Investigation into the circumstances surrounding the death of a young man at HM Young Offender Institution Reading in July 2005

Report by the Prisons and Probation Ombudsman for England and Wales

December 2006

This is the report of an investigation into the death of a young man at HM Young Offender Institution (YOI) Reading in July 2005. He was 18 years of age and was found hanging in his cell from a ligature attached to the light fitting. He had been remanded into custody facing sentence for offences of dangerous driving, taking a vehicle without consent, possession of drugs and breach of a supervision order.

My colleagues and I offer sincere condolences to his family and friends in their sad loss.

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. I regret the delay in completing this report.

A key objective of all my investigations is to ensure that the bereaved family has the opportunity to raise any concerns and contribute to my inquiries. I am grateful to the young man's mother for agreeing to meet with the investigators at what must have been a hugely difficult and distressing time.

The deceased was a troubled young man, who took his prescribed medication only fitfully, and whose potential for self-harm had been identified by the police, the court and prison staff. However, he was also perceived as a threat to other prisoners, making it more difficult for him to share a cell as he wanted. I have identified a number of occasions when Reading failed to follow up on actions that had been agreed in support of this young man. However, I do not underestimate the challenge of caring for prisoners who could present a risk both to themselves and to others.

STEPHEN SHAW CBE
PRISONS AND PROBATION OMBUDSMAN **DECEMBER 2006**

CONTENTS

SUMMARY

1. The young man was remanded into custody at HM Young Offender Institution (YOI) Reading on 16 April 2005, awaiting sentence. He had a history of offending between 2000 and 2005 and was known to misuse illegal substances, particularly heroin. In a pre-sentence report completed for a hearing on 29 July 2004, his Youth Offending Team (YOT) Supervisor expressed concerns that the man would not cope well with a custodial sentence and would pose a 'significant risk of attempted suicide.'

2. The young man was estranged from his family and he was concerned that his girlfriend, who was expecting his child, was not keeping in touch with him. She did visit him while he was in Reading on 18 May, 1 June, 21 June and 22 June. The man's mother said that she was not aware of his drug use before this period in custody. The young man also had a history of deliberate self harm, at home and when in custody.

3. Before arriving at Reading, he was held in police custody between 14 and 15 April 2005. Concerns were expressed about his fitness to be detained. The young man saw a doctor once on 14 April and three times on 15 April. He was put on a constant watch whilst at the police station.

4. On 16 April, at the Magistrates' Court the man headbutted his cell door, and generally tried to self harm. He said he did not want to go to prison and wanted to eat people. He claimed that he hated white people. A suicide and self harm warning form was opened and the young man was checked by staff through regular intermittent checks every couple of minutes.

5. When he arrived at Reading, a First Reception Healthscreen was undertaken, taking into account the concerns from the police station and the suicide/self harm warning form from court. The young man was placed on an F2052SH 'Self Harm At Risk Form' on the basis of that information. He said during the reception healthscreen that he had taken heroin two days previously, and that he also took cocaine. He said he had never been treated for mental illness before, but had tried to harm himself when previously in prison. The man saw the doctor immediately afterwards for an assessment of his physical health. He told the doctor that he had previously made numerous attempts at deliberate self harm, and had tried to hang himself three months previously. The young man was seen to be in good general physical health and was prescribed medication to ease the symptoms of drug withdrawal. But during his time at Reading he consistently refused to take the medication, despite encouragement from staff. He said he had been prescribed treatment for depression by his GP but had not had anything for the last year. No efforts were made to follow up this information.

6. The young man exhibited some bizarre behaviour, such as barking like a dog, covering his cell spy hole and covering his bed with a blanket so he

could not be seen. He shared a cell on two occasions and was content for a period of time. Then for no apparent reason, he assaulted one of his cellmates. He also smashed his TV and video link equipment.

7. The young man remained on the original F2052SH until 11 May 2005. Another form was opened on 13 May and closed on 13 June. On 22 June, he had a visit from his probation officer who recommended that he should be put back on an F2052SH. There is no evidence that any action was taken in light of this recommendation.

8. The young man made several court appearances between 20 April and 24 June, some via video link. The Prisoner Escort Record forms completed for those hearings note his risk of self harm and his drug problem. On 24 June, he was visited at the Magistrates' Court by his YOT Supervisor who expressed concern to custody staff that the man might self harm. This was not specifically noted in his escort record by custody staff.

9. Throughout his time at Reading, the young man was reported to be an angry, frustrated, manipulative and impulsive young man. On two occasions he was moved from shared to single cells after fighting with cellmates and he often changed his mind about whether he wanted to be located in a single or shared cell. The Consultant Psychiatrist recommended that he should be located in a single cell due to his risk to others.

10. The young man did not comply with medication prescribed for him and he was often reluctant to engage with healthcare staff. His medical record confirms that he gave differing accounts of how he felt to different members of staff.

11. Healthcare staff were of the opinion that the young man needed useful occupation to help him cope with custody. However there is little evidence that this was followed up by staff. It took eight weeks for his gym application to be considered, despite several requests being made to staff to progress his application. However, when he completed his gym induction he refused to go to the gym. He only went to the gym once. The man mentioned to healthcare and discipline staff that he felt lonely and was upset as he felt that his pregnant girlfriend was not keeping in touch with him and that he had little contact with his mother.

12. The young man saw a Consultant Psychiatrist on several occasions. The Consultant Psychiatrist concluded that each of his self harm attempts was as a result of recent events rather than longstanding issues.

13. The young man was not referred to the Community Mental Health Team (CMHT) until 6 June, when they were approached to attend a Care Programme Approach (CPA) meeting for the man. A CPA meeting is usually arranged for those who have 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. Although he was

not considered to have a severe and enduring mental illness, it was thought he would benefit from a CPA meeting.

