INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING

THE DEATH OF A MAN AT HM YOUNG OFFENDER

INSTITUTION, READING, IN JUNE 2005

Report by the Prisons and Probation Ombudsman
for England and Wales

March 2007

This is the report of an investigation into the death of a young man at HM Young Offender Institution (YOI) Reading on 26 June 2005. He was found hanging in his cell that morning. The purpose of my investigation was to establish the circumstances and events surrounding his death, including the quality of care provided by the Prison Service. He had been remanded into custody at Reading from Guildford Magistrates' Court. At the time of his death, he was awaiting sentence for various offences

The investigation was led by one of my colleagues. I am grateful for all the assistance that the investigation team received from the Governor of Reading and her staff, including the Deputy Governor, who acted as the establishment's liaison officer.

A key objective of all my investigations is to make sure that the bereaved family has the opportunity to raise any concerns and contribute to my inquiries. In this case, the investigation team was able to meet with his mother and two sisters. I am most grateful to them for agreeing to this meeting at what must have been a very difficult and distressing time.

I offer sincere condolences to this young man's family and friends in their sad loss. The man was only 18 years of age when he died.

STEPHEN SHAW CBE
PRISONS AND PROBATION OMBUDSMAN **MARCH 2007**

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SUMMARY

The young man was remanded into custody at HM Young Offender Institution (YOI) Reading in March 2005, and was awaiting sentence. Before arriving at Reading, he had been placed on a suicide/self harm warning form by Guildford Magistrates' Court following concerns raised by his solicitor and Youth Offending Team (YOT) worker. On arrival at Reading, a First Reception Healthscreen was undertaken. This took into account the suicide and self harm warning form from court, and the fact that the man said that he had self harmed and had tried to hang himself in a Secure Unit around two years previously. However, he was not placed on an F2052SH 'Self Harm At Risk Form' at Reading. He said during the Reception Healthscreen that he was not feeling suicidal and he felt he would cope with detention this time. He saw an alcohol worker on the same day and she referred him to the specialist drugs team, CARATS (Counselling, Assessment, Referral, Throughcare). The CARATS team aim to see identified prisoners within five working days with a view to completing an initial and full assessment of their drug use. There is no evidence that the man ever saw a member of the CARATS team.

The young man saw a prison buddy on several occasions during his time at Reading. The buddy system is a system where prisoners are trained to help other prisoners through difficult times. If prisoners feel they need somebody to talk to, they can talk to a buddy. He also spoke to the Samaritans by telephone on numerous occasions when he could not speak to a buddy.

The young man attended several court hearings between 10 March and 23 June. The Prisoner Escort Record Forms for those hearings did not mention any concerns that he might self harm or commit suicide.

On 8 May, after he had been moved to another wing, he alleged that he was being bullied by another prisoner. The alleged bully was put on a bully watch and the man was moved again to another wing. On 18 May, he was allowed a public expense phone call to his mother. On 20 May, he told an officer that he had not been attending exercise or association as he was still concerned over the bullying issue. He was reassured by the same officer that the issue had been dealt with and he said that the young man seemed happier about the situation.

On 6 June, he was told that his mother would not be able to visit him before her holiday. He seemed to take that news well and spoke to his mother on the telephone, again through a public expense telephone call. On 18 June, he was permitted to make another public expense telephone call, this time to his cousin, but officers could not get through to the number. He was clearly upset that he could not speak to his cousin, so he was located in a shared cell.

On 20 June, the young man tried to call his cousin again, but again there was no answer. It was agreed by staff that he should be allowed to stay in the shared cell for one more night. The young man was upset as he believed his baby had been taken into the care of Social Services. He also fell out of the

top bunk in the shared cell and was taken to Healthcare. He was seen by a doctor and a member of the Outreach team.

On 21 June, the young man was authorised a further two night stay with his cellmate in the shared cell. On 23 June, he was moved back into his own cell in the morning. In the afternoon, he told an officer that he could not stay in the cell alone. That officer agreed that he could go back into the shared cell. He stayed in the shared cell until 25 June. On 25 June, he moved back to his single cell.

At 8.35am on 26 June, an officer found the young man hanging in his cell. Staff responded promptly. No cardiopulmonary resuscitation (CPR) was undertaken because the clinical assessment was that rigor mortis had set in.

