought it would be better to wait until the following morning. He added that he did not know the boy, as he did not usually work on Ash wing, and he relied largely on the experience of the two officers, who knew him well. The SO did not recall discussing other measures such as constant observations.

311. In the meantime, the third officer came to speak to the boy. After a general chat about how their days had been, she asked how he was feeling. He said that he had had “a bit of an evening” and felt very low. They sat in silence for a while, before he asked her why she cared. She told him that, as in the world outside Cookham Wood, there were people who you get along with and relate to and, while they were not friends, they were comfortable enough in each other’s company to sit and talk. She told him that she would come and sit with him any time he needed. He replied “would you?” and she said that she was next in on Thursday (26 January) and would come to see him to catch up then. She noted in the ACCT that he made good eye contact and had good body language at all times.
312. When interviewed as part of this investigation, the third officer recalled that when she told him that she would be back on Thursday, he said “I won’t be here on Thursday”. She described this as being a normal sort of thing for him to say. She then recalled speaking to the first officer and asking her to make sure that she was allocated a role on Thursday in which she would get the chance to speak to the boy. She said she also arranged to become his new personal officer. (This was not recorded in the ACCT document or elsewhere.)

24 January 2012 – events after 9.00pm

313. The first officer handed over to the fourth officer at 8.50pm. The fourth officer checked the boy at 9.00pm, noting that he was at his door talking to an OSG. The OSG recalled at interview that the boy had blocked his observation panel. As she asked him if he was going to unblock it, she noticed that he had stuck a plastic fork through the gap at the side of the door. She started playing with the fork, pulling on it. He asked what she was doing, and she said that she was playing with him. She told the investigators that she was trying to engage the boy in conversation (she had heard the handover between two officers and knew that the observation level had been raised to five observations per hour). He said that he could stab her with the fork. She told him that he could not do a lot of damage with it. She said that he then laughed and pulled the fork back in. He said again that he would not unblock the observation panel. She said that she would go and talk to the fourth officer.

314. Shortly afterwards, the boy rang his cell bell. The third officer said that she would answer it, and let the boy know that she was taking over as his personal officer. He asked for a toothbrush. She told him that she was now his personal officer, to which he replied “I’ve known that for weeks”. She told him that it was now official, and he said “oh right, okay”. She said again that she would see him on Thursday, and he said he would not be there. When she asked why, he said that he would hang himself from his locker. She said that night staff would be happy to talk to him at his door all night. She could not recall what his response was. (This conversation was not recorded in the ACCT document, although the fourth officer noted that, at 9.15pm, the third officer was talking to the boy at his cell door.)

315. When interviewed, the third officer said that she did not “perceive [the threat] as being immediate”. She said that she would have been almost more concerned if the boy had not told her that he would not be there on Thursday. She recalled that she was initially concerned when she was called down to see him, but they had then had “the most normal conversation” with him and had talked about the future, for example about her becoming his personal officer. She recalled him being quite jovial. In summary, she said that she thought that it was right for the level of observations to be raised, but that he did not need to be in a safer cell or to be under constant observation.
316. At 9.23pm, the fourth officer gave the boy a toothbrush, passing it through the gap in the door. He told the interviewers that normally staff would not give young people a toothbrush at night, but did so as he was in a low mood and this was part of his interacting with staff. He was drinking a cup of hot chocolate. He recalled that the boy thanked him.

317. At around 9.30pm, the OSG went to check on the boy but did not get a response. His observation panel was blocked and she could not see anything through the door. After ten or 15 seconds, she went to call the fourth officer. (The investigators have watched the CCTV footage and can confirm that these checks were made as recorded.)

318. The fourth officer was in the wing office with another officer who was working on Beech wing that night, but who was having problems with his computer system and had come to Ash for some advice. The fourth officer tried to get a response from the boy, but was unable to do so. He turned the night light on and looked through the crack in the door, and saw the boy’s legs along the floor. The officers did not use their emergency keys to enter the cell but the fourth officer radioed the Night Orderly Officer (NOO, who was in charge of the prison while it was in night state), the Temporary Senior Officer (T/SO), and asked her to come to Ash wing. (Staff on night duty do not carry a full set of keys, but hold a cell key in a sealed pouch. While they can use the key to open a door in an emergency, according to Cookham Wood’s operating instructions, staff are required to inform the Control Room before they do.)

319. The T/SO told the investigators that she was in the orderly office, talking to the first officer about her concerns about the boy. She telephoned Ash wing and was told that the boy had blocked his observation panel and that staff could not get a response. The first officer heard this conversation and, according to the T/SO, got upset and rushed towards the wing. The T/SO followed her.

320. Another officer was in reception when he heard the fourth officer’s radio call. He contacted Ash wing and asked if he should come over, and the fourth officer asked him to do so.

321. As the first officer was on a day shift, she still had a full set of keys with her. When she arrived at the boy’s room, she looked through the gap in the door and thought she saw him hanging. She told the fourth officer that they needed to go in. The T/SO had also arrived by this time and shouted that they should wait, but the first officer decided to enter immediately.

322. When the first officer opened the door, she hit the boy’s body, as he was only a few inches from the door. After opening the door with the fourth officer, they went in and cut the shoelaces from which he had suspended himself from his locker. The boy dropped to the floor, and the first officer noticed blood come from his face on to the wall.
323. As the shoelaces were still around the boy's neck, the first officer pushed her fingers underneath them and used her cut down tool to release them. She and the fourth officer tried to turn the boy over as the other officer had arrived from reception. When interviewed, they recalled how difficult they found this. The fourth officer said that the boy was covered in blood, his face was swollen and that he could not see him breathing.

324. The first officer started CPR (cardiopulmonary resuscitation) by giving chest compressions. The fourth officer tilted the boy’s head back to try and open his airway, but found that his jaw was locked tight and that he could not get his fingers in enough to try and clear any obstruction. He put his head down next to the boy's nose to see if he was breathing, but he could not feel anything.

325. The T/SO asked another officer to call for an ambulance. He spoke to an OSG in the gate area who telephoned for an ambulance at 9.35pm.

326. The first and fourth officers, and the OSG, continued to give CPR. The fourth officer asked the T/SO to get a mouth guard and gloves. The T/SO then asked another officer to get the emergency response box, which was on the wall of the Ash wing office and contained a mouth guard and gloves. The T/SO recalled at interview that the officer had some trouble getting the box off the wall.

327. When the officer returned to the cell, the first officer asked him to fetch an oxygen tank. He did not know where the oxygen was, so he took over CPR from the first officer. She then returned with the oxygen and, using a mask, began to administer air while the fourth officer continued chest compressions.

328. The officer who had come from reception recalled at interview that he was asked, over the radio, to pick up the Ash wing office telephone. He did so, and found the ambulance crew asking for further details. He told them that it was difficult to answer their questions about the boy's condition as he was not at the cell and did not have a mobile telephone. After he had spoken to the ambulance crew for a couple of minutes, a paramedic arrived and the call ended.

329. The T/SO estimated that the first paramedic arrived at the boy’s cell within eight minutes of being called, after being escorted to the cell by another officer. This officer recalled that the paramedic had parked at the barrier to the next car park, rather than outside the main gate of Cookham Wood. While the paramedic prepared her equipment, she asked the officers to continue to administer CPR, although she alternated at times with the fourth officer. After the paramedic used a defibrillator to deliver an electric shock, and had prepared her own oxygen equipment, the first officer took over from the fourth officer.

330. A second ambulance crew arrived at the boy’s cell, at 9.45pm, escorted by one of the officers. The OSG took over CPR from the first officer while they were briefed by the paramedic.
331. One of the officers returned to the gate as another ambulance was on its way. He and the officer from reception recalled that the third ambulance also had difficulty locating the correct entrance for Cookham Wood, having gone towards HMYOI Rochester before turning round.

332. The T/So returned to the orderly office and informed the duty governor and the Governor, who were both at home. Two officers were contacted at home and asked to come to Cookham Wood to provide cover.

333. The Governor contacted the Head of Children’s Integrated Services and asked him to go to Cookham Wood as he lived closer than her. The Head called the YOT Team Manager at home and also asked her to come to Cookham Wood as he wanted her to contact Tower Hamlets Children’s Services as the boy was a ‘looked-after’ child (which meant he was in the care of the State).

334. Ambulance staff continued to use a defibrillator and also used adrenaline several times in their attempts to resuscitate the boy. Eventually, at approximately 10.10pm, they managed to establish a pulse and decided to take the boy to hospital. Officers cleared the corridor, which was full of equipment, so that he could be carried to the ambulance on a trolley.

335. After the ambulance had left for the hospital, the Head asked the members of staff involved to write a note of their involvement that evening in their pocket books. He also contacted the staff care team to make sure that there was appropriate provision the following morning.

336. At 10.50pm, the Head telephoned the co-ordinating chaplain at home to brief him and ask him to attend the hospital to support members of the boy’s family. He arrived there at 11.00pm.