14. The CPA meeting took place on 1 July. The young man was said to be angry and upset after the meeting, but this information was not passed on to other staff by the member of healthcare who attended the meeting. In fact, there is no mention in his medical record or core (landing) record that this meeting ever took place and the man is recorded to be settled on that day.

15. At 8.05am on 3 July, the duty officer and the wing Senior Officer (SO) found him hanging in his cell. Staff responded promptly. No cardiopulmonary resuscitation (CPR) was undertaken because the clinical assessment of the wing nurse was that rigor mortis was well established. The young man's death was pronounced by a Police Surgeon soon after.

16. The young man's family was initially told of his death by the Police. The Deputy Governor contacted the man's mother shortly after the police contact.

17. My report makes three recommendations in areas where improvements in practice have been identified.

CONDUCT OF THE INVESTIGATION

18. The lead investigator for the Prisons and Probation Ombudsman was assisted by one of her colleagues.

19. During the course of initial inquiries, the investigation team was shown around Reading and visited the cell where the 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.

20. One of my Family Liaison Officers contacted the young man's mother and offered her the opportunity to contribute to the investigation. The investigation team met with the man's mother on 26 July 2005. His mother raised a number of concerns mainly relating to her son's medical treatment and assessment during custody, and what was done to monitor and help him with any physical and mental health problems he had while he was there. These concerns are examined further in this report.

21. 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. Five 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.

22. The investigation team met with the young man's Youth Offending Team (YOT) Supervisor on 16 September. They also spoke to the young man's solicitor.

23. 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 7 July and toxicology report of 8 July. The post mortem report recorded the cause of death as 'hanging (self suspension)'. The toxicology report did not suggest the man had taken excessive amounts of illicit or prescribed drugs.

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

HM YOI READING

25. Reading is a remand centre and young offender institution, holding young adults between 18 and 21 years. The jail was built in 1844 on the site of a former prison. 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 prisoners.

26. The last full inspection by Her Majesty's Chief Inspector of Prisons took place in August 2004. This 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.'

27. 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.

28. 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).

29. This was the second self inflicted death in custody at Reading in 2005 investigated by my office. There are some common issues, particularly relating to healthcare, between the man's case and the other investigation, to which I shall refer later.

THE YOUNG MAN'S TIME AT READING

30. The young man was remanded into custody at Reading on 16 April 2005 from the Magistrates' Court. He had been detained in police custody on 14 April. The Custody Officer assessed his fitness to be detained and a doctor was called. On 14 April, the doctor's assessment read, 'Morose young man. Needs 15 minute checks. Denies he will self harm.' On 15 April, a doctor was again called to assess him, and at 4pm he noted, 'Declined medical attention, been vomiting and probably heroin withdrawal. Needs cell watch.' At 5.30pm, the doctor noted, 'Now accepts meds. May be able to remove cell watch when he settles. May need doctor to see him.' At 10.42pm, the young man was again seen by the doctor who prescribed medication for his nausea. The doctor said 'declines meds at present but offer at times anyway, continued cell watch in view of the threat of self harm.' He remained on a constant watch at the police station.

31. On 16 April, a suicide and self harm warning form was opened for the young man at the Magistrates' Court by a Senior Custody Officer. It said, 'Headbutting cell door, generally trying to self harm. Doesn't want to go to prison. Says he wants to eat people and claims he hates white people.' The man was checked by staff through regular intermittent checks every couple of minutes.

32. The young man was remanded to Reading later that day and all the above information was available for the First Reception Healthcare Screen. The First Reception Healthscreen was undertaken by a Registered General Nurse (RGN)/Registered Mental Health Nurse (RMN). He wrote, 'Heroin and Crack cocaine/refer to doctor re physical health/drug abuse. Epilepsy, only fits when in custody. Last time was in police custody. Has had fits for years. Never sought medical attention.' The young man told the RMN that he had not previously received treatment from a psychiatrist outside prison or medication for any mental health problems. He said that he had tried to harm himself when in prison before and stated he currently felt like harming himself. An F2052SH (suicide and self harm form) was immediately opened for him by the RMN. There is a note that has been added to the warning form from the court, written by the nurse, 'Denies allegation that he hates white people, states he was beaten by a white boy previously in the cell.' The young man was placed on level 1 observation.

33. According to Reading's local policy statement on suicide prevention, level 1 observation is when a prisoner is on an open F2052SH, in a shared or single cell, and an intermittent watch is required, **a minimum of five times an hour,** at irregular intervals. Level 2 observation is when a prisoner is on an open F2052SH in a single cell and requires intermittent watch **at all times**. Level 3 observation is when a prisoner is on an open F2052SH in a shared cell, and an intermittent watch is required if the cellmate leaves the cell for any reason and the prisoner on the F2052SH is left alone. Level 4 observation is required when an F2052SH is opened and the prisoner is actively suicidal and unable to be managed on normal location.

The prisoner would be located in the Care Suite in a safer cell, on a level of observation considered appropriate, in consultation with a Medical Officer.

34. After the First Reception Healthscreen, the young man was immediately referred to a doctor for a secondary assessment. The prison doctor noted that the man admitted heroin abuse and said that he had used heroin two days previously. It was also noted that he had been on medication from his GP for depression but had not taken that medication for a year. The young man's GP records were not obtained. The young man also said that he had made numerous attempts at deliberate self harm, the last time being three months previously, when he attempted to hang himself. His mother had apparently called the police and he ran away before the police arrived as he was on an outstanding warrant. The doctor noted superficial scars on his arms and referred him to the Outreach team. (The Outreach team are healthcare staff with specialist skills, such as dealing with mental health issues.)