This report makes a total of nine recommendations.

CONDUCT OF THE INVESTIGATION

This investigation was undertaken by two investigators from the Prisons and Probation Ombudsman. During the course of initial inquiries, the investigation team were shown around Reading and visited the cell where the young man died. They reviewed all the relevant documentation and established a chronology of events. Notices were issued to staff and prisoners telling them of the investigation and offering them the opportunity of contributing. There were no responses to these notices.

One of my family liaison officers contacted the young man's family and offered them the opportunity to meet with him and the investigator to discuss the purpose of the investigation and to raise any concerns or questions that they would like explored and addressed. They met with his mother and two sisters on 28 July 2005. The family raised a number of concerns - mainly about his cell location before he died, and whether he was on an F2052SH (suicide/self harm warning form) when he died. They also asked some specific questions about the circumstances of his death, and some general questions about Reading. The concerns and questions raised by his family are examined further in this report.

The investigation team met a representative of the local branch of the Prison Officers' Association (POA), and a representative of the Independent Monitoring Board (IMB), to tell them about the investigation process. Six members of staff were interviewed during the course of the investigation. They were all offered the opportunity of being accompanied by a work colleague or Trade Union official.

The investigation team also met with a prisoner who had shared a cell with the young man, and with a prisoner who had spoken to him as a buddy. A buddy is a prisoner who is trained to listen to other prisoners who are having difficulties.

The investigation team contacted Her Majesty's Coroner to tell him of the nature and scope of the investigation. The Coroner provided a copy of the post mortem report of 4 August 2005 and toxicology report of 2 July 2005. The post mortem report recorded the cause of death as 'compression of the neck by ligature (hanging)'. The toxicology report was negative.

The Director of Quality, Standards and Workforce, Reading Primary Care Trust, organised a clinical review of the healthcare provided to the young man while at Reading.

HM YOI READING

Reading is a category C local remand centre and young offender institution holding young adults between 18 and 21 years who are convicted, sentenced or on remand. Reading was built in 1844 on the site of a former small jail. It was designated as a local prison in 1973 and was re-roled as a remand centre and young offender institution in 1992. The operational area it covers includes Thames Valley, Hampshire and the Isle of Wight. The certified normal accommodation, without overcrowding, is 196 and Reading has an operational capacity of 289. The accommodation consists of three main wings, a segregation unit and a separated prisoners unit (SPU) on E wing. There is also a 20-bed resettlement unit, Kennet House, which forms part of the resettlement estate for young offenders. C wing houses young adults on induction on two landings. The third landing is mainly for young adults who work around the prison. B wing is also mainly for workers while A wing is a general wing holding both remanded and convicted young adults.

The last full inspection by Her Majesty's Chief Inspector of Prisons (HMCIP) took place in August 2004. It concluded that Reading was an improving establishment but still had a significant task to continue progressing. The report noted, 'a number of key building blocks are in place, particularly with regard to safety, staff-prisoner relations and resettlement. But there is still much to do, including a radical overhaul of catering, delivery of much more equitable provision of time out of cells and improved and expanded purposeful activity to occupy this time.'

The local strategies for the care of prisoners at risk of self-harm at Reading are in accord with national policy. The local policy for the prevention of suicide is published within the prison and is available to both staff and prisoners.

The deputy governor confirmed that, between September 2004 and September 2005, suicide awareness training had been delivered to 14 newly appointed prison officers, 24 existing uniformed staff (officer support grades, prison officers etc), 6 contracted staff and 2 members of the Independent Monitoring Board (IMB).

Reading will soon be introducing a new system for suicide prevention, the assessment,care in custody and teamwork programme (ACCT).

There was another self inflicted death in Reading, a week after this young man's tragic death, which is also being investigated by my office. That report has not yet been finalised but there are some common issues, mainly concerning healthcare, which have been addressed by Reading PCT in a review, as detailed later in this report.

THE YOUNG MAN'S TIME AT READING

The young man was remanded into custody at HMYOI Reading on 7 March 2005 by Guildford Magistrates' Court, **charged with various offences which were alleged to have happened on 18 and 19 February 2005.**

A suicide and self harm warning form had been opened for him at Guildford Magistrates' Court. This was done following information from his solicitor, and his Youth Offending Team (YOT) worker. The warning from the court said, 'Acts of self harm (ligature around neck) during last period of custody in Vinney Green Secure Unit. Overdose within the last six months.' The warning form noted his solicitor's comments, 'It should be noted that I believe that the young man is vulnerable and a high risk of self-harm/suicide. He should be kept on a suicide watch. This view is shared by YOT supervising officer.'

The young man was seen in reception at Reading on 7 March and a First Reception Health Screen was undertaken by a Prison Service staff nurse. The staff nurse noted that there was a suicide/self harm warning form from the court. The young man told her that he had self harmed by cutting his wrists around one and a half to two years ago in a Secure Unit, and that he had also tried to hang himself then. The staff nurse did not open an F2052SH for him as he told her that he did not have any current thoughts of self harm or suicide. She signed and dated a copy of the warning form from the court, at Section 8, 'Confirmation of action taken by healthcare screener' to indicate that she did not open an F2052SH. She noted that he should be referred for a mental health assessment, and he saw a psychiatric consultant on 18 March. The staff nurse confirmed in interview that she has never undertaken any suicide or self harm awareness training. Some healthcare staff mentioned during interview that they sometimes felt pressured to complete initial reception health assessments quickly.

The young man told the staff nurse that he drank 17 pints of alcohol a day and she referred him to an alcohol worker, who also saw him on 7 March. She then referred him to the CARATS (Counselling, Assessment, Referral, Throughcare) team on the same day. The CARATS team help prisoners identified as having drug problems. There is no evidence that the young man ever saw a member of the CARATS team. However, he was adequately supported for his alcohol problems by the alcohol worker through follow up meetings on 8 March, 11 March and 14 March. Unfortunately, one meeting which he had scheduled with her, for 15 March, was cancelled due to a shortage of staff to unlock prisoners.

The young man received a full induction and was located on the 'Induction Wing', C wing, until he was relocated to normal location on 10 March, in a single cell.

On 10 March, he was escorted from Reading to Guildford Magistrates' Court. The Prisoner Escort Record (PER) which accompanied him from Reading

said there were no concerns of any self harm or suicidal intentions. The young man was convicted but not sentenced at court that day.

On 16 March, a prison doctor prescribed medication to help him sleep. He considered that the young man was a risk of self harm, although not currently suicidal. He did not diagnose mental illness but recommended that he needed Community Mental Health Team (CMHT) input and support.

The young man was seen by a mental health nurse, on 17 March. She noted that he had no suicidal thoughts and appeared settled.

On 18 March, his records were reviewed by a psychiatric consultant. The doctor did not examine or meet him in person as a former doctor's report indicated that he had no symptoms of mental illness and the prison's doctor referral was for long term support and did not indicate any new mental illness. The psychiatric consultant followed protocol in outlining her findings in the notes and discussing them with nursing staff, rather than directly with the prison doctor who worked a different shift pattern to her. The consultant concluded that a Care Programme Approach (CPA) meeting was not appropriate for the young man as he did not have a severe mental illness. A CPA meeting is normally reserved for those who have a severe and enduring mental illness. It is used to bring services together for those vulnerable prisoners who may suddenly be released to ensure continuity of care. The consultant found that he was vulnerable because of his learning difficulties, and expressed concern in her notes that he did not come under the remit of the CMHT because he was not mentally ill, or the learning disabilities team because he was so mildly disabled. She said that the young man should be reviewed if his mental state changed.

The young man saw a buddy on 19 March, 20 March, and 21 March. An entry on 23 March indicates that he asked to see a buddy. The duty buddy told a member of staff that he was asking for cigarettes so his request to talk to a buddy was denied. However, he was offered access to a Samaritans phone instead which he declined.

At 3.10am on 31 March, he again asked to speak to someone but he was told, due to the time of night, that he could only use the Samaritans telephone which he accepted. He spoke on the Samaritans telephone until 3.50am. On 5 April, he again spoke on the Samaritans telephone. There is an entry in his core record to say this was his third call that week. There is no evidence that healthcare staff were aware of this. On 15 April, he progressed from standard to enhanced status on A3 landing. On 19 April, he again appeared at Guildford Magistrates' Court, and he was remanded back to Reading.

