ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Secretary of State for Justice** **2. Tower Hamlets** **3. Medway Youth Offending Team** **4. Governor Cookham Wood** **5. Oxleas**
1	**CORONER** I am Patricia Harding, senior coroner, for the coroner area of Mid Kent and Medway
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 1st February 2012 I commenced an investigation into the death of Alex Kelly age 15. The investigation concluded at the end of the inquest on 16th December 2014. The conclusion of the inquest was that Alex Kelly died from a hypoxic brain injury having suspended himself on the 24th January 2012 from a ligature made from his shoelaces which was attached to a locker within his cell at Cookham Wood Young Offenders Institution where he was serving a sentence. He died at Medway Maritime Hospital on the 25th January 2012. The jury were unable to determine his intention in suspending himself but found that his emotional state was significantly compromised at the time. The jury further concluded: 1. That there was a systemic failure by Tower Hamlets Social Services to allocate a named social worker which hampered communication with other agencies, the ability to address ongoing concerns about Alex's mental health issues and his continuity of care all of which led to an inadequate level of support for a vulnerable looked after child. Additionally Tower Hamlets failed to address Alex's placement on release, his wish to see his grandmother. 2. At Cookham Wood Young Offenders Institution the effective sharing and evaluation of important information was hampered by the number of different types of systems used to record information concerning Alex Kelly, a lack of communication between staff and departments and a lack of communication with external parties all of which led to a reduced ability to safeguard Alex effectively.Additionally a review of the safeguarding provisions on the 24th January 2012 should have included requesting Alex to move to a supervision cell for the night and maintain constant observations and removing his laces.

4	**CIRCUMSTANCES OF THE DEATH** Alex Kelly was a vulnerable and immature 15 year old who had suffered repeated serious sexual abuse as a very young child. He became a looked after child at the age of 6 with Tower Hamlets the Corporate Parent. He was fostered for 10 years with a family in Medway. In early adolescence Alex developed identity issues. He had variously been diagnosed with ADHD, and assessed as mildly autistic but it was common ground that his deep rooted problems had never really been addressed in the community. Alex first became involved with the Youth Courts in 2010 and until August 2011 appeared repeatedly before the Youth Courts having offended and breached orders. On the 1st August 2011 Alex was remanded to Cookham Wood YOI and was later bailed on the 9th August 2011. This was his first time in custody. On the 10th October 2011 he was further remanded to Cookham Wood and sentenced the following day to a 10 month DTO. Whilst in custody Alex was diagnosed by a psychiatrist within the mental health in-reach team with ADHD and conduct disorder and was prescribed medication. Alex initially engaged well with the regime but his behaviour began to deteriorate in December 2011 and an ACCT was opened on the 23rd December 2011 because of his low mood and a refusal to engage in education, activities and association. The ACCT was closed on the 3rd Jan 2012 but reopened on the 6th and remained open until his death. A Behaviour Improvement Plan designed to encourage him to engage was opened on the 29th December 2012 and remained open until late January. Throughout January 2012 Alex received a number of adjudication awards for blocking the observation panel to his cell or tattooing. Awards prevented him from engaging as envisaged by the Behaviour Improvement Plan. Alex had repeatedly made marks on his arms throughout January 2012 which were variously regarded as tattooing or self-harm. Alex's presentation throughout the period was variable, sometimes appearing in relatively good spirits but very often refusing to engage and remaining in his cell. Alex made a number of threats to take his own life by 'stringing up' but when tasked about this issue smiled or appeared to prison staff to treat it as a joke. He progressed to writing notes to the same effect and then to making ligatures with his shoe laces. On the evening of the 24th January 2012 Alex for the first time spoke of the sexual abuse that he had suffered and indicated it was all he ever thought about. He said he wanted to kill himself and that there wasn't anything officers could do about it as there would be sufficient time between observations. A short time later he telephoned his foster carers and was seen to be upset and after started to cry but stopped himself when an officer noticed. He then told another officer who had a good relationship with him and who had been asked to speak with him because he was upset, that he was going to hang himself. He repeated this to the same officer a short time later. Officers thereafter responsible for observing Alex were not informed of these disclosures. Alex's observations were around this time increased from 3 to 5x hour. He was seen inside his cell drinking a hot chocolate at which time his observation panel panel was partially blocked. When an officer next went to check 15 minutes later there was no response and the panel was blocked. Officers entered his cell 4 minutes later to find him hanging from his shoelaces which were tied to a locker Whilst he was at Cookham Wood YOI Alex had repeatedly stated he wanted to see his grandmother and from the beginning of January 2012 had stated that he did not want to return to his foster parents on release. At the time of his death his placement was unresolved and a number of telephone calls Alex made before he died were seeking to find a placement with people he knew

5 **CORONER'S CONCERNS**

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

I heard evidence that steps had been taken to address the matters listed below, but regard such steps as works in progress with further work to be undertaken or of sufficient importance that they require to be reported

The **MATTERS OF CONCERN** are as follows. –

Re: Secretary of State for Justice

Alex Kelly a vulnerable looked after child of 15 years with complex unresolved emotional issues and undiagnosed mental health issues was sentenced to a Detention and Training Order to be served at a Young Offender's Institution without the benefit of a forensic psychiatric assessment. Whilst I heard evidence from a psychiatrist associated with Cookham Wood YOI that the mental health in-reach team were able to address Alex's mental health needs whilst in custody, I am aware of the deaths of a number of other children in custody who similarly had not had forensic psychiatric assessments and it is for this reason I am reporting the concern. Whilst hearing evidence in relation to lessons learned I heard from the Service Manager of Medway Youth Offending Team that they have now secured the services of a psychiatric mental health nurse to assist them in the effective management of the young people for whom they have responsibilities which I was told was proving effective and is to be continued