35. The RMN gave the young man the medication to help with his withdrawal symptoms, but he spat it out. He refused to take any medication. A full explanation of withdrawal was given to him. The young man consistently refused to take his medication, as detailed throughout this report. This information was not relayed by senior nursing staff to medical staff and alternatives do not appear to have been offered to him.

36. A cell sharing risk assessment was undertaken by a prison officer who recommended that the young man remain in a single cell. On the assessment form, the RMN noted that the young man had reactive depression and had previous self harm history and used heroin. The young man was assessed as a medium risk of sharing a cell with others. (That is, there was no immediate risk if he shared a cell, but the situation would have to be reviewed regularly.)

37. The young man received a full induction and was located in a single cell on the induction wing. On 17 April, the duty senior officer (SO) and the wing officer undertook another cell sharing risk assessment for him. Following this, the young man was located in a shared cell. He still refused to take his withdrawal medication.

38. On 18 April, the young man was seen by a substance misuse nurse. He was still refusing to take his medication despite the obvious withdrawal symptoms from which he was suffering. The young man was also seen by the staff nurse (an Outreach Worker) who noted that he appeared to be low in mood and said that he was feeling suicidal. The young man had lost his glasses and was referred to an optician, but there is no evidence that he ever saw an optician.

39. On 19 April**,** the young man had an F2052SH review and was to continue on Level 1 observation. He was said to be angry and still refused to take his medication. However, he saw the substance misuse nurse again and

agreed to take his medication. He was reported not to want his family to be informed of his whereabouts or for them to visit him.

40. On 20 April, the young man appeared at the Magistrates' Court and is reported to have exhibited bizarre behaviour, howling like a dog. He was sentenced to 28 days imprisonment for failure to surrender to bail on 12 May 2004 and 20 November 2004. He was remanded to appear again at Court, via video link, on 29 April on some of the outstanding charges. The remainder of the outstanding charges were to be dealt with by the Crown Court. On return to Reading, he was seen for another health check. It is unclear who saw him. No changes in his condition were reported. He was later seen by the staff nurse who noted that he was much more settled and getting on well with his cellmate.

41. On 26 April, the young man was seen for an F2052SH review. He was still refusing to take his medication. He was low in mood and was finding it hard to engage with others. He did, however, agree to be referred to the mental health team. Level 1 observations were to be continued until 28 April when he was due to appear at the Crown Court.

42. On 27 April, the young man was again seen by the staff nurse who noted that he seemed brighter. He told her that he could not contact his family, as he did not have any of their phone numbers. It was also noted that he had applied to join the gym and to attend education. The gym facilities are open to all prisoners once they have successfully completed their induction. The usual waiting time is seven days- the end of induction week- if the prisoner applies at the onset of the induction programme.

43. The young man attended the Crown Court on 28 April. The wing nurse saw him before his court appearance and said he looked tired and made very little eye contact. He returned to Reading on remand later that day.

44. On 29 April, the young man appeared at the Magistrates' Court by video link. He was again remanded in custody until 20 May. Later that day, he was moved to the Segregation Unit after he threw a television at officers. He also damaged video link equipment beyond use. The wing nurse saw him in the Segregation Unit. The young man was later found making a noose with his t-shirt and was seen by the senior healthcare officer. He was moved to a reduced risk cell with fire retardant clothing. (Reduced risk cells at Reading are cells specially designed with reduced ligature points. Modifications include moulded furniture and bed to reduce ligature points, flush taps and safer design windows and recessed light fitting. The build was to Safer Custody Specification of the time, carried out by external contractors.)

45. On 30 April, the young man was assessed as fit for adjudication in relation to the incident the previous day. He spoke to his mother, and during their conversation made several threats to self harm. He said that he would like to be in a shared cell and was moved to a shared cell later in the

afternoon. The young man was assessed as fit for adjudication, although the entry is not signed.

46. On 1 May, the young man went outside on exercise and later attended the chapel. On 2 May, he joined in the association period. He saw the staff nurse and told her that he was angry at being remanded again, but had no thoughts of self harm. He agreed to see a psychiatrist. On 3 May, the young man saw a Consultant Psychiatrist. She concluded that the young man was at risk of self harm or suicide and that he should not be moved to a single cell, although that was what he now wanted. He was having difficulties sleeping and was not eating. He was upset that he had not heard from his girlfriend. The psychiatrist was of the opinion that the man's self harm attempts were as a result of something that had happened within the previous day or two, and that he was a risk to others and probably to himself. She recommended that the young man should have increased daytime activities and relaxation or acupuncture. There is no evidence that the relaxation or acupuncture were followed up.

47. On 4 May, the adjudication hearings for both incidents on 29 April were concluded. The young man pleaded guilty to both charges. Punishment relating to attempting to throw the TV at staff was suspended for a month and the charge relating to the video link equipment was dismissed.

48. On 5 May, the young man's F2052SH was reviewed and he was said to appear more settled and was spending more time out of his cell. He maintained good eye contact and understood why he could not have a single cell. He was feeling more comfortable sharing with his cellmate. He wanted the F2052SH to be closed. The observation level was reduced from Level 1 to Level 3. On 6 May, the young man refused association. He said he was still having difficulty sleeping.

49. On 7 May, the young man was seen by the RMN. There was no change in his condition. Later that evening, the young man assaulted his cellmate by throwing tea at him. The young man was subsequently found in a struggle with his cellmate and his cellmate tried to restrain him. The young man continued to struggle and tried 'to headbutt' his cellmate, sustaining minor injuries. He was moved to the Segregation Unit to prevent a fight escalating. Later, the young man was found making a noose with bedding by the second wing officer. The young man told him that he had nothing left to live for and his cellmate had ruined his life. The Level 3 observations were increased to Level 1. He was located in a reduced risk cell overnight.