On 25 April, he appeared at Bristol Magistrates' Court via videolink. The case was adjourned until 9 May 2005. On 27 April, he was moved to the third landing on C wing and located in cell C3-23.

The young man again appeared at Bristol Magistrates' Court by videolink on 6 May. The case was adjourned for a pre trial hearing on 6 June, by videolink,

and a trial date was set for 29 June. For operational reasons, he was moved to a shared cell on C3 landing, cell C3-2, that day.

After he had been moved to cell C3-2, the young man claimed that he was being bullied by his cellmate. He was immediately relocated to cell B3-7 (a single cell) on 7 May and the alleged bully was placed on a bully watch after the young man submitted a statement about the incident. There is no evidence that healthcare staff were made aware of this information.

The young man attended Bristol Magistrates' Court on 17 May and remanded again until 23 June. On 18 May, he requested a public expense call to his mother which was granted. According to PSO (Prison Service Order) 4400, Chapter 4, prisoners can use official telephones if there are urgent legal or compassionate circumstances such as imminent court proceedings or a domestic crisis. Operational Managers have discretion to authorise these calls which are made at public expense.

On 20 May, he told a wing officer that he had not been attending exercise or association as he was still concerned over the bullying issue. The officer reassured him and he seemed happier. On 1 June, he was appointed as a Segregation Unit cleaner.

On 6 June, the young man was told that his mother could not visit him before she went on holiday as visits were fully booked. He seemed to take the news well and was given a public expense telephone call to his mother. Again, there is no evidence that this information was communicated to healthcare staff. On 13 June, he was referred by the prison doctor to a consultant neurologist regarding his PANDAS.

On 18 June, the young man requested a public expense telephone call to his cousin but there was no answer. He was clearly upset that he could not speak to his cousin (it seems that his cousin may have been looking after the young man's baby), so he was moved to a shared cell, B3-4. This is confirmed by the cell occupancy history record. An entry in his core record says, 'Appears agitated and states that he needs a telephone number and a letter sent to him has not turned up. His cellmate is keeping an eye on him.'

On 18 or 19 June, the young man was seen in the treatment room by a healthcare assistant, as he had been asking for sleeping tablets. When he was asked why he needed sleeping tablets, he said that he had lost his baby. This was taken by the assistant to mean a bereavement. The healthcare assistant did not feel it was appropriate to discuss such a sensitive issue in the treatment room, so he was told somebody would see him in his cell. The information was passed to the mental health nurse and a member of the Chaplaincy team who were asked to see him. There is no evidence of the outcome of this request.

On 20 June, staff tried his cousin's telephone number again but they could still not get an answer. He was still sharing cell B3-4 with another inmate. The senior officer (SO) agreed to allow him to stay in the shared cell for that night,

20 June. The young man was told that he would have to go back to his own cell after that. That day, he went to see the prison doctor because he had fallen out of the top bunk-bed and hurt his ankle. The doctor concluded that he had not suffered any bone injury, but he noted that the young man said he was low in mood. The doctor concluded that the young man was not clinically depressed, but he referred him to Outreach and advised him of the support available to him. The young man was brought to healthcare by a mental health nurse following the doctor's referral. He told her that the mother of his baby had been taken into custody and she had left the baby with his cousin. When his cousin took the baby to hospital after an accident, the baby was taken from her as she was not the mother and Social Services became involved. His immediate family (mother and sisters) were not aware of the baby at that stage, and he was upset at Social Services taking the child into care and possible family reaction if they were to find out.

The young man also spoke about the baby to his cellmate who described him as being very upset when he found out that his baby had been taken into care. The cellmate said that the young man told him that he was determined to look after the baby when he got out of prison.

The young man was reassured by the nurse and he was put on a sleep watch as he asked for something to help him sleep. (Prisoners are put on a sleep watch before sleeping tablets are issued. That is, their sleep patterns are observed for three nights, not necessarily consecutively, over a period of a week.) There is no evidence of the outcome of the sleep watch. Nor is the treatment which he received on 20 June consistent with his treatment on 16 March when the prison doctor prescribed something to help him sleep without a sleep watch. He said that he did not intend harming himself.

On 21 June, a Principal Officer (PO) authorised him to stay for a further two nights in the shared cell.