337. The boy’s foster parents arrived at the hospital at 12.20am on 25 January. The co-ordinating chaplain gave them the details of what had happened, and took them through to the accident and emergency department, where the boy was being treated. They were asked to wait in the relatives’ room while he was taken for a scan.

338. Throughout the night, the co-ordinating chaplain and the Head kept in close contact. At 1.35am, the Head confirmed that the YOT Team Manager had still not been able to get hold of Tower Hamlets Social Services. The boy’s foster parents told the chaplain that they had been given permission by their support social worker to telephone the boy’s father. He asked if they had the out of hours number for Tower Hamlets and they said they would ask their support social worker.

339. After this was agreed, the chaplain called the Head at 2.05am with the contact details for Tower Hamlets. He also expressed his concern that the foster parents had the burden of contacting the boy’s father when this should have been for social services as he was a looked-after child.
340. Shortly afterwards, doctors spoke to the boy’s foster parents. They said that they were going to move the boy to the Intensive Care Unit (ICU) and would assess his condition again at 8.00am. However, they also told them to expect the worst, and that they thought the boy had suffered some form of brain damage, the extent of which was unclear.

341. At 2.40am, the boy’s father and uncle arrived at the hospital. The chaplain met them and told them what he knew about his condition. He also asked if the father had any contact with the boy’s mother, but he said that he did not and, as far as he knew, she had not had any contact with her son.

342. YOI staff arriving at Cookham Wood for early shifts were asked to wait in the orderly office and were briefed about what had happened by the Governor. They were advised that the staff care team was available if they needed support.

343. Later that morning, the Governor spoke to groups of young people in landing groups on each of the accommodation units and told them what had happened to the boy. Members of the care team and chaplaincy were present at these meetings to identify any young people who had concerns, and those on ACCTs (or whose ACCTs had recently closed) were seen individually.

344. The same day, Cookham Wood had a planned family visit day, which the Governor decided should continue. The duty governor spoke to the parents at the start of the day to tell them what had happened and to listen to their concerns.

345. At 10.45am, the senior consultant in charge of the boy’s care at hospital called the foster parents, the boy’s father and uncles and the chaplain into a room to explain the results of the test they had conducted. The consultant explained that the boy had suffered severe brain damage and, because of the lack of oxygen to his brain, it was likely that he would be severely disabled if he survived. The consultant said that they would keep the boy sedated and review him again in 24 hours. If he had not made any improvement, they would then withdraw medical interventions. In the consultant’s opinion, it was unlikely that the boy would survive.

346. The co-ordinating chaplain left the hospital at 11.58am. He noted that at that time no one had arrived from Tower Hamlets. Shortly afterwards, he called the Roman Catholic chaplain at the hospital at the boy’s father’s request and left a message asking him to contact him. The Roman Catholic chaplain called the co-ordinator chaplain at 1.35pm and agreed to visit the boy’s father.

347. In the meantime, the Kent NOMS regional office contacted an operational manager from HMP Swaleside to ask him to assist the co-ordinating chaplain, who had been at the hospital since the early morning. The operational manager, who was a trained FLO, was briefed by the Head of Children’s Integrated Services and arrived at the hospital at 1.30pm. He introduced
himself to the officers on the escort team and the Deputy Governor. The Deputy Governor introduced him to a member of Tower Hamlets council, who had arrived after the co-ordinating chaplain left. Members of the boy’s father’s family, and his foster parents, were also introduced to the FLO.

348. After the boy’s condition deteriorated, his father asked the FLO to try to contact the Roman Catholic chaplain again. As the chaplain had to come from Rochester, the FLO asked the hospital Church of England chaplain to comfort the family in the meantime.

349. According to the FLO’s log, the Roman Catholic chaplain arrived shortly after 3.00pm, and at the boy’s father’s request, baptised him. (A log kept by the escort officer states the time as 4.05pm.) His foster parents had also arrived back at the hospital as his father had called them to let them know that his son’s condition had deteriorated.

350. At 4.00pm, the FLO spoke to the nurse who was looking after the boy. She told him that the boy’s eyes were fixed and dilated and that they were struggling to maintain his blood pressure. At about the same time Kent Police arrived and, after speaking to the boy’s family, took his clothing for evidence.

351. The boy’s blood pressure was stabilised at 5.30pm, after medical staff managed to get a second fluid line into him. The FLO was told that the consultant would review his condition at 8.30pm, and then complete a full clinical assessment the following morning. After making sure that all parties had his contact details, the FLO left the hospital. At 7.20pm that evening, the boy died.

After the boy’s death

352. Twenty minutes after the boy died the escorting team informed the FLO, who informed the co-ordinating chaplain, who had already been told by another chaplain. He went to the hospital to support the family. The FLO informed the NOMS Kent Area office and Kent Police of the death. Later that evening, the chaplain telephoned the foster parents (who had not been at the hospital) to offer his condolences. The Governor wrote letters of condolence to the boy’s father, his mother and his foster parents.

353. The next morning, the co-ordinating chaplain and FLO met the Governor and Deputy Governor at Cookham Wood to brief them on the previous day’s events. At 11.30am, the chaplain spoke to a representative of Tower Hamlets council, and they agreed that Tower Hamlets would deal with the funeral arrangements. The representative told him that he would be visiting the boy’s father later that afternoon, and his foster parents the following day.

354. At 3.00pm, the chaplain spoke to the boy’s mother. She was too distressed to speak for very long, and handed the phone to her partner. The chaplain told him what investigations would take place and made sure he had a land line number and address for them. He said that he would telephone them again the next morning.
Later that afternoon, the chaplain spoke to one of the boy’s uncles, and his foster parents, and arranged to visit them both the next day.

The chaplain spoke to the boy’s mother again at 8.55am the next day, 27 January. He explained his role again, and asked if she would prefer contact to be face to face or by telephone. She said that she would prefer face to face contact. He offered either to pay for her to visit Cookham Wood and see her son’s cell, or for him to travel to Scotland, where she lived, to visit her. She decided that she would prefer him to visit her, as she did not wish to see the cell or meet the Governor. They arranged this for 31 January.

Later that morning, the Head of Young People chaired a debrief meeting for all staff involved in finding the boy on 24 January. (Normally, these are called “hot debriefs” and are held as soon as possible after the incident. The debrief was held on the first occasion when staff had returned to work.) Those at the meeting discussed what had happened both during the day on 24 January, and when the boy was found.

Several recommendations were made as a result of this debrief. It was proposed that the death in custody contingency plan be updated with current telephone numbers for staff and that the gate instructions should prompt night staff to ask more questions about an emergency when they contacted emergency services. Other recommendations involved the arrival of ambulances at Cookham Wood and the provision of emergency equipment.

Meanwhile, at 10.00am, the chaplain visited the boy’s foster parents at their home. The representative from Tower Hamlets Council was also there. The foster parent’s asked about how the boy had been found, and why he had shoelaces in his possession. The chaplain explained the different investigations that would take place. They arranged for the foster parents to visit Cookham Wood on 1 February, to meet the Governor and speak to staff who had known the boy.

That afternoon, the chaplain visited the boy’s father and uncle. They were concerned that the boy’s name had been given out in a press release. They also discussed the arrangements for the funeral, and agreed that the chaplain would liaise with the boy’s mother to see if there was anything she would like included in the service. The uncle was concerned about the first inspection report on Cookham Wood as a juvenile establishment, which had been very critical and had been referred to in various press reports. The chaplain told him how he could access the full report, but also reminded him that there had been two further inspections which had found Cookham Wood to be a safe place for young people. The boy’s father and uncle arranged to visit Cookham Wood on 2 February.

Later that evening, the chaplain received a further call from the boy’s uncle, who had some further questions about the funeral and the night that his nephew had been found.
362. A funeral service and a memorial service were held for the boy. Staff from Cookham Wood attended both services, and continued to offer support to his family. A separate memorial service was held at Cookham Wood.
ISSUES

Allocation to Cookham Wood

363. The boy was 15 when a custodial punishment was considered following his persistent offending and breaches of his YRO. At that age, he could be placed in an STC, a YOI or a Secure Children’s Home (SCH).

364. Allocation of young people who are sentenced or remanded to custody is the responsibility of the YJB. To guide the YJB, a placement alert form is completed by the local YOT which suggests the most appropriate placement. In July 2011, at which point it was possible that the boy might be remanded or sentenced to custody, Medway YOT advised that an STC (preferably Medway STC) would be the most appropriate placement. The reason given was his vulnerability but the full thinking behind the recommendation is not spelt out. It appears to be because it was considered that he needed the individual support and attention that the STC would be able to provide compared to a much less well resourced YOI.

365. However, after he was remanded into custody on 1 August, he was placed at Cookham Wood. The duty YOT court officer that day told investigators that she was unaware of the YOT worker’s recommendation that the boy should go to an STC. It is difficult to understand how she was unaware of the recommendation as this was clearly on the record. Nevertheless, because of this she did not propose the recommendation for an STC placement to the court which therefore did not consider it. The court simply decided that he should be remanded into custody. At the time this meant the YJB had no option but to place him in a YOI. For an STC placement there would have had to be a court ordered secure remand. We understand that the legal distinction between these two disposals was removed on 3 December 2012.