50. On the evening of 8 May, the young man was moved to a single cell in the segregation unit and was said to be pleased to be out of the reduced risk cell. However, he was vomiting and was referred to see a doctor. The wing nurse also questioned whether he should be referred back for further mental health assessment by the consultant psychiatrist. Meantime, Level 1 observations were to be continued.

51. On 9 May, the young man was seen by the prison doctor. He was no longer vomiting and was assessed as fit for adjudication. The Adjudication Record shows that he pleaded guilty and the charge of fighting was proved. The young man was to be removed from normal location and to remain in the segregation unit for a further three days. He said he would try to get along with his cellmates in the future. Although he said he had no suicidal thoughts at that time, Level 1 observations continued.

52. The man attended the Crown Court on 10 May. A bail application was refused and he returned to Reading. He was seen by the wing nurse before and after the court appearance. He told her that he did not want to be seen by a psychiatrist again. He said he was fine. He returned to the Segregation Unit when he came back from court.

53. On 11 May, the young man was moved from the Segregation Unit to normal location on C Wing. He had an F2052SH review and the document was closed by a review panel of the duty principal officer (PO), the wing PO, the wing officer and the staff nurse. The review summary said that, "apart from an impulsive incident whilst segregated there has been little concern over his intentions to self harm. He has stated that he is so happy to be out of the Segregation Unit and has no intentions of harming himself. Induction staff have no concerns other than preferring him to share a cell with a compatible person." This was agreed by the man, who said he would talk to staff if he had a problem. He also agreed that he would see staff if he felt he needed medication. The F2052SH was closed with a note that continued support was needed from staff and healthcare and a compatible cellmate would be helpful. There is no evidence that any action was taken to locate him with a compatible cellmate at this stage.

54. On 13 May, the F2052SH was re-opened by the wing nurse. In view of the incident on 7 May with his cellmate and later when he had been discovered making a ligature, she was concerned that the man still had thoughts of killing himself and felt that the F2052SH had been closed prematurely. She noted that he had seen the psychiatrist on 3 May, but was still refusing to take his medication. Level 1 observation was again started and the wing nurse put a comprehensive care plan in place for him. The young man was to be monitored closely by healthcare staff, to establish a trusting therapeutic relationship with staff and his food and fluid intake were to be monitored. The wing nurse recommended that he should see a psychiatrist again to reassess and monitor his mental state. Staff were to encourage him to become more active, as he was spending a lot of time sleeping in his cell. The investigation found no evidence that staff followed the care plan.

55. On 14 May, the young man's F2052SH was reviewed and Level 1 observations were to continue. The prison doctor recorded that the man was feeling low and fed up. She concluded in her assessment that he seemed immature, had poor coping skills and was reluctant to accept help (Samaritans and buddies). The young man agreed to take medication and

was prescribed amitryptilline to help him sleep. The doctor noted that the man had previously taken anti-depressants which had not helped.

56. On 16 May, the young man's F2052SH was further reviewed and Level 1 observations continued. The young man was later found making another ligature from sheets. He was seen by the duty nurse who advised him to seek occupation as he got bored easily. He said that he had not been making a ligature, it was a washing line. He also said that he had no intentions of self harm, but was fed up and bored as he did not have any visitors. He was upset as he had not had contact from his girlfriend and could not get in touch with his mother. However, it was noted that he had made contact with his mother on 30 April prior to his adjudication, so he had apparently located her telephone number.

57. On 17 May, the young man told the wing nurse that he did not have any thoughts of self harm. She noted that he spent most of the day sleeping and then could not sleep at night. He covered his 'spy hole' and refused to remove the covering until staff entered the cell.

58. On 18 May, the young man was seen by the staff nurse in his cell. He told her he was tired. She spoke to officers about his gym application, which had apparently been made two weeks previously. They said they were chasing it up for him. The young man said he had no thoughts of self harm. On 19 May, he was seen by the wing nurse. He said he was 'low' as his pregnant girlfriend had not been in touch, and he had not heard from her since early May. However, prison records indicate that he had a visit from his girlfriend on 18 May. On 20 May, the young man appeared at the Magistrates' Court via video link. He was again remanded in custody until 3 June, to appear again via video link for sentencing. During 20 May, he barricaded himself in his cell and threatened to kill himself. Staff found ligatures in his cell and he was moved to the Segregation Unit and placed in a reduced risk cell. He was spoken to by a member of healthcare about the importance of taking his medicine.

59. On 21 May, the young man attended an adjudication hearing about barricading himself in his cell the previous day. The Adjudication Record shows that he pleaded guilty and the charge was proven. The punishment was removal from the wing for seven days. Although the punishment was suspended for two months, the young man was already in the Segregation Unit. He was seen by the wing nurse. He again told her that he was fed up, as he had not heard from his girlfriend. He had not been taking his medication. He persuaded the wing nurse to move him out of the reduced risk cell, but he was to remain on Level 1 observation. During the previous night, staff had noted that he had exhibited bizarre behaviour, screaming and barking like a dog, which he denied. The wing nurse recommended that he should be seen by a psychiatrist on 27 May and should be encouraged to take his medication. He agreed to see the psychiatrist. During the night he made another noose and was moved back to a reduced risk cell.

60. On 22 May, the wing nurse saw the young man again. The young man was still refusing to take his medication and now told her that he did not want to see a psychiatrist again. He was agitated and angry towards staff. On 23 May, the man had an F2052SH review. It was decided to maintain Level 1 observations. He was taken to healthcare and saw the staff nurse and a Community Psychiatric Nurse (CPN). He told them that he was still waiting for a response to his gym application and wanted to be on normal location in a shared cell. He was then located in a reduced risk cell which he flooded.