On 23 June, the young man appeared at Guildford Magistrates' Court via videolink for his pre-trial hearing, which was subsequently adjourned until 15 August. He was moved back to his own cell (B3-7) during the morning by a movements' officer. His cellmate said that the young man asked him that morning whether he could go back into the cell with him and he told him that he had no objections to that. At 4.15pm, he told the movements' officer that he could not face being in a cell alone. The officer then put him back in cell B3-4 with his cellmate. This is confirmed by his cellmate and by the cell occupancy history record. The movements' officer spoke to healthcare about his concerns about the young man and a healthcare assistant, passed the information on to her colleague, a staff and mental health nurse. He was taken to the Health Care Centre where he played pool and spoke to the mental health nurse and to a healthcare nurse. The healthcare assistant said she left to go home at around 4pm and the young man was still talking to the mental health nurse and to the healthcare nurse. The healthcare assistant did not make a record of this session as she assumed that the two nurses would do so. In fact, there is no record of this contact.

The cell occupancy history record was not updated with his movements after 4.22pm on 23 June, when he is shown as being located in the shared cell B3-4. There is also no entry in his core record to show where he was located on 24 June. (It subsequently came to light during the inquest that the prison wing observation book noted that the young man was moved to a single cell on 24 June).

On 25 June, an officer made an entry in his core record that he was waiting for sleeping tablets which would not be available until 27 June.
The entry in his core record by the officer noted, 'Apparently waiting for sleeping tablets but none available from healthcare until Monday. I have told him that all of the time I am on the landing I do not have a problem with him sharing with his old cell mate, in an attempt to stop him getting depressed. However, due to previous entry, he needs to go back in his cell (B3-7) for the time being.' (There are two entries before this, both written on 23 June by another officer. The first reads, 'Returned back to cell this morning, accepts situation and feels ready to return.' The second reads, 'At 16:15hrs asked to go back in with his cellmate as he couldn't face being on his own.') Despite his note written on 25 June, the officer said in interview that the decision to put him back in a single cell was made by a Principal Officer. The officer said in interview that the young man was already in the single cell (B3-7) when he arrived for work on 25 June. He said another member of staff told him that the young man had been returned to his old cell, apparently because he was working in the Segregation Unit and was on an enhanced regime which meant that he was entitled to a single cell. There is no record of his move back to the single cell in the cell occupancy history record. However, there is no reason to believe that he was moved back to his single cell before 25 June. His cellmate confirmed in interview that the young man shared with him until 24 June, which was the last day they shared the cell. The cellmate said that he felt he supported the young man by listening to him, particularly when he talked about his baby. He said that the young man confided in him and was content when he was in the shared cell with him. In his opinion, the young man would still be alive if he had been allowed to stay in the shared cell with him. He said that the young man looked a bit annoyed when he was told that he would have to go back into his single cell. (It subsequently came to light during the inquest that the prison wing observation book noted that the young man was moved to a single cell on 24 June).

On 25 June, the young man was seen in healthcare by the mental health nurse. An entry in his medical record by her says, 'Seen and spoken to. States he has been requesting to see the doctor for more than a week now. States he is feeling a bit low and seems healthcare does not care. Reassured once again and knows where and what to do should he be unable to cope any more. To be seen by the doctor on Monday 27 June.' There is no evidence of what reassurance was offered.

On 26 June, the young man was found hanging in cell B3-7. The cell occupancy history record indicates, incorrectly, that he was still in cell B3-4.

EVENTS OF 26 JUNE

On 26 June at around 8.35am, the wing officer was unlocking prisoners on B3 landing. He arrived at the young man's cell, B3-7, and tried to open his cell door but thought it was barricaded as he could not open it. He managed to push the door open a little and saw his leg across the bottom bunk. He had used the ceiling light conduit to attach the ligature. He had pulled the cover over the conduit away from the anchor point ultimately exposing the conduit. This essentially meant that he bypassed a modification made following a previous death in September 2004. This modification was that covers were put over all exposed conduits. Since his death, further modifications have been made to these light fittings. The covers have now been attached with anti-pick mastic.

The wing officer immediately shouted for help from the orderly officer SO. It appears that other staff then arrived to assist at approximately the same time. A second SO said he arrived there at around 8:38am. A second officer then arrived immediately after. There is a record of an alarm call being made to the control room at 8.38am, but it is unclear who raised the alarm. The wing officer and the second SO supported the young man's weight and the second officer cut the ligature, having obtained the ligature scissors from the orderly officer SO. His body was then lowered to the floor. The staff nurse responded to the alarm call, she says at 8.36am, but this is clearly an approximate timing. As she arrived, she heard someone say that the young man was hanging. She called to healthcare officer HCO to bring the resuscitation equipment. The staff nurse then entered the young man's cell, she checked his vital signs and found that he did not have any pulse, that his pupils were fixed and dilated and that his hands and feet were cold. She did not feel that resuscitation was appropriate, as in her opinion, rigor mortis appeared to be well established. She discussed her opinion with the HCO who agreed with her. No cardiopulmonary resuscitation (CPR) was undertaken by those attending on the basis that rigor mortis had set in.

At 8:41am, an ambulance was called by a governor and at 8:45am paramedics attended and confirmed his death. At 9:45am, the deputy governor held a 'hot' debrief for all the staff involved. At 10.47am, the young man's death was pronounced by a police surgeon. All actions were in accordance with the local contingency plan for dealing with deaths in custody**.**

Events after the young man's death

The deputy governor explained that the prison care team were on site after the young man's death to help any staff who needed support. He said that he saw all staff involved before they went off duty. He also saw the staff nurse and the healthcare officer HCO in the Healthcare Centre. The aim of these 'hot' debriefs was to thank staff involved and to provide immediate support to them and to assess any further ongoing support required. As a result, two members of staff went off duty. Staff were advised of ongoing care arrangements through the Staff Care and Welfare Team and the local Care Team. They were also advised of the Samaritans and the Care First facility which provides a 24 hour counselling service. A governor also spoke to the staff involved before the deputy governor arrived at the prison. The deputy governor spoke to all staff at the end of the morning shift and to all staff attending for afternoon duty. Another governor spoke to staff attending for night duty.

A notice to staff and all prisoners, which gave details of what had happened, was issued at around 10am on 26 June. Prisoners located on B3 landing were reminded of the support available, including the Samaritans. All prisoners on open F2052SH forms had case reviews.

The Police Constable, Guildford Police, informed the young man's older sister of her brother's death on 26 June as his mother was on holiday. He gave the young man's sister the contact details for the deputy governor, but she said that she did not want any further contact with the prison at that time. The PC arranged to go with the young man's sister to the airport to meet his mother and break the news to her. The deputy governor spoke to the young man's sister on 27 June and arranged for the young man's mother to contact him on her return from holiday. The PC went with the young man's sister to the airport, in the early hours of 28 June, to meet the young man's mother, and broke the sad news to her. His mother and sister contacted the deputy governor and subsequently visited the prison. They spoke to members of staff and prisoners who had known the young man, including his cellmate. They found the visit to the prison very helpful.

The deputy governor told the investigation team that initial contact was made by Guildford Police - and not by the prison - primarily because he was duty governor on the morning of 26 June and, as it was the weekend, there was a minimum number of staff on duty. The deputy governor had to manage events, and he did not feel that there was anybody else on duty with the appropriate specialist skills to break the news to the young man's family.

An operational debrief was held on 6 July, chaired by the governor. A critical incident debrief was arranged by the Staff Care and Welfare Team and was held on 27 July and was attended by officers and senior officers that dealt with the case.

A memorial service was held at the prison on 4 July, the day of the young man's funeral. The governor and the staff nurse attended the funeral.

CONSIDERATION AND CONCLUSIONS

The man who is the subject of this report was clearly a troubled young man who was relying increasingly on illegal drugs and alcohol. He had self harmed and attempted to commit suicide in secure locations, prior to being located in Reading. He had a medical condition, PANDAS, for which he was receiving medical attention and was referred to a consultant neurologist on 13 June.

The initial healthcare reception screening at Reading was undertaken by a staff nurse. On the strength of the information available to her about the possibility of the man self harming or committing suicide, I am surprised that the nurse did not open an F2052SH for him. I am aware that he told her he had no current self harm or suicidal thoughts, but I am concerned that there may have been an over-reliance on what the young man said, and that insufficient account was taken of his previous history. The fact that no F2052SH was opened had an impact on the Prisoner Escort Record (PER) which was completed for him when he next appeared at court on 10 March. There was nothing on that PER to indicate any concerns. I am also concerned that the staff nurse has not received any suicide or self harm awareness training.

Recommendation:
A training needs analysis should be carried out to cover training for healthcare staff in suicide awareness, risk assessment and prevention, taking into account the new ACCT procedures due to be implemented.

I am concerned that some healthcare staff report they sometimes felt under pressure to complete the First Reception Health Screens quickly.

Recommendation:
A review of the First Reception Health Screen process should be undertaken to ensure that healthcare staff are able to give sufficient time to prisoners to ensure individual concerns and needs are met.

The young man was referred to an alcohol worker on 7 March 2005. At the same time, he was referred to a CARATS worker. There is no evidence that he ever saw a member of the CARATS team.

Recommendation:
The Governor should review procedures to ensure that all referrals to specialist services are followed up as soon as practical.

The young man saw a buddy on 19 March, 20 March, and 21 March, and used the Samaritans telephone three times in the week of 31 March. Although he had seen a psychiatric consultant, on 18 March, I am concerned that his subsequent frequent use of buddies and Samaritans did not trigger any action, such as a further mental health assessment or the opening of a suicide/self harm warning form. Taken together with the warnings of previous acts of self harm when he arrived at Reading, and the doctor's assessment on

16 March that he was at risk of self harm, it seems to me that there was a further missed opportunity to open an F2052SH document and provide the young man with some additional support.

Recommendation:
The governor and healthcare manager should consider whether, in cases where a prisoner has seen a buddy and spoken to Samaritans on a number of occasions, consideration should be given, on a case by case basis, as to whether a mental health assessment should be carried out and if appropriate whether consideration should also be given to raising a suicide/self harm at risk form.

I am concerned that there is no existing method for discipline staff to communicate important information to healthcare staff. Important information in the man's core record about the bullying episode, Samaritans calls and the refusal of a visit from his mother, were recorded in his core record but were not conveyed to healthcare staff.

Recommendation:
The governor and healthcare manager should implement a sound method for discipline and healthcare staff to communicate important information about prisoners to each other.

I am satisfied that the bullying issue on 7 May was correctly dealt with and appropriate action was taken. Following a statement from the young man, the alleged bully was put on a bully watch and the young man was moved to another wing.

It is not clear why he was put back into a single cell on 25 June or who authorised that move. (It subsequently came to light during the inquest that the prison wing observation book noted that the young man was moved to a single cell on 24 June). It is possible that he was put back in the single cell as a privilege, as he was on enhanced status and was working on the segregation unit. I am concerned that this was contrary to his own wishes. It does not appear that account was taken of his request to remain in a shared cell. Nor was any consideration given to his state of mind. His cellmate was a support for him, and was content to continue sharing the cell with him. Although I understand why prisoners on enhanced status are offered single cells, this should be an offer not a requirement. Consideration should always be given to what is best for the care of the individual.

Recommendation:
In considering prisoners on enhanced status for single cells, the governor should remind staff that consideration should always be given to what is best for the care of the individual

I am concerned that there is no record of the young man's cell move on 25 June.

Recommendation:
The governor should remind staff of the need to ensure that prisoner records are updated as appropriate with relevant information.

There is also evidence of inconsistency in the treatment of prisoners by healthcare staff. He was put on a sleep watch on 20 June by a member of healthcare before sleeping tablets could be issued to him. However, three months earlier, he had been prescribed medication by a doctor on 16 March to help him sleep, without a sleep watch being undertaken.

Recommendation:
The healthcare manager should remind colleagues that the sleep watch policy should be consistently applied by healthcare staff before sleeping tablets are issued to prisoners.

There is no evidence of the outcome of the sleep watch started on 20 June. Nor is there a record of the young man's interaction with healthcare staff on 23 June.

Recommendation:
The healthcare manager should remind colleagues that the Medical Record should always include details of the outcomes of medical consultations and interventions, thus enabling appropriate continuity of care.

I am pleased that modifications have already been made to light fittings in the prison so that conduit covers are now attached with anti-pick mastic.