366. At the time of the boy’s court appearances, Medway YOT did not have a dedicated court worker and instead used a duty roster system. This has now changed and there is now a full time court worker. This should help ensure that the flow of information between YOT workers and the court officer is more consistent.

367. There were places available at Medway STC on 1 and 2 August so that if the court had agreed a court ordered secure remand, the YJB would have been able to place the boy at Medway STC. When we interviewed staff from Medway YOT, they were not sure why he had gone to Cookham Wood on 1 August rather than Medway STC. As he was only 15 and had never been in custody before we are surprised that Medway YOT did not follow up the placement decision with the YJB and identify why the YOT recommendation for an STC had not been followed. This would have enabled them to identify that the YOT recommendation had not been put to the court and consider whether any action was necessary. We make the following recommendation:

The Head of Medway Youth Offending Team should ensure that when a recommendation on a placement alert form is not followed, the reasons
are established and recorded, and any appropriate remedial action taken.

368. The mistake at the hearing in August, which led to the boy being placed at Cookham Wood, seems to have been pivotal in him returning there when he was before the court for sentencing in October. The boy’s YOT worker had changed and his new YOT officer did not make the recommendation for an STC which the previous YOT worker had made in July. It is difficult to see why this was the case as there is little evidence that anything had changed since her assessment other than him spending a previous brief period of remand at Cookham Wood. She indicated that Cookham Wood would be an appropriate allocation for him. This judgement seems to have been based on his previous stay there, but that was only for just over a week when he was remanded in August.

369. While the boy said that he had no concerns returning to Cookham Wood, we believe that the previous recommendation of the YOT worker - who knew him best – that he should go to an STC should have carried more weight. While we cannot know what difference an allocation to an STC might have made to him, he was a vulnerable 15 year old and his circumstances warranted, at the very least, a full discussion of the most suitable location for him. There is no record of what factors the YJB placement team took into account when considering his allocation when he was sentenced in October 2011, but we believe the previous recommendation for an STC place should have been fully considered. We make the following recommendation:

The Head of Medway Youth Offending Team and the Youth Justice Board should ensure that decisions to recommend and place children under 17 to a Young Offender Institution rather than a Secure Training Centre are fully considered and documented and based on the best interests of the child.

Clinical care

Initial health screen on 1 August 2011

370. When the boy was remanded to Cookham Wood on 1 August 2011, he was given a routine health screen by a nurse. Although the clinical reviewer describes the screen as “comprehensive” and notes that there was no evidence that he was at risk of self-harm or suicide, he also remarks that he told the nurse that he had “multiple scars over his body”, but that these were not documented. He said that these were because of his “lifestyle”, but this was not explored further. He was seen by another nurse for a secondary health screen on 3 August. The clinical reviewer again says this was comprehensive, but there was no reference to these scars. The scars are not mentioned again in his clinical record.

371. While the origin of the scars is unknown, an examination of them might have shown that there was a pattern of self-harm, for example through cutting. Although this might not have been the case with the boy, we believe that it is
important that any signs of self-harm are recognised as early as possible and we therefore make the following recommendation:

The Head of Healthcare should ensure that any potential indicators of a history of self-harm, such as evidence of scarring, is fully explored during health screens.

Initial mental health screen

372. On 12 August, a psychologist then working at Cookham Wood made an entry on SystmOne which he stated was a “retrospective note for 09/08/11”. He noted that the boy had undergone a standard mental health screen when he arrived at Cookham Wood. The results indicated that he met the criteria for the mental health team as he had some signs of a diagnosable mental illness (ADHD). However, he was given bail before he could be assessed further.

373. The clinical reviewer notes that two tools were used to assess the boy. These were the Strengths and Difficulties Questionnaire (SDQ) and the Screening Questionnaire Interview for Adolescents (SQUIFA). Neither of these documents was uploaded to SystmOne, but they were held instead on a stand-alone computer only accessible to the mental health team. Later assessments were often made on word documents and not on the templates on SystmOne. This could make them difficult to find. The clinical reviewer believes that a young person’s medical record is incomplete on SystmOne when healthcare staff do not use the templates. As a result, there is a risk that this information would not follow a young person if they transferred establishment. We agree and make the following recommendation:

The Head of Healthcare should ensure that all mental health documentation, including SDQ and SQUIFA, is appropriately entered on SystmOne.

The boy’s return to Cookham Wood on 10 October

374. The boy returned to Cookham Wood on 10 October. The psychologist notes that he was seen by a nurse, who referred him to the mental health in-reach team as a result of his previous diagnosis of ADHD. However, he was not given a full health screen assessment even though he had been away from Cookham Wood for two months. The next day, he went to court and was sentenced. When he returned, he was not seen by a member of health care, even though his status had changed to a sentenced prisoner.

375. The psychologist notes that a full health screen should have been completed when the boy returned on 10 October and, also, that he should have been assessed following his court appearance the next day. We agree and make the following recommendation:

The Head of Healthcare should ensure that all young people arriving at Cookham Wood have an appropriate health screen, including on return from court when their status has changed.
Ongoing mental health care

376. The boy was seen regularly by a consultant psychiatrist with experience in treating ADHD. He was prescribed the appropriate medication, atomoxetine and aripiprazole. He also saw members of the mental health in-reach team regularly and they frequently attended ACCT reviews and made comprehensive notes of these reviews in his medical record.

377. The boy last saw the psychiatrist on 20 January 2012. He said he did not have any suicidal thoughts or plans. They discussed his frequent failure to take his medication. He agreed to start taking it regularly. A nurse attended an ACCT review on 23 January and recorded that the boy looked “relaxed and smiling” during most of the review. The clinical reviewer notes that “this was the last formal review that was conducted before [his] death, there appears to be no indication that [he] was suicidal”. Overall, the clinical reviewer notes that the boy’s needs were “adequately assessed by the mental health in-reach”, and that the assessments and treatment plans from the psychiatrist were comprehensive.

Missed medication

378. The boy was prescribed atomoxetine and aripiprazole by the psychiatrist to help control ADHD and, whenever they met, he agreed to take his medication. However, following their meeting on 11 January, he failed to collect his medication later that day and then at least once on 12, 13, 14, 15, 17, 18 and 19 January. Although a nurse noted on 13 January that the mental health in-reach team should be told if he missed any more medication, this does not seem to have been done.

379. On 20 January, the boy and the psychiatrist met again, and he restated his intention to take his medication. An ACCT review was held that afternoon, and it was noted that he had failed to take his medication on 18 and 19 January. Following these reviews, he did not collect his medication in the morning of 21 January, in the morning and evening on 22 January, and in the morning on 23 January. In total, he missed 14 doses between 11 and 23 January.

380. At interview, the psychiatrist said that one of the purposes of the medication was to control ADHD and reduce the level of impulsivity. We cannot know what the impact of him not taking his medication had on his actions, but it is a concern that he missed so much medication without any apparent action being taken.

381. Cookham Wood has an extensive policy on dealing with issues around self-harm and suicide prevention. The policy has a section entitled “Failure to take medication”. This states:

“A failure on the part of a young person to collect and/or take medication prescribed to them can be a sign of increased risk or emotional instability.
“The strong link between mental illness and self-harm and suicide must not be forgotten.

“In the event that a young person fails to collect or is not provided with ANTI-PSYCHOTIC OR ANTI-DEPRESSANT MEDICATION (their emphasis) Healthcare staff will IMMEDIATELY:-

- Brief the Duty DPSM [Developing Prison Service Manager]/Orderly Officer as to the situation;
- Record an entry within the observations book.

“The Duty DPSM/Orderly Officer and Healthcare staff will ensure that the young person is engaged with to ascertain why they have failed to collect their medication, and … all appropriate encouragement [is given to them] to take it. We cannot force a young person to take their medication, but we can encourage and provide action and support to any reasons they give for failing to collect, for example, dealing with bullying.

“The situation and the individual will need to be effectively monitored to ensure they are safe.

“Healthcare staff will also ensure staff [it is not clear if this refers to prison or healthcare staff] are effectively briefed as to a potential increase in risk when they are aware that new medication, for example, anti-depressants, is being commenced.”

382. Aripiprazole is an anti-psychotic covered by this section of the policy. There is, however, no evidence that healthcare staff followed the procedures in the policy when the boy did not take his medication and it is not clear what the implications of the failure to take the anti-psychotic drug were. It should also be remembered that he was a child of 15 and should not necessarily be presumed to have the capacity to decide about his medication without full discussion. The policy envisages that someone would talk to a young person when they fail to collect their medication and encourage them to take it, but, other than when he saw the psychiatrist, this does not appear to have happened. We believe that it is essential that staff follow the policy in order to help keep young people safe. We make the following recommendation:

The Head of Healthcare should ensure that all healthcare staff are aware of, and follow, the relevant provisions of the Cookham Wood suicide and self-harm prevention policy when a young person fails to collect anti-depressant or anti-psychotic medication.