61. On 24 May, the young man was seen in healthcare by several members of the healthcare team, including the CPN. He said that he did not have any thoughts of self harm. He was returned to normal location.

62. On 26 May, he appeared more calm and relaxed and agreed with the wing nurse that he would see a psychiatrist. An appointment was made for him on 27 May, but this did not go ahead although the reason why is unclear. Another appointment was made and he saw the psychiatrist on 31 May. The young man said he had no thoughts of deliberate self harm, and was encouraged by staff to spend more time out of his cell.

63. On 30 May, the staff nurse visited the young man during association and spoke to him about taking his medication. He told her that he felt bored in his cell alone. A note was made that officers should pursue his gym application, which had been made for the third time the previous week. The staff nurse in fact pursued the gym application and encouraged him to occupy himself. He told her that he was worried about his girlfriend and had not had any contact with his mother. Wing staff advised him to call his mother and sisters and to re-apply for a shared cell which they would follow up. There is a note in the F2052SH that observations were reduced from Level 1 to Level 3. However, the young man was in a cell on his own and Level 3 observations are for those occupying shared cells. The staff nurse recommended that a cell sharing risk assessment should be completed to decide whether the young man could share with his cousin who had recently been located in Reading. There is no evidence that this ever happened.

64. On 31 May, the psychiatrist undertook a psychiatric review. She concluded that the young man needed more activities and was still a suicide risk. Observations were again increased to Level 1. The young man said he wanted to share with his previous cellmate, but this was not considered appropriate. The psychiatrist prescribed medication for him and was to review him in two weeks, but that did not happen. The doctor noted that the young man needed a Care Programme Approach meeting (CPA). A CPA meeting is usually arranged for those who have a severe and enduring mental illness. It is used in prisons to bring services together for those vulnerable prisoners who may suddenly be released. The young man did not have a severe and enduring mental illness, but it appears that the psychiatrist considered that a CPA meeting would be useful. The man

finally went on his gym induction on 31 May, eight weeks after being located in Reading.

65. On 1 June, the young man seemed brighter, according to the wing nurse, and said that he had no ideas of suicide or self harm. He was concerned about his court appearance the next day. He also had a visit from his girlfriend which apparently went well.

66. On 2 June, the young man appeared at the Crown Court, and was remanded back to Reading. On 3 June, he appeared at the Magistrates' Court via video link. He was remanded in custody until 17 June.

67. Between 2 June and 5 June, the young man continued to refuse to take his medication and spent most of his time in his cell, refusing to go to association. It is unclear what action staff took in relation to this. On 4 June, he asked to speak to the Samaritans but later changed his mind.

68. On 6 June, the CPN contacted the local Community Mental Health Team (CMHT) and an officer from SMART, part of the CMHT, to invite them to a CPA meeting on 1 July. The young man had an F2052SH review, and the conclusion was that the form should remain open. There is a note in his medical record that his gym application was still outstanding and he was bored. However, records show that the man had his gym induction on 31 May and his F2052SH notes that he refused to go to the gym on 6 June. The man's F2052SH remained open.

69. On 7 June, the young man was seen by the CPN. He was said to be low in mood, but not suicidal. He complained that he did not get enough money to pay for tobacco to last him a week and asked for money to buy more tobacco. That request was refused. He also said he wanted to go into a shared cell with somebody he could get on with and that he hated being in Reading. The CPN noted that the care plan for him was that he should stay in a single cell, that the CPA date of 1 July should be changed as it clashed with a court appearance, and finally that outreach should monitor him.

70. On 8 June, the young man attended the gym. Between 8 June and 12 June**,** he was seen by various healthcare staff. He said he was not suicidal, but he still refused to take his medication and would not talk about it. He was still on an F2052SH which he wanted closed. He said he wanted a job, enhanced status and to share a cell. He refused to go to the gym on 11 June.

71. On 13 June, the prison doctor saw the young man and he complained of a chalazion (meibomian cyst), a swelling in the eyelid which is usually easily treated without the need for any surgery. The doctor referred him to the optician. However, he never saw the optician. The young man also spoke to the staff nurse and told her he wanted to apply for an art and design course which she said she would support. He told her that he did not have any thoughts of suicide and still wanted to share a cell.

72. The F2052SH was closed following a review by an officer, an SO, a PO and the duty nurse. The review team concluded that, 'The man is once again using his support mechanism to get attention, he states he has no thoughts of self harm and what he says to staff is taken the wrong way. He wants to stay at Reading when he gets sentenced and we asked him that he needs to start investing time in improving his employment prospects.' The PO, the SO and the officer told my investigation team that they were content to close the F2052SH at that stage. They explained that the young man told them during the review that he was definitely not feeling suicidal and said that he was using the system as a way to stay at Reading, as he did not want to be transferred to another prison.

73. The SO, the PO and the officer said that they had spoken to the young man before the review and tried to encourage him to engage in more purposeful activity within the prison. They reinforced this and further encouraged him to occupy himself constructively. The SO said that he spoke to the education department during the review and arranged for the young man to undertake an assessment with them. My investigation team was unable to speak to the wing nurse as she no longer works at Reading.

74. Also on 13 June, the young man saw his solicitor. She told the investigation team that she saw him while he was in custody at the Police Station and later at the Magistrates' Court before he arrived at Reading. She said he was struggling with withdrawing from drugs and that she was concerned for his wellbeing, as he expressed thoughts of committing suicide. She thought that those taking care of him were aware. She saw him twice at Reading. The young man cancelled a third meeting. She felt that he had psychiatric problems and would have trouble completing a prison sentence. When the solicitor saw him for the last time on 13 June, he made eye contact with her and she felt he had 'turned a corner'. She said that he seemed much better. He did not mention any issues with how he was being treated in Reading. She explained that the man pleaded guilty to the charges and did not lodge an appeal.

