Investigation into the circumstances surrounding the death of a man at HMYOI Reading in 7 September 2005

Report by the Prisons and Probation Ombudsman for England and Wales

March 2007

This is the report into the investigation of the death of a man in September 2005 at HM Young Offender Institution Reading. He was found hanging in his cell, and had left a note indicating that he had committed suicide.

I would like to offer this public expression of sympathy and condolences to the man's relatives and friends on their loss. 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. The man was adopted as a child and had renewed contact with his biological father during the year before his death. He had nominated a friend as his next of kin. One of my Family Liaison Officers contacted the man's adoptive parents, his biological father and the friend during the investigation. I know they have all waited patiently for this report and very much regret the delay in its completion. I hope it begins to offer answers to their many questions.

The investigation was led by my investigators who were assisted by a colleague. A clinical review was conducted by a lady from Reading Primary Care Trust. I am very grateful for their comprehensive and detailed work. The man had contact with staff from a number of other agencies. All were contacted as part of the investigation and I am indebted to them for their assistance. I thank the staff at HMYOI Reading and particularly the governing Governor who acted as the establishment's liaison officer with my office.

The man was a troubled 19 year old who, two days before he was found hanging, had been sentenced to five years imprisonment. He had said that he might self-harm when sentenced and this increased risk was known to some members of Reading's staff. However, after his return from court, he was not placed on any self-harm monitoring procedures.

My report contains a large number of recommendations, reflecting the seriousness of the matters raised by this investigation.

Stephen Shaw CBE
Prisons and Probation Ombudsman **October 2006**

CONTENTS **PAGE**

Summary
The Investigation Process

Background Information
HMYOI Reading

Key Events
Previous period in custody
From the man's arrest
The man's transfer to Reading
4 September
5 September
6 September
Finding the man

Issues

Recommendations

Recommendations from the Clinical Review

SUMMARY

The man was initially remanded to HMP Highdown in January 2005. Following sentence for an unrelated matter, he was transferred to HMYOI Feltham where he remained until being moved to HMYOI Reading on 18 July. There had been a number of concerns regarding the man's conduct towards other prisoners following an incident on a previous period on remand. Consequently, he was always located in a single cell and showered alone.

On 3 August 2005, the man was placed on self-harm monitoring at Reading after he had indicated that he might harm himself. He was seen by a psychiatrist for the purpose of preparing a report for sentencing on 9 August. During this interview the man said that he would consider suicide if he received a prison sentence. A psychiatrist assessed the man as not suicidal at that time, but informed healthcare staff of his increased risk following sentence. The man's self-harm monitoring was closed on 13 August.

On 5 September 2005 the man appeared at Kingston Crown Court for sentencing and received a total of five years. Having learned of the man's vulnerability to self-harm in the psychiatric report and pre-sentence report, both his barrister and the court probation officer expressed their concern to the custody staff. However, staff did not consider him to be at risk and did not complete an 'At risk of self-harm' form which would have travelled with the man and alerted staff at Reading to any risk.

Upon his return to Reading, he was seen by a nurse who knew him and was aware of his increased vulnerability following sentence. However, as she did not assess the man to be at any immediate risk she did not open a self-harm monitoring form. The man was located back to his cell.

The man spent most of the following day in his cell as the prison was in 'patrol state' as officers were attending a training course. He briefly saw a nurse who knew him, and they spoke about his recent sentence. The man's demeanour gave her no cause for concern. He also chatted with a number of fellow prisoners about his sentence but did not express any worries.

The man did not collect his medication for insomnia that evening. Cell bell records indicated that he rang his bell on three occasions between 7.49pm and 8.55pm. None of the officers on duty can recall answering the man's bell. A number of prisoners in the vicinity described hearing some shouting either by the man or to him, but their reports were not consistent.

On 7 September, during the roll count at 6.00am the man was found hanging. The alarm was raised and staff attended immediately. Resuscitation was not attempted as it was clear that the man had been dead for some time. He was declared dead at 6.23am. He left a note.

In addition to a long list of recommendations made by the clinical reviewers, I have made a further ten recommendations of my own.

THE INVESTIGATION PROCESS

1. The lead investigator conducted a preliminary visit to HMYOI Reading on 10 September 2005 and returned on a number of occasions to interview staff. During the course of initial enquiries, the investigation team was shown around the prison and visited the cell where the man died. They reviewed all the relevant documentation and established a chronology of events.

2. Notices were issued to staff and prisoners telling them of the investigation and offering them the opportunity to speak with my colleagues. No-one came forward as a result. My investigators met with representatives of the local branch of the Prison Officers' Association (POA) and members of the Independent Monitoring Board (IMB).

3. Fifteen members of staff, both discipline and healthcare, were interviewed at Reading. Two officers involved in the events went off on long-term sick following the death and were eventually interviewed in February 2006 following their return to duties. The nurse who saw the man on his return from the court left the Prison Service, for unrelated reasons, soon after his death, but kindly agreed to be seen and interviewed at the prison.

4. Given that the man died within 48 hours of being sentenced, my colleagues widened the scope of the investigation and contacted all staff with whom he came into contact during this time. This included escort staff, the senior probation officer at court, the man's barrister and Serco staff who managed the cells at Kingston Crown Court. Scheduled interviews with Serco staff were terminated at the request of their area manager so that legal advice could be taken. It is my understanding that Serco conducted their own investigation and subsequently provided my investigator with statements from staff. These are annexed.

5. The probation officer, who prepared the man's pre-sentence report was interviewed. The author of the psychiatric report, spoke with my investigator on the telephone. A copy of my report will be made available to the National Probation Service.

6. The man's biological father and nominated next of kin were met in person by the lead investigator and one of my Family Liaison Officers (FLOs). The man's adoptive parents were contacted by both two of my (FLOs).

7. The clinical reviewer led a team which undertook a clinical review of the healthcare provided for the man whilst at HMYOI Reading. The review is annexed.

8. A draft version of this report was sent to the Prison Service. An action plan was provided in response. The Prison Service indicated whether they accepted the recommendations or not. The responses can be found under the recommendations section of this report and have been reproduced verbatim.

9. Neither the biological father nor the nominated next of kin commented on the draft. However the adoptive parents raised several matters, the majority of which were dealt with by way of a letter. Paragraph 71 has been added to the draft report in response to a query made by them.

HMYOI READING

10. Reading is a remand centre and young offender institution, holding young adults aged between 18 and 21 years. The certified normal accommodation, without overcrowding, is 196. The prison has an operational (maximum) 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.

11. Her Majesty's Chief Inspector of Prisons conducted an inspection of Reading in 2004. