Re : JAKE REGINALD HARDY DECEASED

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **The Secretary of State for Justice** 2. **The Youth Justice Board** 3. **The National Offenders Management Service** 4. **HM YOI Hindley**
1	**CORONER** I am Alison Hewitt, Assistant Coroner for the coroner area of Manchester (West).
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7 of Schedule 5 to the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On the 31st January 2012 an investigation was commenced into the death of Jake Reginald Hardy, aged 17 years. The inquest was heard between the 24th February and the 4th April 2014. The inquest jury concluded that : 1. On the 20th January 2012 Jake Hardy was found partially suspended in his cell at HM Young Offender Institute Hindley. The medical cause of his death was I a Hypoxic / Ischaemic Brain Injury, due to I b Cardiac Arrest, due to I c Hanging. 2. He died as a result of his own deliberate act but the evidence did not establish, beyond reasonable doubt, whether he intended that act to cause his death.

3. His death was caused or more than minimally contributed to by failures by the State to protect his life, namely :

(i) a failure to provide him with adequate personal officer support and monitoring;

(ii) a failure adequately to record and consider reports of previous self-harm and thoughts of self-harm and suicide;

(iii) a failure adequately to refer to the Safeguarding Department observed and reported verbal abuse;

(iv) a failure to record on C-Nomis and in the wing observation book observed and reported verbal abuse;

(v) a failure from the 29th December 2011 onwards to investigate reports that he was being verbally abused by other young persons and to take action to address such abuse;

(vi) a failure on the 18th January 2012 onwards to provide, update and utilise under the ACCT process an adequate care map in respect of his risk of self-harm;

(vii) a failure from the 18th January 2012 onwards to move him from cell F1/24 to a different location;

(viii) a failure on the evening of the 20th January 2012 to permit him to use the telephone;

(ix) a failure on the evening of the 20th January 2012 to supervise association properly and to protect him from the negative behaviour of other young persons towards him;

(x) a failure on the evening of the 20th January 2012 to review the level of his risk of self-harm;

(xi) a failure on the evening of the 20th January 2012 to review the regularity with which he was checked; and

(xii) a failure on the evening of the 20th January 2012 to review the suitability of his location for his safety overnight.

At the conclusion of the inquest the Interested Persons requested time to make, and respond to, written submissions concerning my duty to make a report to prevent future deaths. I granted the request because of the complexity of the facts and issues considered during the inquest and the quantity of documentary material relating to changes which have been made since Jake Hardy's death. I have received written submissions from

all the Interested Persons, the last being received on the 22nd May 2014. I have since taken time to review the evidence and to consider all the submissions and all the documentary material before me.

4 CIRCUMSTANCES OF THE DEATH

Jake Hardy was a 17 year-old young man from Chesterfield, Derbyshire who was sentenced to a detention and training order and sent to HM YOI Hindley, Wigan in December 2011. He was a young person with a number of vulnerabilities. He had been diagnosed as having learning and behavioural difficulties, had been issued with a Statement of Special Educational Needs and had attended a "special needs school". He had a low reading age and was emotionally immature. He also had a history of being bullied by his peers at school and some history of self-harming behaviour and suicidal ideation. He relied heavily on his family, especially his mother, for emotional support.

As the jury's findings show, several of the policies and procedures then in place within the HM YOI Hindley designed to identify, monitor and protect vulnerable detainees and those at risk of self-harm were not utilised either as fully as they should have been or at all in relation to Jake. Further, there were failures by prison and clinical staff both to consider and to record relevant information in Jake's records.

Over the seven weeks that Jake was in HM YOI Hindley he told staff on a number of occasions that he was being verbally bullied by other detainees but no referral was made to the Safeguarding Department until shortly before his death. Further, a written report made in late December 2011 by Jake's Youth Offending Service worker, linking the verbal abuse to Jake's risk of self-harm and suicide, did not result in effective protective steps being taken.

After evening lock-up on the 17th January 2012, Jake smashed the television in his cell and used the broken glass to self-harm. He was placed on an "Assessment Care in Custody and Teamwork" ("ACCT") process but the jury found that, when it was reviewed, there was a failure to create an adequate "care map" in respect of his risk of further self-harm.

When questioned about the incident, Jake stated that he was being verbally bullied and that detainees in other cells were shouting out obscenities about his family. Subsequently, perpetrators of the verbal abuse were identified but no action was taken to re-locate either them or Jake, in part because Jake resisted this. Jake's mood and presentation between the 17th and 20th January was variable but concern for his mental health and his safety were raised when he was disciplined for

	breaking his television. On the 20th January 2012 Jake appeared to be calm and cheerful during the day but he became angry and upset when the prison staff supervising evening association forgot to unlock his cell as he had wanted to telephone his mother, to whom he had not spoken for several days, before the other detainees were released from their cells. He was told by the staff that he could use the telephone later, although this was not in fact permitted because of his subsequent behaviour. During the association period Jake remained in his cell and a number of detainees congregated outside his door. The evidence revealed that some of those detainees behaved in a harassing manner towards Jake, opening and closing his observation flap, hitting his door and calling and gesturing to him. Supervising staff did not take any or sufficient steps to prevent or stop this. Jake was again angry and upset and he repeatedly tried to cover his observation panel with paper and he was kicking his door for over an hour. Further, shortly after evening association was finished, Jake was found to have broken the furniture in his cell. Despite Jake's presentation and behaviour, the prison staff failed prior to final lock-up to review under the ACCT procedure the level of Jake's risk of self-harm, the regularity with which he was to be checked overnight and the suitability of his location for his safety overnight. Jake was found by night staff less than an hour later, on a routine check, to be partially suspended by a ligature tied to a window bar.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed a large number of matters giving rise to concern. However, I heard evidence and have been provided with documentary material showing the changes which have taken place within the Youth Justice Board, the Youth Offending Service and HM YOI Hindley since Jake's death and I am satisfied that action has already been taken to address many of the matters giving rise to concern. For example, the Youth Justice Board has improved its documentation used for the placement of young offenders and has introduced "Asset Plus" for information recording and risk assessment. There have also been wide-ranging and significant changes to the policies and procedures in place at HM YOI Hindley. These include the introduction of a new "Managing Vulnerability Policy", routine risk assessment 10 days after a detainee's arrival, an improved safeguarding referral process, improved risk assessment tools and more individualised intervention plans. Matters of concern have also been addressed by the Greater Manchester West Mental Health NHS Foundation Trust and Bridgewater Community Healthcare NHS Trust.

Despite the changes which have taken place, some matters giving rise to concern continue and these are set out below. In my opinion there is a risk that future deaths will occur unless action is taken in relation to these continuing matters. In the circumstances it is my statutory duty to report to you.

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

A. To (i) the Secretary of State for Justice
(ii) the Youth Justice Board

1. It was apparent from the evidence I heard that a significant proportion of the children and young persons placed in HM YOI Hindley are vulnerable and have complex needs. This may well be true of the children and young persons placed in other Youth Offender Institutions also.

Clearly, the nature and extent of Jake Hardy's vulnerabilities were not unusual amongst this population, with many detainees having some form of learning difficulty. I was told that other detainees are vulnerable for different reasons, for example because they have been abused or neglected or their upbringing has been adversely affected by a parent's misuse of alcohol or drugs. Many are "looked after children". I was also told that these detainees' "complexities affect their reaction to authority and boundaries and are probably the reason they ended up in custody in the first place".

It was also apparent that vulnerable detainees are likely to lack the emotional and intellectual maturity and resilience they may need to cope with the pressures of life in custody (such as separation from family and bullying) and that the risk of self-harm and suicide can increase in consequence. I was told that safeguarding these detainees is made more difficult by the prevalence of their volatile and unpredictable behaviour.

Overall, the evidence suggested that the placement of vulnerable children and young persons with complex needs in the environment of a Youth Offender Institute (particularly if some distance from home) does, in some cases, result in an increased risk of self-harm and suicide which it is often difficult for prison and clinical staff to manage effectively, even with the benefit of the various policies and procedures which are in place.

2. As stated above, significant changes of policy and procedure have been introduced at HM YOI Hindley in order to address concerns raised

about the identification, monitoring and protection of vulnerable children and young persons and those at risk of self-harm and suicide. It may well be that some or all of those changes would provide better protection to detainees in other Young Offender Institutes but I am not aware that consideration has been given to the adoption of these changes elsewhere in the estate.