383. The clinical reviewer also highlighted in his report that healthcare staff in the treatment room do not have access to the ACCT register and, therefore, are not sure who is on an ACCT. He suggests that a daily list of those young people who are on ACCTs is made available to the treatment room. While all young people who fail to collect their medication should be monitored, we agree that there should be an additional safeguard to ensure that young
people who are identified as at risk of suicide and self-harm and fail to take their medication are reviewed. We make the following recommendation:

**The Head of Healthcare and the Head of Safer Custody should ensure that an up-to-date list of young people on ACCTs is provided to staff in the treatment room to allow them to identify quickly any concerns about medication for those young people.**

**Management of medicines**

384. The clinical reviewer gives a full account in his clinical review of how medication is issued and how this is recorded on prescription charts and SystmOne. He noted that all treatment sessions are recorded on SystmOne under the name of the pharmacy technician, although she was often not the person running the session.

385. He also found the boy’s prescription charts hard to follow. The handwriting was difficult to read, there were several crossed out items and it was difficult to establish which drugs were current and which had elapsed because of the way the chart had been arranged.

386. As a result, he recommends that there should be a review of the ways medicines are managed at Cookham Wood. We agree that improvements are needed and make the following recommendation:

**The Head of Healthcare should ensure that medicines management practice, including the use of prescription charts and SystmOne, enables the issue of medication to be attributed to an individual and that charts are completed in a clear and systematic way.**

**ACCT**

**Training**

387. The policy on how the ACCT process is administered at Cookham Wood is set out in their suicide and self-harm policy. The policy states that it is “mandatory” for all staff in contact with young people to receive the “required and approved training”. Page 13 of the policy states that this training should be, as a minimum, the foundation level of the nationally approved ACCT training package.

388. We have been provided with a list of those trained. It is clear that the vast majority of staff have received training and that many have been refreshed. This includes civilian staff such as education staff, for whom a training event was held on 10 October. (It is perhaps not a coincidence that the tutor, who attended that course, opened an ACCT for the boy only two weeks later.) However, during the course of this investigation, it has become clear that some members of staff had not received the training. In particular, according to the training list, the psychiatrist and a nurse have not received any training. While entries in the ACCT document show that they have a good working
knowledge of the process, it is important that all staff receive the training in line with the agreed policy. We therefore make the following recommendation:

The Governor should ensure that all staff who are in contact with young people receive ACCT training.

Management of the ACCT process

389. Annex 10 of the Cookham Wood suicide and self-harm prevention policy discusses the ACCT process. In the section “Aims and Requirements of Case Reviews”, there is a list of people who might be approached to attend reviews. These include the family of the young person, chaplaincy, personal officer, substance misuse workers, healthcare or mental health team, race equality officer, voluntary organisations, YOT worker, child protection coordinator, external YOT or social services worker, resettlement worker, education and IMB members.

390. While one of the review meetings (on 6 January) was very well attended, this was because it followed a planned case review meeting to which a wide range of attendees had been invited. All of the nine ACCTs from 28 December were attended by the first nurse and the boy’s YOT caseworker in the prison attended six of them. However, there was only limited attendance by members of the YOT, chaplaincy, his family or social workers. We believe that full multi-disciplinary reviews are particularly important in the cases of children who are regarded as at risk of suicide and self-harm. Prison Service Instruction 64/2011, which now covers this issue, states explicitly that the YOT should be involved.

391. Six of the 12 ACCT reviews were chaired by different SOs. When the second ACCT was opened in December 2011, it was the Christmas period. This meant that some staff covered roles on wings where they did not usually work. As a result, the first three reviews were chaired by different SOs but after that from 3 January, six of the eight ACCT reviews were chaired by the first SO who clearly knew the boy well. The ones on 10 and 13 January were chaired by two different senior officers, although the first SO was on duty during this period. While there is no evidence that the change in chair had any adverse effect on the him, and while also acknowledging that other review team members attended these meetings, it is important that the case manager is consistent to allow continuity of care.

392. We found that several of the CAREMAP issues listed in the ACCT document were not sufficiently focused on addressing the reasons for the boy’s behaviour, but instead focused on the behaviour itself. Examples include issues such as “refusal to associate/attend activities”. When the second ACCT was closed on 3 January, it was not clear that the issues on the CAREMAP had been addressed.

393. While we have concerns about the appropriateness of the ACCT process for children, which we discuss later in this report, it is the system that is currently
in place. It is therefore important that staff follow the process. We therefore make the following recommendation:

The Governor should ensure that there is continuity of case management in ACCT case reviews, that reviews include all appropriate people involved in a young person’s care and that care plans adequately reflect the young person’s needs, level of risk, and the triggers of their distress.

Enhanced case reviews

394. The Cookham Wood suicide and self-harm prevention policy also discusses the use of enhanced case reviews. (This section is largely taken from Prison Service Order PSO 2700, Suicide and Self-Harm, which was in operation at the time of the boy’s death.) The policy states that “where young people are assessed as at risk and supported via an ACCT plan and they also exhibit one of the following:

- Prolific, sustained and/or extreme incidents of self-harm behaviour
- Active suicide intent or periodically “on and off” constant levels of supervision for a considerate period of time.

And one of more of the following:

- Presents a risk to others
- Behaviour/actions causes disruption to the regime
- Offences against discipline
- Repeated and prolonged anti-social behaviour
- Enhanced levels of unlock
- On a constant level of supervision for 8 days or more
- Using evening setting to self-harm
- Behaviour has led staff to use measures of last resort ie segregation, special accommodation, body belt, alternative clothing, medication without consent

The ACCT review must be conducted by enhanced teams”. The policy then lists those who should, or must be invited, to enhanced case reviews. It sets out the requirements of the review, and highlights that enhanced case reviews should be considered by those conducting regular ACCT reviews, those conducting management checks, and managers or duty governors supervising incidents. PSO 2700 indicates that enhanced case reviews should involve all relevant disciplines and include more specialists and a higher level of operational manager than a typical ACCT case review team. An appropriate psychologist and all specialists who work with the individual at risk should attend reviews. Family involvement is also recognised as being potentially beneficial and should be considered.

395. The boy undoubtedly met several of the criteria in the second list. His behaviour could be construed as being disruptive to the regime, as officers
had to deal with him differently to others, such as the frequent need to enter his cell to clear his blocked observation panel. He had a number of disciplinary charges, many warnings under the rewards and sanctions scheme and his behaviour towards many of the officers was anti-social. He was regarded as very vulnerable.

396. It is less clear that the boy met the first criteria. His self-harm took the form of tattooing, but this was neither prolific nor sustained nor extreme. However, he did display signs of active suicide intent. While mental health professionals, including the psychiatrist who saw him on 20 January, did not identify any ‘major depression or psychosis’, the psychiatrist did note that he appeared to be distressed. It is not clear what, if any, information the psychiatrist had at that time from the wing but around that period he was increasingly referring to intentions to kill himself. On 14 January, he said he would “string up [as he had] had enough of life.” He continued to express such thoughts, sometimes in written notes, over the following days. The ACCT review of 17 January identified that this was a concern. On 18 January, he again referred to killing himself and, on 20 January, shortly after seeing the psychiatrist, he was found with a noose in his cell. A further noose was taken from him on 21 January and, on 22 January, he was found to have painted on the side of his locker “I am going to kill myself.” On 24 January, not long before his fatal act of self-harm, he said he was “going to string up from the locker”.

397. Despite all these potential indicators, no thought appears to have been given at any stage as to whether the boy’s case should have been considered at enhanced ACCT case reviews. The enhanced case review process would have meant more senior level attention to reviewing his care and support and would also have helped ensure that all the relevant people were involved and consulted at each review. The criteria for enhanced reviews used in Cookham Wood’s suicide and self-harm strategy simply replicate those used for adult prisoners. We consider that this does not sufficiently take into account the special status of the young people at Cookham Wood as children and the extra responsibility to protect them:

The Governor should ensure that enhanced case reviews are used for all young people who meet the criteria and that consideration is given to using the enhanced process whenever a young person is identified as being at risk of suicide and self-harm, with reasons for decisions documented.

The level of observations on the evening of 24 January

398. The first and second officers became very concerned about the boy on the evening of 24 January. He had talked to the first officer about the abuse he had suffered as a child, which he had not done before. He had also told the third officer that he was going to “string up from the locker”. After he made a telephone call to his foster parents the second officer saw him crying, which she considered was very unusual for him.
In response, the first officer asked the third officer to come and speak to the boy, after he said that he would only speak to her or another officer he named. He told the third officer that he felt very low and said he would not be there when she was next on duty. However, she said that after she spoke to him she felt that he presented the same as he had over the previous couple of weeks and she regarded his demeanour and manner of speaking as normal.

The first and second officers discussed the boy with an SO. They agreed that because of their concern the level of observations should be raised from three to five every hour, with a further review arranged for the next day. When interviewed, the SO said that he did not know the boy as he did not usually work on Ash wing. He therefore relied on the judgement of two experienced officers who knew the boy well. He said that he did not recall discussing other options, such as moving him to a gated cell and constant supervision.