I have reported above that Guildford Police delivered the news of the young man's sad death to his sister, and left contact details for her to telephone the prison. The deputy governor spoke to her the next day. My strong preference is that, wherever possible, a senior manager from the prison where a prisoner has died should break the news to the family. Where this is not possible (such as when the family live a long distance from the prison), then consideration should be given to asking a senior manager from a prison in the nearby area to visit the family and break the news. The Prison Service's newly revised guidance Liaison with Bereaved Families Following a Death in Custody (Prison Service Order 2710) explores these issues. It recommends that the news is broken to a family as soon as possible after the death, face to face, by a dedicated family liaison officer, along with the chaplain, governor or most senior individual available. I note that at the time of the young man's death this new PSO would not have been available to staff.

The deputy governor explained that he was managing events at the prison on a weekend, with a minimum number of staff on duty. He said that he did not feel he had any other member of staff on duty with the appropriate specialist skills to deliver the news in an appropriate manner. I am conscious that the family have been complimentary about the contact they have had with the police and prison.

I remain of the view, however, that the police should only be asked to break the news of the death, without prison staff in attendance, when distance and the time of night make this truly necessary.

Clinical Review Recommendations

The clinical review made a number of additional recommendations which I endorse. I am aware that Reading PCT has developed an action plan in light of the recommendations from their clinical reviews undertaken for this investigation, and from an investigation following another self inflicted death at Reading on 3 July. In addition, the Director of Quality, Standards and Workforce at Reading PCT presented an interim paper to the prison partnership board on 7 October which outlines the key issues.

The Director of Quality, Standards and Workforce for Reading PCT has also met with staff to give verbal feedback and to address concerns and issues arising from the two reviews. She has made plans to meet with the prison advisor to discuss the policies and guidelines that are already in place in Reading YOI, and is attending a reception session to see how the process works. In addition, the Healthcare Manager has arranged for an externally facilitated workshop for team building and she is co-ordinating a workshop to explore the assessment process and record management. Finally, the healthcare manager has arranged a separate meeting to discuss findings and recommendations with healthcare staff. I commend all these actions.

RECOMMENDATIONS:

OPERATIONAL:

The governor and healthcare manager should consider whether, in cases where a prisoner has seen a buddy and spoken to Samaritans on a number of occasions, a mental health assessment should be carried out and if appropriate consideration should be given to raising a suicide/self harm at risk form.

The governor and healthcare manager should implement a sound method for discipline and healthcare staff to communicate important information about prisoners to each other.

In considering prisoners on enhanced status for single cells, the governor should remind staff that consideration should always be given to what is best for the care of the individual

The governor should remind staff of the need to ensure that prisoner records are updated as appropriate with relevant information.

HEALTHCARE:

A training needs analysis should be carried out to cover training for healthcare staff in suicide awareness, risk assessment and prevention, taking into account the new ACCT procedures due to be implemented.

A review of the First Reception Health Screen process should be undertaken to ensure that healthcare staff are able to give sufficient time to prisoners to ensure individual concerns and needs are met.

The governor should review procedures to ensure that all referrals to specialist services are followed up as soon as practical.

The healthcare manager should remind colleagues that the sleep watch policy should be consistently applied by healthcare staff before sleeping tablets are issued to prisoners.

The healthcare manager should remind colleagues that the Medical Record should always include details of the outcomes of medical consultations and interventions, thus enabling appropriate continuity of care.

OBSERVATION OF GOOD PRACTICE:

Notwithstanding my concerns that the advice now incorporated in PSO 2710 was not followed, I consider Reading's contact with the young man's family to have been very sensitively handled and I commend those involved. It must have been a comfort for the family at an immensely difficult time.

The Prison Service has accepted all the recommendations apart from: 'The governor and healthcare manager should consider whether, in cases where a prisoner has seen a buddy and spoken to Samaritans on a number of occasions, a mental health assessment should be carried out and if appropriate consideration should be given to raising a suicide/self harm at risk form.' Having considered the recommendation the Prison Service has responded that they believe there could be potential for prisoners to be dissuaded from seeking support from Buddies/Listeners and Samaritans if they thought the frequent use of the scheme would mean they would undergo a mental health assessment. Staff are aware of those prisoners who have sought such support which in itself can alert staff to the fact that the prisoner may be at risk of self-harm. Staff can then decide on a case by case basis whether there is a need to open an ACCT.

There were no comments from the young man's family.

It subsequently came to light during the inquest that the prison wing observation book noted that the young man was moved to a single cell on 24 June.