75. On 15 June, the young man saw the staff nurse again and told her he was fine. Wing staff noted that he had been asking to share a cell. This was not considered appropriate as the psychiatrist had recommended a single cell as the young man had assaulted a cellmate. However, there is a note that healthcare should ask the doctor if that could be reassessed. There is no evidence that this happened.

76. The young man had been advised, on 20 April, during the induction process that he should attend education and foundation classes were recommended as his basic skills score was low. At that time the foundation classes were full, so he was put on a waiting list to attend. He was allocated a place starting on 20 June. He attended his first class on the afternoon of 20 June. He attended further classes on 21 June, 23 June, 24 June, 28, 29 and 30 June. He had a visit on 22 June so could

not attend, there was no class on 27 June and he refused to attend on 1 July.

77. On 21 June, after a meeting with the young man, his Probation Officer suggested that he should be put back on an F2052SH. As a result, on 22 June, the SO and a governor noted that the man should be reassessed by healthcare. There is no evidence that this happened.

78. On 24 June, the young man appeared at the Magistrates' Court. The man's previous YOT worker told the investigation team that he visited the young man in custody at the court, following a telephone call from the Probation Court team about the outstanding breach of supervision orders. He said there was no statutory obligation on him to visit the young man at that time, as he was no longer the responsibility of the Youth Offending Team. He said he visited the young man as he had not heard from him since November 2004 and he thought he might have been able to offer him support. He described him as being 'low' at that time, but said that the man seemed pleased to see him. He said he was honest when talking to the man about what was going to happen and about the possibility of a long sentence. The YOT supervisor explained that he told custody staff the young man had mental health problems and a history of self harm and depression and that he thought that he was likely to self harm. He could not recall whether custody staff made a written note of his concerns. The relevant Prisoner Escort Record notes that the young man had a visit from the YOT supervisor at 12.53pm, but does not note the concerns which the supervisor said he expressed for the man. When the young man returned to Reading, he had a further reception health check which noted no change in his condition and recorded that the man stated he was fit and well. It is not clear who undertook that health check.

79. On 27 June, the young man saw the prison doctor as he was complaining of a headache. He asked the doctor if he could share a cell. The doctor recommended that the Outreach team liaise with landing staff about this. There is no evidence that a shared cell was ever considered at this stage. The young man denied any thoughts of deliberate self harm or depression, and was spending more time out of his cell at work.

80. On 1 July, a CPA meeting went ahead, with the young man, the CPN and the officer from SMART. There are no records of this meeting. The CPN told the clinical review team that the young man was angry and frustrated after it. She said that during the meeting the man had been angry, but objective to a point about his future. The young man had not been able to engage with the CPA for more than a short time. She said he walked out of the meeting after 15-20 minutes and was accompanied back to the wing. She recollected she had been concerned that the young man had been angry and asked the returning officer to keep an eye on him. She also recalled she had been unable to complete the CPA forms as she had been called away for an emergency after the meeting. There is no note in the young man's medical record or his core record (landing record) that

the meeting ever took place. The young man's medical record says that he had no problems that day.

EVENTS ON 3 JULY 2005

81. On 3 July, the duty officer checked the F2052SH forms on A1 landing, where the young man was located in a cell on his own. As he came to the young man's cell at approximately 8.05am, the officer noticed that the observation hatch of the young man's cell was covered with paper. He spoke to the SO on duty about the situation and they both went back to the young man's cell. The SO called through the door to the man and knocked on the door several times, but there was no reply. The SO shouted for assistance from landing officer 1 and landing officer 2. As the SO opened the door she saw the young man hanging by a ligature, made from torn bedding and attached in a figure of eight format around the light fitting. She entered the cell and felt the young man's face which was cold. The SO and landing officer 1 lifted the young man's legs. Landing officer 2 and landing officer 3 removed the ligature. Landing officer 3 had followed the other two landing officers to the cell. The third wing officer also arrived around the same time. The young man was placed on the top bunk and the SO and the third wing officer checked for a pulse but were unable to find one.

82. At around 8.15am, the wing nurse arrived from healthcare and found the young man's skin was cold to touch and there were no signs of life. The nurse brought resuscitation equipment with her to the cell, but no attempt was made at resuscitation as, in her opinion, rigor mortis appeared to be well established.

83. The SO had radioed the control room for an ambulance at 8.13am and the paramedics arrived shortly after at 8.20am and confirmed the young man's death. The local Police were contacted at 8.40am to notify the young man's next of kin. At 8.40am, the Deputy Governor held a 'hot' debrief for all the staff directly involved and obtained initial statements from them. The Chaplain provided support to staff involved and the local care team were notified and attended later in the morning.

84. The Deputy Governor issued a notice to staff and all prisoners, which gave details of what had happened. The IMB and the Samaritans were notified and two Samaritans attended during the morning and afternoon to provide support to staff and prisoners. All prisoners on open F2052SH forms had case reviews.

85. Police attended with scenes of crime officers. The young man's death was pronounced by a Police Surgeon at 11.45am and the body was taken to the hospital mortuary at around 12.30pm. By this time the Deputy Governor had made initial contact by telephone with the young man's next of kin, his mother, following the Police notifying her of the young man's death.

86. The Deputy Governor told the investigation team that initial contact was made by the Police, and not the prison, primarily because he was duty governor on the morning of 3 July and, as it was the weekend, there was a minimum number of staff on duty. The Deputy Governor had to manage the aftermath of the young man's death and did not feel that there was anybody else on duty with the appropriate specialist skills to break the sad news to the young man's family.

87. The young man's mother agreed to visit Reading later in the day. She arrived at Reading at around 5pm, with the young man's father, and met with the Governor, the Deputy Governor and the Chaplain. Initial questions from the family were answered and the investigation procedure was explained. The mother did not want any member of the Prison Service to attend the young man's funeral.