Alex Kelly was under an ACCT between 23rd December 2011 and 3rd January 2012 and 6th January 2012 until his death. During the operation of the ACCT there was a continued conflict between the ACCT process and disciplinary procedures; outside agencies and carers were not asked to contribute; specific acts by Alex were seen as obstructive/challenging behaviour rather than signs of distress or a means of communicating that he needed help (his foster carers who had not been asked to contribute had some experience of Alex using non-verbal methods of communication); the ACCT reviews tended to focus on addressing specific or recent behaviours rather than the reason for the behaviour; although Alex was frequently mentioned at weekly safer regimes multidisciplinary meetings, a holistic approach was never adopted as to how he could best be supported or whether the YOI could support his needs.

Re: Tower Hamlets

1. Allocation
   a) Alex Kelly was without a named social worker for a period of two months at a time when he was in danger of being sent to custody and after he was sent to custody. Difficulties in allocation were not escalated to senior management

2. IT
   a) Social workers did not transfer documentation including emails onto Framework i in a timely manner or at all
   b) There was no system in place for ensuring that urgent electronic communications were flagged/diverted when the recipient was absent from work

3. Custody
   a) Social workers did not all appear to appreciate that their responsibilities as Corporate Parent included a role in a looked after child's welfare whilst in custody

Re: Medway Youth Offending Team

1. Involvement with other agencies
   a) Shortcomings in other agencies which affected the ability of the YOT to manage the young person were not brought to the attention of management

2. Placement within the Secure Estate
   a) There were inconsistencies in recommendations as to placement in a STC/YOI which were not reconciled
   b) Youth Offending Team keyworkers did not all appear to appreciate that their responsibilities included a role in the young person's welfare whilst in custody
   c) Members of the Youth Offending Team did not all appear to appreciate that the Youth Offending Team could initiate a transfer within the secure estate

3. Caseworker based at Cookham Wood YOI
   a) Outside agencies sharing responsibility of the welfare of a young person in custody and foster carers were not kept informed of significant events, asked to participate in ACCT reviews or asked for input into the management of the young person
   b) Although involved in the ACCT reviews the caseworker was unaware of the range of options available to safely manage the young person including requests to transfer to a different type of secure accommodation and the use of enhanced reviews
   c) Paperwork was not submitted for early release on the basis of non-compliance with the regime and concerns about absence of a placement without consultation with any person responsible for making decisions in relation to early release

Re: Cookham Wood YOI

1. Communication with outside agencies
   a) Outside agencies sharing responsibility of the welfare of a young person in custody and foster carers were not kept informed of significant events, asked to participate in ACCT reviews or asked for input into the management of the young person

2. ACCT
   a) Officers were inconsistent in the recording of significant events; entries being made in either the wing observation log, ACCT ongoing record or not at all
   b) At least one officer did not appear to appreciate the importance of significant incidents/disclosures or report them
   c) Significant events in a lengthy ongoing record were not highlighted and therefore not obvious to officers reviewing safeguarding provisions
   d) Officers were unaware of the need to involve outside agencies in the ACCT review process, the range of options available to them to safely manage the young person including requests to transfer to a different type of secure accommodation and the use of enhanced reviews
   e) The safer regimes meetings were not provided with all relevant information and were not used to their full effect. The minutes of the meetings were not fully recorded
   f) A holistic approach was not taken to the safe management of the young person during ACCT reviews or Safer Regimes meetings when it was apparent that he was struggling with the regime and that interventions were not working

3. Conflict between Regimes
   a) Officers did not always seek advice before placing the young person on report for tattooing when there was an indication in the ACCT documentation that adjudication awards would lead to a heightened risk of self-harm
   b) There was a conflict between the use of a behaviour improvement plan and adjudications which was not recognised at the time

	4. Early Release a) Paperwork was not submitted for early release on the basis of non-compliance with the regime and concerns about absence of a placement without consultation with any person responsible for making decisions in relation to early release 5.Cell entry a) There appeared to be an inflexible approach to cell entry requiring the presence of three prison officers even though YOI was in patrol state and concerns were sufficient to require entry **Re: Healthcare at Cookham Wood** **NB: the service provider has changed since the death of Alex Kelly. The new provider is in the process of determining the systems and procedures being put in place at Cookham Wood** 1. Sharing of Information a) Officers concerned with the management of the young person were not informed in terms of his non-compliance with medication and the potential effect of the failure to take the medication 2. Medication management a) a)Medication was found stockpiled in the young person's cell; staff dispensing medication had not ensured it had been taken when it was probably recorded as having been taken b) b)Any failure to take medication was not sufficiently flagged for healthcare/prison staff to deal with the issue 3.Recording of information a) Not all occasions when the young person was seen by the in-reach team were recorded on System One
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you AND/OR your organisation have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **27 February 2015**. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: Messrs. Bhatt Murphy representing [redacted] father of deceased [redacted] foster carers Messrs. Radcliffes Le Brasseur representing the psychiatrist and to the Local Safeguarding Board. I am also under a duty to send the Chief Coroner a copy of your response.

	The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.	
9	**28th December 2014**	**SENIOR CORONER**