We have considered whether this response was appropriate to the situation as it appeared that evening. The boy had started to talk, apparently for the first time, about the abuse he had suffered, and had cried immediately after a telephone call to his foster parents. Both behaviours were unusual for him. He had expressed thoughts of killing himself to the first and third officers and told the third officer he would not be there when she was next on duty. However, she did not regard this as unusual.

Had these circumstances occurred during the day we believe that they would have, or should have, triggered an immediate ACCT case review. We understand that it would have been impractical and difficult to hold a multi-disciplinary ACCT review at that time of the evening, but this made it all the more important that all the options to safeguard the boy until that could happen, should have been fully considered. We recognise that the officers acted appropriately in reacting to his changed presentation by arranging for him to speak to the third officer, who he particularly trusted, and by facilitating a telephone call to his foster parents. The level of observations was raised to five an hour. It might be that this was an appropriate response and a fully considered ACCT review could have come to the same conclusion. However, not all the options to safeguard him had been fully considered. The SO said that he accepted the views of the officers who knew the boy, which was understandable, but we consider that all the available alternatives, such as the use of constant observation should have been considered. This was not done.

We also note that the discussion between the first officer, the second officer, and the SO which resulted in raised observations was not noted in the ACCT record. The outcome was recorded in the wing observation book, but the reason why the decision was reached was not explained. We make the following recommendation:

The Governor should ensure that whenever information is received suggesting a young person on an open ACCT is at increased risk, there is full consideration of all the options, action is taken and this is recorded in the ACCT documentation.
Possession of shoelaces

404. The boy made several references to hanging himself in the last few weeks of his life. He posted notes saying that he was about to “string up” either in his observation panel or under the door of his cell. An officer found him with a noose in his cell, the first officer and a colleague took some shoelaces from him and he mentioned shoelaces to his tutor on 23 January and to the third officer on the evening of 24 January that he would hang himself from his locker.

405. We have considered whether he should have been allowed to keep his shoelaces in his cell. PSO 2700, which set out the Prison Service policy on suicide prevention and self-harm management and was in force at the time of his death, said ‘Reducing access to the means of suicide or self-harm can form part of the care of people considered to be actively suicidal or at regular risk of self-harm. Hanging (with the ligature attached to a ligature point) is the most frequent method of self-inflicted deaths for both genders’. The PSO then said “However, removing personal belongings from a person who is feeling hopeless and depressed (especially items of clothing, belts or shoelaces) can increase feelings of distress and therefore increase the risk of suicide, self-harm or a higher risk method of self-harm. Fear of losing their normal possessions can discourage prisoners from disclosing suicidal feelings. …. Where possible, prisoners at risk should be allowed to retain their belongings unless it is clearly unsafe to do so”. While the PSO advised that staff should not remove items from at-risk prisoners as a matter of course, it said “The case review team must decide this having first considered alternative responses”. It makes it explicit that case review teams must “Consider and agree whether any items which the prisoner might use to self-harm should be removed from the prisoner”.

406. The Governor told investigators that she did not think that it would have been appropriate for the boy’s shoelaces to have been removed, describing this as “humiliating and degrading”. As with decisions about the level of observations required, this might well have been an appropriate conclusion but there was no evidence that ACCT reviews considered this. This is a surprising omission as he frequently referred to using shoelaces to hang himself. This does not seem to have been addressed as an increasing pattern indicating heightened risk, but as individual separate incidents on each occasion. The starkest example of this was the ACCT case review of 20 January, which did not mention that an officer had discovered him with a noose made of shoelaces earlier that day. The officer said she told the boy that if necessary they would take all his shoelaces from him and reported it to the wing SO, but the incident does not appear to have been discussed with others involved in his care.

407. We accept that even if YOI staff had removed his shoelaces, there were other items he could have used to hang himself. However, he had repeatedly referred to using shoelaces to hang himself and had previously tied nooses with shoelaces. We also understand that he had never previously attempted to self-harm in this way. Nevertheless, it is a concern that the possession of
shoelaces does not seem to have been taken into consideration as a risk factor combined with the fact that he was a 15 year old child known to act impulsively. Nor were the risks discussed fully with him himself. We make the following recommendation:

The Governor should ensure that ACCT reviews identify and discuss trends in behaviour that indicate an increase in risk and consider and document whether it is necessary to remove items from young people in order to help protect them.

ACCT documentation

408. The boy’s ACCT documentation was generally well maintained, with some comprehensive notes in the ongoing record and several well-recorded case reviews. Although staff were clear of what was expected of them, investigators found it difficult to interpret the front cover of the ACCT documents and the level of observations that were required at any one time. There were also a number of incidents which we would have expected to have seen in the ACCT documents there were not recorded. Examples include an officer issuing a yellow card to him on 29 December for blocking his observation panel, comments in the ACCT review of 17 January about graffiti in his cell which was not recorded in the ongoing ACCT record, an officer’s discovery of a noose on 20 January and the discussion between the first officer, the second officer, and an SO on 24 January about the level of observations.

409. It is clearly important that staff have as much relevant information as possible when assessing risk and that this is fully recorded in ACCT documentation. We make the following recommendation:

The Governor should ensure that levels of observations and significant events are properly recorded in the ACCT document.

Use of disciplinary charges

410. The boy was charged with 13 different disciplinary offences for breaches of YOI rules during his time at Cookham Wood which led to a number of adjudications. (Some of these hearings dealt with more than one charge.) Seven of these adjudications took place while he was on an ACCT.

411. Officers reacted in very different ways to the boy’s behaviour. Several of the charges related to him verbally abusing or threatening staff, others to him blocking his observation panel. On many occasions in similar circumstances no charges were laid. Charges were usually brought by officers who were not so familiar with him, and this did not promote a consistent and child-centred approach. In most cases, we do not consider that using the formal adjudication system is a helpful process for managing children. Alternative ways of dealing with the problem of him covering his cell observation panel, such as considering leaving his door open, do not appear to have been considered. This might have been a more appropriate and helpful approach.
to dealing with an impulsive child of 15 regarded as at risk of suicide and self-harm.

412. Of the charges that were proven, on seven occasions he received punishments of loss of association of between three and seven days. One of his CAREMAP goals after the opening of the ACCT on 23 December 2011 was for him to “return to good attendance and good interaction” on association. However, at a hearing on 31 December, he was given a punishment of three days loss of association, which was directly at odds with the goal of his ACCT CAREMAP.

413. When the ACCT was reopened, it was less clear which parts of the CAREMAP remained in place. However, officers continued to raise the boy’s lack of engagement with others as a cause for concern. Despite this, at the adjudication on 9 January, he was given seven days loss of association and eating out of his cell; on 14 January, he was given a punishment of seven days loss of eating out of his cell; on 18 January, seven days loss of association and three days loss of eating out of his cell; and on 20 January, seven days loss of association and seven days loss of eating out of his cell.

414. This approach only served to reinforce his isolation and was not consistent with the efforts made under the ACCT process to try and get him to engage and interact with staff and other young people. It is important that all information is taken into account when deciding on the level of punishment during adjudication hearings and punishments should not undermine ACCT CAREMAP goals designed to keep a young person safe.

415. We also note that the boy was twice found guilty of failing to comply with a rule or regulation because he had tattooed himself. A third charge was dismissed by the adjudicator who believed that the tattooing was an act of self-harm. The same morning, the Safer Regimes meeting also noted that any future acts of tattooing by him should be considered as self-harm. The records of the other adjudications do not indicate any consideration about whether this was a form of self-harm. The adjudicator at the hearing on 9 January said he was unaware of the entry in the boy’s ACCT document of 6 January, that “further adjudication awards [for self-tattooing] would exacerbate his problems, heightening the risk of self-harm.” We make the following recommendation:

**The Governor should ensure that a consistent approach is taken to the use of the formal disciplinary process, that officers and adjudicators consider whether formal disciplinary charges are appropriate for young people considered at risk of suicide and self-harm, and that punishments do not conflict with agreed objectives aimed at reducing risk.**

**Use of the rewards and sanctions scheme**

416. The boy’s behaviour frequently brought him into conflict with staff. He was often issued with yellow cards, usually for failing to go to education or
blocking his observation panel. Sanctions included loss of television or turning off the power supply to his cell. The application of sanctions seemed to have little effect on his behaviour and we acknowledge that he was kept at silver level under the scheme when his behaviour might have been regarded as warranting a downgrade to bronze level. At the review held on 6 January, it was decided that this would not be in his best interests and we agree with that decision. Nevertheless, it was difficult to see how the operation of the rewards and sanctions scheme was part of a coherent approach to his management.

417. Under Cookham Wood’s policy, it is recognised that it is inappropriate for the person issuing the yellow card to be the same person who decides on the sanction as this would be open to abuse. The records would indicate that this policy was often not followed. There were also times when the boy was on an open ACCT when the power to his cell was turned off, yet there was no record in the ACCT or on P-NOMIS to explain why. A number of the decisions appeared arbitrary and unregulated. The policy requires decisions to be recorded on Sanction Administration forms, but Cookham Wood was unable to provide any for him which would indicate they were not completed.