88. Reading has paid the cost of the funeral. They have also agreed, in principle, to pay the stonemason's bill for the headstone but the bill has not been sent to them yet. A proposal has been sent to the Prison Service's Director of Operations to approve a generous payment towards the headstone.

CLINICAL REVIEW

89. The investigation team advised Reading Primary Care Trust (PCT) of the young man's death on 5 July 2005. The PCT then arranged to undertake a clinical review of the healthcare provided to the man while at Reading, in accordance with the agreement between the Department of Health and the Prisons and Probation Ombudsman. A multi-disciplinary panel was convened to undertake the review. This consisted of the lead reviewer (Director of Nursing and Clinical Services Bracknell Forest PCT), a GP and Professional Executive Member, Reading PCT), a RMN (Locality Manager Community Mental Health Team, Reading PCT) and the Head of Adult Services, Reading PCT.

90. The clinical review has highlighted a number of issues relating to healthcare within Reading and, as in the investigation of the previous death in Reading, has made a number of far reaching recommendations which will need to be considered jointly by Reading PCT, Reading's Healthcare Manager and the Governor. The recommendations cover many of the same issues identified in the earlier investigation.

91. The investigation has also been provided with an update of the clinical review, dated October 2005, which clearly demonstrates the commitment of the Primary Care Trust and the prison to learn from the findings of the clinical review to try and prevent any future deaths in custody.

CONCERNS RAISED BY THE MAN'S FAMILY

92. The young man's mother raised concern about her son's treatment from the time of his arrest and location in police custody until his death at Reading. She asked particularly what steps were taken to deal with her son's apparent mental health problems and his threats to self harm during his time in custody.

93. The mother also raised specific questions about who visited her son, whether he had any personal letters in his cell and who telephoned the man while he was in Reading. Prison records show that since his reception on 16 April, the only person the young man had personal visits from was his girlfriend, on 18 May, 1 June, 21 June and 22 June. He had legal visits on 25 April (a WPC and PC), 10 June (WPC and PC), 13 June (Solicitor) and 21 June (Probation Officer).

94. No personal letters were found in the young man's cell, the only incoming letters were from his legal advisor, and were left with the man's property. Only one outgoing letter was found in his cell, addressed to his girlfriend. The Police have the original letter.

95. There is a pin phone print out of all the calls the young man made, but it is a series of telephone numbers which are not allocated to a particular named person and would be difficult to decipher.

CONSIDERATION AND CONCLUSIONS

96. The young man was a complex character and he clearly had a troubled time before and during his remand at Reading. He was known to the Youth Offending Team and had served a previous term of prison custody. During his custody at the police station between 14 April and 16 April 2005 there were concerns for his wellbeing and he was placed on a constant watch. He also exhibited erratic behaviour when in custody at the Magistrates' Court on 16 April, where a suicide and self harm awareness form was opened and he was on constant watch. This information was available when he arrived at Reading where a further suicide and self harm awareness form (F2052SH) was opened immediately after he arrived. Although this was closed on 11 May, there were still concerns about his wellbeing, so another F2052SH was opened between 13 May and 13 June. The young man's behaviour continued to give cause for concern as he made nooses or ligatures on at least five occasions, exhibited bizarre behaviour and covered his observation hole on occasions.

97. The young man was moved several times while he was at Reading and there was an ongoing issue about whether to locate him in a single or shared cell. Decisions were based upon the need to balance the risk of the young man harming himself, with the risk he posed to others. On 30 April, the young man asked to share a cell and on the same day he was placed in a cell with another prisoner. However, by 3 May, the young man had changed his mind, wanting to be in a single cell, although the psychiatrist decided the risk of self-harm or suicide was too great for this to be allowed. On 7 May, the young man assaulted his cellmate and he was moved to a reduced risk cell in the Segregation Unit, where his behaviour remained unpredictable and erratic. Nevertheless, four days later, on 11 May, the F2052SH review stated that a compatible cellmate would be helpful for him. The investigators found no evidence to indicate that this was followed up.

98. On 30 May, the staff nurse recommended that a cell-sharing risk assessment should be carried out to decide whether the young man should be allowed to share with his cousin who had recently been located in Reading. Once again there is no evidence that this happened. On 7, 8, and 13 June the man asked to share a cell but this did not happen. There is also a note in his record that healthcare should ask the psychiatrist if his decision could be reassessed. Again, there is no evidence that this occurred. On 27 June, when the young man saw the prison doctor about a headache he again asked if he could share a cell. The doctor recommended that the Outreach team should liaise with landing staff about this. There is no evidence that any such liaison happened, although it was noted that the young man denied any thoughts of deliberate self harm or depression, and was spending more time out of his cell engaged in purposeful activity.

99. As a consequence of his behaviour and concerns about the risk to others, the majority of his time at Reading was spent in a single cell and he spent some time in a reduced risk cell following self harm threats. It seems clear that recommendations made on at least four occasions that the cell sharing risk assessment should be re-assessed were not acted upon.

100. **I recommend that auditable systems and procedures are put in place for the care of more vulnerable prisoners. This should include documented liaison between healthcare staff and discipline staff to ensure that the prisoner is placed in the most appropriate location and any action in this respect is carried through in a timely manner and that staff caring for the prisoner are aware of circumstances that may escalate thoughts of self harm or suicide.**

101. The young man had F2052SH forms opened on two occasions. There did not appear to be a clear system of risk assessment for opening or closing these forms and information was not shared between disciplines. In particular, the role of healthcare in the process did not appear to be clear. The young man saw the psychiatrist on 3 May and she considered that he was a risk of self harm. However, on 30 May the F2052SH level was reduced to Level 3, despite the fact that he was due to see the psychiatrist on 31 May. When the psychiatrist did see him, she considered that the risk remained high and requested that the level be raised to level 1.