B. To (i) the Secretary of State for Justice
(ii) the Youth Justice Board
(iii) the National Offenders Management Service
(iv) HM YOI Hindley

1. A number of the prison staff from HM YOI Hindley who gave evidence at the inquest clearly lacked (a) any or sufficient aptitude or temperamental suitability for the demands of working with vulnerable young persons with complex needs and/or (b) any or sufficient understanding of those needs and their causes (such as the nature and effect of specific learning difficulties and the effect of abuse or neglect in childhood).

I have been told that these matters are now addressed to some extent by the Youth Justice Board and HM YOI Hindley but that further changes are being considered to the way in which prison staff working in Young Offender Institutes are recruited, screened for aptitude and trained. I report this concern so that any outstanding further steps can be considered.

2. The evidence revealed an almost complete failure to provide Jake Hardy with the benefit and protection of a Personal Officer, despite a comprehensive scheme being in place. Currently the scheme is of pivotal importance for the identification and monitoring of vulnerability and risk.

There remains a concern about whether all officers at HM YOI Hindley have a sufficient understanding of this role and its importance and about the absence of any system to alert managers to any failure by a Personal Officer to meet his obligations under this scheme or to audit his performance. This concern may be of relevance to other Young Offender Institutes also.

3. Cells containing ligature points (such as window bars) are still in use at HM YOI Hindley for detainees who have been assessed to be at risk of self-harm or suicide. This concern may be of relevance to other Young Offender Institutes also.

4. Verbal bullying by means of detainees "shouting out" at night is a common problem in HM YOI Hindley and can increase the risk of self-harm and suicide by those targeted, especially overnight. The fabric, lay-out and design of the cells in HM YOI Hindley does not remedy this problem. Further, it is difficult for the night orderly officer on duty on a wing, who is there alone, to tackle the problem effectively. There is no effective system in place to ensure that the problem is routinely monitored and tackled effectively, whether by means of additional staff or otherwise. This concern may be of relevance to other Young Offender Institutes also.

5. The children and young persons detained at HM YOI Hindley are provided with a weekly credit which they may use to telephone family or other approved numbers. Calls are made from a communal telephone located in the association area of a wing. Prison staff have a discretion to permit further calls to be made from an office telephone for good reason.

I was told that in-cell telephony has been introduced in newly built parts of the children and young persons' estate but it is not available in HM YOI Hindley and other Young Offender Institutes. Currently, therefore, these detainees are not able to speak privately on the telephone and there is no sufficient system in place to ensure that a child or young person in crisis or in need of emotional support (whether by reason of being bullied or experiencing feelings of self-harm or suicide) can speak to a family member without significant delay.

6. The shift patterns of Senior Officers working on the wings within HM YOI Hindley are such that they do not always overlap and handover is often by means of written entries in a "handover book". The handover book I saw contained short notes addressing random matters and there was apparently no routine recording of a more comprehensive review of the shift. There is no system in place to ensure that important information and outstanding tasks are sufficiently recorded by one Senior Officer at the end of his shift and then read by the next Senior Officer at the start of his shift.

It was clear from the evidence that it is the Senior Officer's responsibility to have an overview of what is happening on the wing and matters of relevance to the safeguarding of detainees housed there. Therefore, the passing of key information and outstanding tasks between Senior Officers on a wing is of real importance to the safety of detainees. This concern may be of relevance to other Young Offender Institutes also.

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6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths by addressing the concerns set out above and I believe you or your organisation has the power to take such action in respect of those concerns identified as relating to you.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by the 26th August 2014. 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 and to the other organisations listed below which may find it useful or of interest : • [redacted] • Derbyshire Youth Offending Service • The Greater Manchester West Mental Health NHS Foundation Trust • Bridgewater Community Healthcare NHS Trust • Derbyshire Local Safeguarding Children Board • Wigan Local Safeguarding Children Board • HM Inspectorate of Prisons • Independent Advisory Panel on Deaths in Custody • Prisons and Probation Ombudsman I am also under a duty to send to 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	**30th June 2014** **Alison Hewitt**