418. Some of the sanctions which can be imposed under Cookham Wood’s rewards and sanctions policy, such as loss of television or loss of association are ones that would normally only be imposed under YOI Rules after a formal disciplinary hearing and we would consider are not appropriate for the rewards and sanctions scheme. Nor is there any reference in the policy as to how the scheme takes into account the needs of young people who are at risk of suicide or self-harm which Prison Service guidance for such schemes in adult prisons requires and we would expect to see in a rewards and sanctions scheme for children.

419. We consider that some of the sanctions imposed on the boy, such as the loss of electric power to his cell, were not appropriate for a 15 year old child regarded as at risk of suicide or self-harm and they were not properly regulated. Although a number of officers said that the boy did not seem to be bothered by the sanctions imposed on him, we note that he frequently asked officers when his power would be turned back on or when he would get his television back. We make the following recommendation:

The Governor should ensure that sanctions imposed under the rewards and sanctions policy are legitimate and appropriate, take into account individual circumstances, and that all decisions and actions are fully documented including in ACCT records where applicable.
Overall management of the boy’s risks and behaviour

420. It is apparent from the documentation and from our interviews with YOI staff that the boy was regarded at Cookham Wood as being very vulnerable and problematic. As well as the ACCT, he also had a BIP open, a CABS document had also been opened at one point, several STIIR forms had been submitted and there were several other interventions, for example through social work and through the mental health in-reach team.

421. It is also apparent that there was no overall coordination of approach in how staff engaged with and managed him. This is seen starkly in the disparity between ACCT CAREMAP goals and adjudication punishments and is also evident in the number of yellow cards the boy received while staff were also trying to engage with him. He was a 15 year old boy who had been diagnosed with ADHD. A consistent approach to the management of his behaviour could only have helped him respond more positively.

422. In his case there were multiple issues to be considered: his ADHD, his poor behaviour, his educational difficulties, the abuse he suffered as a young child and the subsequent detachment from various members of his family. However, there was little coordinated professional management of all these complex dimensions of his risk and vulnerabilities and little apparent senior management involvement in the ACCT process. There seemed to be a lack of understanding that children and young people in emotional distress and with mental health problems might exhibit difficult and challenging behaviour as a sign of their distress.

423. To an extent, the boy’s management is reflected in some of the key findings in a report by the office of the Children’s Commissioner for England into the emotional wellbeing and mental health provision in the youth justice system, and in particular those in detention. (“I think I must have been born bad” – June 2011.) The report found “There is limited understanding of child and adolescent development and limited recognition, understanding and management of neuro-developmental problems [which included ADHD]. Little attention is paid to the crucial importance of relationships both in supporting emotional wellbeing and managing challenging behaviour… There is evidence of inconsistency and wide variation in the understanding of the impact of previous experiences, including abuse and care experiences on the young person’s emotional wellbeing and mental health, by custodial and care staff”.

424. We do not criticise individual members of staff at Cookham Wood, indeed many were obviously caring and developed a very good knowledge of the boy, a point that his foster parents made to the investigators. Nevertheless, YOIs holding children run by the Prison Service essentially reflect the procedures of the Prison Service. Most staff have a generic Prison Service background and many of their dealings with children in custody reflect that culture and experience. The Children’s Commissioner’s report noted a particular concern about the minimal training for prison officers working with children.
425. We do not believe that the ACCT process – essentially designed for adult prisoners - is necessarily a suitable vehicle to deal with the complexities and special vulnerabilities of children. Imprisoned children are among the most vulnerable children in the country and those judged as at risk of suicide and self-harm even more vulnerable. It is unsatisfactory that their case management and management of their risk is identical to that for adult prisoners, with little overt recognition of their special status as children.

426. This is illustrated by the contradictory and inconsistent impact of the disciplinary process and the rewards and sanctions scheme on efforts to safeguard the boy. Similarly, an inherently adult prison orientated perspective is visible in the response to the boy’s propensity for covering his cell observation panel. Staff made great - if uncoordinated - efforts to prevent this when a more reflective and child centred approach might have been possible, for example by redirecting staffing resources, simply to allow his cell door to be open when his risk was regarded as raised on 24 January.

427. While we have made recommendations in this report based on the current ACCT process we consider that his case illustrates that it is not fit for purpose in young offender institutions holding children. We consider a more high level and holistic approach is needed in caring for young people under 18 who are assessed as at risk of suicide and self-harm which focuses more on the need to safeguard children. We have identified the same concern in the report into the death of another young person recently. We repeat the recommendation made in that case here:

The National Offender Management Service and Youth Justice Board should devise a more child-centred approach to managing risk of suicide and self-harm, which takes an appropriate holistic view of all aspects of a young person’s risk and vulnerabilities, with cases actively considered at senior management level and involving a range of qualified professionals to meet the identified needs of each young person at risk.

Case note entries in P-NOMIS

428. P-NOMIS is the Prison Service electronic system on which officers enter case notes and observations. The boy’s P-NOMIS records include some comprehensive entries but the first entry was not made until 26 October, over two weeks after he was sentenced on 11 October.

429. In this entry, an officer refers to the boy’s deteriorating behaviour but there are no previous records in his case notes on P-NOMIS. While we understand that he would have been monitored under the ‘enhanced baseline procedures’ when he first arrived we would have expected to see a record of early interaction in the P-NOMIS case notes. He was given a yellow card warning in reception on 11 October, the day he was sentenced yet there was no mention of this in his P-NOMIS case notes. He was 15 years old and the YOT had some concerns about his vulnerability. There was no entry commenting on his arrival and how he was settling in.
430. We would expect to see a personal officer entry to show they have introduced themselves shortly after the young person’s arrival and regularly after that. The boy’s personal officer was able to talk about him in depth and made one comprehensive note in his P-NOMIS record and one other note. However, as he was not based on a different landing, the boy had more interaction with other officers. We make the following recommendation:

The Governor should ensure that personal officers introduce themselves shortly after arrival and are able to interact regularly with the young people they are responsible for. Personal officer and other staff should make frequent entries in P-NOMIS case notes about a young person’s well being and progress and record any significant incident or event.

Referral to the Phoenix Unit

431. Several members of staff thought that the boy would benefit from some time on the Phoenix Unit. The first officer and a colleague each referred him for the Phoenix Unit and two SOs (including the first SO) also tried to persuade him to move there. Another SO recalled that the boy said that staff would have to restrain him to get him to the Phoenix Unit. The third officer also said that the boy refused to go.

432. His reasons for not wanting to go there are less clear. The investigators have tried to establish whether there is a particular view among young people at Cookham Wood about the Phoenix Unit and the reasons why people go there. The response from staff and young people was inconclusive. One officer said that young people refer to it as a “victim’s unit” and one of the young people we spoke to agreed with this view. Other staff, and another young person, said that young people who returned to the wings from the Phoenix Unit were not treated differently. The young person added that he thought the Phoenix Unit would have been a good place for the boy.

433. It is possible that the Phoenix Unit could have provided the boy with the support he required. However, although we do not know why, he appears to have been adamant that he did not want to go there. It is a concern that a number of staff believed that the boy’s needs would have been catered for better on the Phoenix Unit, yet he himself was allowed to operate a veto. We accept that this was not an easy situation, but if more efforts had been made to promote the benefits of the Phoenix Unit to him, through a co-ordinated case work approach, he might have agreed to move. While it is good practice to consult young people about such a move, and an enforced move could have been self-defeating, ultimately decisions about the placement of a child have to be made in their own best interests.

The Governor should ensure that all allocations in Cookham Wood are based on the best interests of young people and the need to ensure their safety.
Bullying

434. We have considered whether there is any evidence that the boy was being bullied, as that is often a factor in apparently self-inflicted deaths by young people in custodial institutions. We have spoken to staff and other young people, and none of them had any concerns that he might have been bullied. One of the young people we spoke to said that there was no bullying at Cookham Wood, although we recognise there is always likely to be an issue of bullying in such institutions. Another young person said that staff were very good at dealing with it when it occurred. During the focus groups of young people conducted for the last HMIP inspection, young people said they generally felt safe at Cookham Wood and that it was easy to avoid violent incidents. In the Inspectorate survey, 23% of young people said they had felt unsafe at Cookham Wood, which was better than the national comparator of 32% at other similar establishments. The third officer said that she did not think that the boy was being bullied.

435. On 26 November, an officer raised a STIIR after witnessing an encounter between the boy and two other young people. We understand that this was an incident when the two young people had been pressuring others for canteen items and that the boy had not been specifically targeted. The boy said he did not feel threatened by this, and the other young people were dealt with because of their general behaviour. Another officer opened a CABS document on 23 December, as she was concerned that his withdrawn behaviour might have been linked to bullying. When she spoke to him about this later in the evening, she became concerned that he might harm himself, and opened an ACCT instead. We believe that this was appropriate. We are satisfied that there is little to indicate that the boy was a victim of bullying at Cookham Wood.