102. The F2052SH remained open and, on 6 June, the young man's behaviour was said to be unpredictable and he was still considered to be at risk of self harm. However, a week later, with no further medical assessment, it was noted that the young man was considered to be 'manipulating' the system and the F2052SH was closed. I consider that there was a lack of clarity over the roles of healthcare and discipline staff in the process of opening and closing self harm risk forms and that the actual risks were not fully considered.

103. I am pleased to record that the Prison Service has implemented a new system of assessment, Assessment Care in Custody Teamwork (ACCT) that is being rolled out to all prisons. At Reading, ACCT training is well underway with an expected implementation date of 19 June 2006. All residential and resettlement staff will be trained in the use of the new system which is designed to assess and manage risk more effectively with a greater input from the prisoner and other members of the multi-disciplinary team.

104. During his secondary healthscreen at Reading, the young man told the prison doctor that he had been on medication from his GP for depression but had not taken that medication for a year. The young man's GP records were not obtained or efforts made to follow up the information given to healthcare staff.

105. **I recommend that Reading PCT, in partnership with the Governor, should be asked to develop a policy for ensuring a prisoner's past**

medical history is obtained in a timely manner.

106. The young man refused to take his medication during his time in Reading, but this was not relayed by senior nursing staff to other medical staff and alternatives do not appear to have been offered to him. There is evidence that on a number of occasions follow up action for his care was delayed, or not undertaken at all. The referral to the Community Mental Health Team was not undertaken until 6 June and the recommendation that he should attend relaxation or acupuncture was not followed up. The young man saw the psychiatrist on 31 May. He was due to see her again two weeks after that date, but this did not happen.

107. The young man's probation officer expressed concerns about him to staff on 22 June and told them that she felt that he should be put back on an F2052SH. There is a note that discipline staff made healthcare aware of these concerns, but no action appears to have been taken as a result. I am also concerned that the CPA meeting held on 1 July was not documented and, more importantly, the result of that meeting was not communicated to healthcare or discipline staff.

108. **I recommend that the Governor and Healthcare Manager issue guidelines for healthcare and specialist staff to communicate important information about prisoners to each other and that follow-up action, including referrals to specialist services, is taken as soon as possible.**

109. Nevertheless, it is clear that both healthcare and discipline staff thought that the young man could benefit from increased daytime activity. He was referred to Education after his F2052SH was closed on 13 June and he attended an assessment on 20 June. There are indications in the records that staff encouraged him to come out of his cell and engage in useful activity. Although there was a delay in processing his gym application, he only attended once after he completed the gym induction and there is evidence that he refused to go on other occasions. The gym issue aside, the evidence is that staff had concern for his welfare and did all they could to ensure that he engaged in purposeful activity. Unfortunately, he was either unwilling or unable to benefit from these efforts.

110. The YOT supervisor visited him at the Magistrates' Court on 24 June and during that visit was concerned about his wellbeing. He said that he told custody staff that the young man had mental health problems, and a history of self harm and depression, and that he thought that the young man was likely to self harm. He could not recall whether custody staff made a written note of his concerns. The relevant Prisoner Escort Record does not note the concerns which the YOT supervisor said he expressed for the young man. When the man returned to Reading, he had a further reception health check which noted that he was fit and well.

111. The local police delivered the news of the young man's death to his mother. The Deputy Governor then telephoned the mother and arranged

for her to visit the prison. 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.

112. 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. In view of this, I consider that the decision taken was a reasonable one.

113. The clinical review makes a number of recommendations which I endorse. As noted in the investigation for the other self inflicted death at Reading on 26 June, I am aware that Reading PCT has developed one action plan in light of the recommendations from both clinical reviews.

RECOMMENDATIONS:

OPERATIONAL

1 I recommend that auditable systems and procedures are put in place for the care of more vulnerable prisoners. This should include documented liaison between healthcare staff and discipline staff to ensure that the prisoner is placed in the most appropriate location and any action in this respect is carried through in a timely manner and that staff caring for the prisoner are aware of circumstances that may escalate thoughts of self harm or suicide.

2 I recommend that the Governor and Healthcare Manager issue guidelines for healthcare and specialist staff to communicate important information about prisoners to each other and that follow-up action, including referrals to specialist services, is taken as soon as possible.

HEALTHCARE

3 I recommend that Reading PCT, in partnership with the Governor, should be asked to develop a policy for ensuring a prisoner's past medical history is obtained in a timely manner.

OBSERVATION OF GOOD PRACTICE:

4 The records kept by the wing nurse were comprehensive and demonstrated her knowledge of the man and her concern for him as demonstrated particularly by her care plan of 13 May.

5 The referral made by the CPN to the local CMHT was comprehensive.

There are no comments on the draft report from the man's family.

The Prison Service has accepted most of the recommendations, including those of the clinical review. However they do not accept the recommendation that 'a formal risk assessment and score should be produced for the opening, review and closure of the F2052SH. Care plans should be laid out and the review of elements of these recorded at each review.' They explain that staff complete a recorded Case Review in accordance with National Guidelines and procedures, which includes a Care Plan. No scoring is included in this process as it is not part of the 2052SH procedure. ACCT does have risk indicators, but again is not scored.

The Prison Service partially accepts the recommendation that, 'Key events that affect an inmate's behaviour or attitude should be communicated as a matter of urgency. This should be written as well as oral form.' They explain that internal factors relating to a prisoner's behaviour will be recorded in the wing file, observation book and 2052SH/ACCT, if applicable. External matters will be actioned, providing the prison is notified of these.