Disclosure of previous abuse

436. The first officer had a very detailed conversation with the boy on the evening of 24 January, in which he pressed her to see what information she knew about his background. He did not disclose any new information during this discussion, which she recorded in great depth on his ACCT record. We asked the Head of Children’s Integrated Services at Cookham Wood whether staff at Cookham Wood were given guidance or training in handling such situations. He advised that there was nothing formal in place. We note that the 2011 Children’s Commissioner’s report also found little evidence that custodial institutions holding children paid attention to issues of disclosure or provided a safe environment which supported children and young people to discuss previous abuse. The report cited a 2008 YJB study which found that one in twenty boys in custody had reported previous sexual abuse. (This was much higher for girls.)

437. The first officer was placed in a difficult situation when the boy pressed her for details of what she knew about his past. She appears to have handled the situation as well as she could and tried to get him to identify other smaller problems with which she could provide some practical help to ease his
anxieties. This seemed to be a useful approach to divert him to other issues, but at that stage he was focused on his previous experience. It is a concern that prison officers who have to deal with such situations are not given advice and training on how to handle discussions with young people who refer to past abuse.

The Governor should ensure that all staff working with young people are trained in how to respond to disclosure of past abuse and make appropriate onward referrals.

Emergency response

438. At the time the emergency was called, Cookham Wood was in night state. During this time, usually only the night orderly officer (NOO, who on this occasion was a T/SO) and her orderly officers have keys. Other officers on duty have a cell key in a sealed pouch to use in an emergency.

439. Cookham Wood’s night operating instructions make it clear that, if an officer believes that a life might be at risk, they can enter a cell using the key, after first contacting the control room to let them know that this is what they intend to do. However, when they could get no response from the boy on the night of 24 January, the fourth officer and an OSG did not appear to consider there was an immediate risk to life. They followed the standard, rather than the emergency procedure by asking the T/SO to come to Ash wing so they could open the cell and obtain a response.

440. We believe that the officers should have considered this to be an emergency. They were aware that their colleagues had been very concerned about the boy. They knew that he was regarded at risk of suicide and self-harm and the number of required observations had been increased as a result of the additional concerns. Shortly afterwards, they were unable to obtain a response from him and could see his legs on the floor. We understand that the boy had frequently not responded when asked during observations on previous occasions, but this time he was clearly and very recently identified as being at greater risk of harming himself. In these circumstances, we believe the officers should have gone straight into the cell when they did not get a response. As this was not a situation where an officer was on his or her own, it is hard to understand the hesitation in doing so.

441. The decision to call the NOO reflected a cautious Prison Service approach to opening a cell during night state, rather than an overriding duty to safeguard a child. The night instructions at Cookham Wood for opening a cell are very similar to those of any other prison. We consider that in a prison holding children there should be different priorities. The need to protect the lives of children does not have to be balanced in quite the same way as when dealing with the possible security implications of opening a cell at night in a high security prison.

442. The first officer was still in the prison as she had only just finished writing up her account in the boy’s ACCT document. She still had the set of keys that
officers carry when on a day shift. When she realised where the emergency was, she ran to his cell and used her key to enter immediately, despite being told not to by the T/SO. We believe that she acted entirely correctly. She was concerned that a child’s life was in danger and that it was important to enter the cell as quickly as possible. The suggestion that she should have waited for authority is an example of Prison Service procedures designed for the security of adult male prisoners rather than, as in this case, to help protect the life of a child.

443. While the operational guidance makes it clear that staff should enter cells when they believe there is an emergency, they first have to identify that there is an emergency. We accept that YOI staff will have to use their judgement and assess the risk to themselves and others before opening a cell, but we believe that staff should understand that the threshold for an emergency might be lower where children are concerned and the security implications of opening a cell not usually so great as in adult prisons. We make the following recommendation:

The Governor should ensure that all staff understand, subject to an appropriate individual risk assessment, their responsibility to enter a cell without delay if there is a risk to the life of a child.

Access for emergency services

444. The paramedics and ambulances arrived at Cookham Wood relatively quickly – the T/SO estimated that the first paramedic arrived at the boy’s cell within eight minutes of being called. Despite this, one of the paramedics and one of the ambulances were unsure where to go once they reached the site, which also includes HMYOI Rochester and Medway STC. Another officer said that a paramedic had gone past the entrance to Cookham Wood and to the barrier to the next car park. He also had to guide one of the ambulances in. Other officers said that an ambulance meant for HMYOI Rochester had once arrived at Cookham Wood, while fire engines had also had difficulty finding the correct establishment.

445. As the site is complex, with three different adjacent establishments, it is easy to see how emergency services might get confused, especially at night. There is one sign at the entrance to the site which has a map of the layout, but this is not clear even in daylight. There is a need to ensure that emergency services know how to get to each establishment and if necessary that staff are outside to guide them when they arrive. We make the following recommendation:

The Governor should ensure that contingency plans ensure that emergency vehicles are appropriately directed to Cookham Wood.

First aid training

446. Of the staff who attended to the boy on the evening of 24 January, only the fourth officer was on the list of those who had been first aid trained. However,
the officers involved administered CPR quickly and the paramedics were satisfied when they arrived that CPR was being conducted appropriately. Nevertheless, such an emergency underlines the need to ensure there are sufficient first aid trained staff on duty at all times and in all parts of the YOI.

447. The first time a defibrillator was used during the emergency response was when the first paramedic arrived with one. The investigators were concerned that there might not be adequate provision of defibrillators at Cookham Wood. At the time of the boy’s death there were three defibrillators. Staff from South East Ambulance Service had visited Cookham Wood on 16 January 2012 to review the provision and distribution of defibrillators and recommended that two additional defibrillators should be provided, so that each residential unit (Ash, Beech and Cedar), the gym and the staff unit have easy access to a defibrillator if required.

448. However, it is only worth providing defibrillators if staff are confident about using them. The fourth officer, the one officer with up to date first aid training, could not recall if he had ever received any training in the use of defibrillators. The T/SO said that she did not think that many people would have known how to use the equipment contained in the emergency boxes. We make the following recommendation:

The Governor should ensure that there are sufficient first aid trained staff on duty at all times who understand how to use defibrillators and other emergency equipment.

Support for young people

449. In the morning of 25 January, the Governor informed all young people at Cookham Wood that the boy had harmed himself. Those on ACCTs, or where an ACCT had recently been closed, were seen individually to check the impact on them. A young person who lived in the cell opposite the boy, and who saw much of the emergency response, was given extra support. In the days that followed, extra youth club sessions were arranged to help occupy and support all the young people at Cookham Wood.

450. The Head of Children’s Integrated Services also arranged for the education psychology team to come in from Medway Council to support young people (and staff) in the same way as they would if there was a death in a school. This was a good and commendable example of partnership working.

Support for staff

451. We are satisfied that, after the boy harmed himself on 24 January, the staff involved appear to have been offered appropriate care. Most of those we interviewed appreciated the sensitive way in which they had been informed of what had happened and of the availability of the care team. It was apparent that care was ongoing to provide support for those who needed it, both from the YOI care team and their trade union representatives, who provided another helpful avenue of support for staff. Several interviewees mentioned
that after he died they had received telephone calls from colleagues, which they found helpful.
CONCLUSION

452. We believe that too little consideration appears to have been given to whether Cookham Wood was the appropriate place for the boy and whether a secure training centre would have met his needs better. Nevertheless, it is apparent that many members of staff at Cookham Wood knew him well and used a variety of methods to try and get him to engage with the regime. However, these attempts lacked co-ordination and were sometimes at odds with each other, with punishments given that directly contradicted the plans made in the self-harm monitoring procedures. We are concerned that the boy frequently did not take his medication, which his psychiatrist said might have led to increased impulsivity, and that this information was not shared with the staff who had to manage him. This was in contravention of Cookham Wood’s own policy. Before the boy hanged himself, YOI staff recognised he was at increased risk, but it is not apparent that all the options that might have protected him were fully considered. We do not consider that the Prison Service suicide and self-harm monitoring procedures are suitable to manage the complex vulnerabilities of children and a more high level and holistic approach is needed.
RECOMMENDATIONS

The following recommendations were made in the draft report. Responses from the services in remit are included in italics following each recommendation.

To Medway Youth Offending Team

1. The Head of Medway Youth Offending Team should ensure that when a recommendation on a placement alert form is not followed, the reasons are established and recorded, and any appropriate remedial action taken.

   Response: recommendation accepted:
   Any deviations to be picked up via post court reviews by Operational Manager and appropriate action taken to alert establishment to vulnerability issues. Action in place in September 2012.

To Medway Youth Offending Team and the Youth Justice Board

2. The Head of Medway Youth Offending Team and the Youth Justice Board should ensure that decisions to recommend and place children under 17 to a Young Offender Institution rather than a Secure Training Centre are fully considered and documented and based on the best interests of the child.

   Response from Medway Youth Offending Team: recommendation accepted
   All placements forms are to be kept and agreed by a Duty Manager before submission to the YJB placements team. Regular reviews of placement decisions will be made by the YOT Court Team meeting and via case supervision. Action in place in September 2012.

   Response from the Youth Justice Board:
   All placement decisions made by the YJB have the child’s best interests at their heart, though you will appreciate that there are other related factors that often need to be considered alongside this. While we recognise that SCHs and STCs are able to offer different support to children and young people who are at particular risk, we do not consider that the YOI sector is not capable of meeting the needs of children with complex requirements and need to be clear that we expect all the establishments we commission to be able to provide a safe environment for the children we place in them. In recognising this, we also understand the context of your recommendation and will consider carefully how we can meet it, not only when we work with Medway YOT, but all Youth Offending Teams.

To HMP Cookham Wood

3. The Head of Healthcare should ensure that any potential indicators of a history of self-harm, such as evidence of scarring, is fully explored during health screens.

   Response: Recommendation accepted
   All primary care nursing staff responsible for carrying out health screens will be regularly reminded of the importance of fully exploring any potential indicators of a history of self harm through briefings.
A quality assurance process will be introduced to check health screens to ensure such indicators have not been missed.

4. The Head of Healthcare should ensure that all mental health documentation, including SDQ and SQUIFA, is appropriately entered on SystmOne.

Response: Recommendation accepted
The Head of Healthcare will ensure all mental health documentation is entered on System One. A quality assurance process will be introduced to check compliance.

5. The Head of Healthcare should ensure that all young people arriving at Cookham Wood have an appropriate health screen, including on return from court when their status has changed.

Response: Recommendation accepted
A quality assurance process will be introduced to ensure that health screens are conducted as appropriate.

6. The Head of Healthcare should ensure that all healthcare staff are aware of, and follow, the relevant provisions of the Cookham Wood suicide and self harm prevention policy when a young person fails to collect anti-depressant or anti-psychotic medication.

Response: Recommendation accepted
All primary care nursing staff will be regularly reminded of the suicide and self harm policy and in particular the actions to be taken when a young person fails to collect specific medications through regular briefings.

7. The Head of Healthcare and the Head of Safer Custody should ensure that an up-to-date list of young people on ACCTs is provided to staff in the treatment room to allow them to identify quickly any concerns about medication for those young people.

Response: Recommendation accepted
A list of young people on ACCT will be kept in the treatment rooms.

8. The Head of Healthcare should ensure that medicines management practice, including the use of prescription charts and SystmOne, enables the issue of medication to be attributed to an individual and that charts are completed in a clear and systematic way.

Response: Recommendation accepted
Electronic prescribing commenced on 6 November 2012, which will address this action.

9. The Governor should ensure that all staff who are in contact with young people receive ACCT training.

Response: Recommendation accepted
Individuals who work with young people in Cookham Wood but who are not directly employed by Cookham Wood will be identified as requiring ACCT training so they can be provided with it.
Regular sessions of ACCT training will be a part of the annual training plan.

Briefing on the ACCT process will be given to all staff working with young people as part of the induction process.

10. The Governor should ensure that there is continuity of case management in ACCT case reviews, that reviews include all appropriate people involved in a young person’s care and that care plans adequately reflect the young person’s needs, level of risk, and the triggers of their distress.

Response: Recommendation accepted
This action has already been taken. All young people on ACCT now have a consistent case manager who chairs all reviews except in unforeseen circumstances. The case manager does not change with change of location of the young person.

A quality assurance process ensures that review meetings are appropriately attended and care plans are comprehensive.

11. The Governor should ensure that enhanced case reviews are used for all young people who meet the criteria and that consideration is given to using the enhanced process whenever a young person is identified as being at risk of suicide and self-harm, with reasons for decisions documented.

Response: Recommendation accepted
We will review the criteria for enhanced case reviews to ensure that consideration is given to enhanced case reviews whenever a young person is identified at being at risk and that consideration for enhanced case reviews is reviewed regularly with young people subject to ACCT.

A quality assurance process will review ACCT documents to ensure this consideration is being made appropriately and documented fully.

12. The Governor should ensure that whenever information is received suggesting a young person on an open ACCT is at increased risk, there is full consideration of all the options, action is taken and this is recorded in the ACCT documentation.

Response: Recommendation accepted
We will ensure all residential managers, case managers, orderly officers and duty governors are briefed regularly on the need to give consideration to the full range of options when a young person is identified as being at increased risk, particularly at times of the day when it might be difficult to hold a multi-disciplinary review.

We will quality assure ACCT documents to ensure this happens.

13. The Governor should ensure that ACCT reviews identify and discuss trends in behaviour that indicate an increase in risk and consider and document whether it is necessary to remove items from young people in order to help protect them.
Response: Recommendation accepted
We will ensure that all case managers are fully aware of the relevant part of PSI64/2011 which provides guidance on the issue of items in possession and develop a local policy on this issue which ensures appropriate discussions take place in ACCT reviews and are documented.

14. The Governor should ensure that levels of observations and significant events are properly recorded in the ACCT document.

Response: Recommendation accepted
We will strengthen our quality assurance processes to ensure ACCT documents include all relevant information.

15. The Governor should ensure that a consistent approach is taken to the use of the formal disciplinary process, that officers and adjudicators consider whether formal disciplinary charges are appropriate for young people considered at risk of suicide and self-harm, and that punishments do not conflict with agreed objectives aimed at reducing risk.

Response: Recommendation accepted
We will review the policy to ensure that we give clear guidance on this issue. In particular, we will brief case managers on the need to inform other staff on the approach to managing a young person's behaviour which has been agreed in case reviews.

Adjudicators will be provided with the ACCT document when a young person is subject to one so that they can, if appropriate, give a sanction which is consistent with care plan objectives and does not have the potential to increase risk.

16. The Governor should ensure that sanctions imposed under the rewards and sanctions policy are legitimate and appropriate, take into account individual circumstances, and that all decisions and actions are fully documented including in ACCT records where applicable.

Response: Recommendation accepted
We believe that the 'instant sanctions' which can be awarded to a young person under our IEP scheme are legitimate as the process follows the principles of 'natural justice'. The process is more appropriate for the management of young people than the adjudication process for low level poor behaviour.

We will ensure that case managers give consideration to the management of a young person's behaviour as part of the case review process to ensure consistency between behaviour management and management of vulnerability and risk.

17. The Governor should ensure that personal officers introduce themselves shortly after arrival and are able to interact regularly with the young people they are responsible for. Personal officer and other staff should make frequent entries in P-NOMIS case notes about a young person's well being and progress and record any significant incident or event.

Response: Recommendation accepted
We will ensure that the Personal Officer scheme is working appropriately by strengthening the assurance systems which check on entries to P-NOMIS.

18. The Governor should ensure that all allocations in Cookham Wood are based on the best interests of young people and the need to ensure their safety.

Response: Recommendation accepted
We will ensure that location of a young person is regularly reviewed within the ACCT case review process and that if a young person does not agree with a decision on location there is an agreed policy in place to deal with this effectively.

19. The Governor should ensure that all staff working with young people are trained in how to respond to disclosure of past abuse and make appropriate onward referrals.

Response: Recommendation accepted
We will develop a training package for staff which will help them to deal effectively with disclosure of past abuse and incorporate this in to the local training plan.

20. The Governor should ensure that all staff understand, subject to an appropriate individual risk assessment, their responsibility to enter a cell without delay if there is a risk to the life of a child.

Response: Recommendation accepted
We will review instructions for procedures around opening of cell doors on night state to ensure they clearly remind staff of their responsibility to ensure there is no delay if there is potential for risk to the life of a child.

21. The Governor should ensure that contingency plans ensure that emergency vehicles are appropriately directed to Cookham Wood.

Response: Recommendation accepted
We will review and improve signage to the prison and also review contingency plans to give consideration to deploying staff at the entrance to guide in vehicles.

22. The Governor should ensure that there are sufficient first aid trained staff on duty at all times who understand how to use defibrillators and other emergency equipment.

Response: Recommendation accepted
An ongoing schedule of first aid training has been established to ensure appropriate numbers of trained staff. Particular emphasis has been placed on CPR and defibrillator training.

Additional defibrillators have been installed.

The British Heart Foundation ‘Vinny Jones’ advert which advises people on what to do in an emergency situation has been utilised in staff briefings to underpin training provision.
National Recommendation

23. The National Offender Management Service and Youth Justice Board should devise a more child-centred approach to managing risk of suicide and self-harm, which takes an appropriate holistic view of all aspects of a young person's risk and vulnerabilities, with cases actively considered at senior management level and involving a range of qualified professionals to meet the identified needs of each young person at risk.

Response from the National Offender Management Service:
This recommendation raises significant issues which NOMS and the YJB need to carefully consider before substantively responding. To ensure this is done comprehensively and appropriately for the risks involved, a working group of the Safer Custody and Learning Board has been created. The PPO will be asked to contribute.

Response from the Youth Justice Board: recommendation accepted:
We completely support the direction implied through this recommendation – that the ACCT process as currently operated is not sufficient for the needs of young people – and have always stated our preference for a child centred approach both through the systems used and through our desire for a bespoke estate for children and young people.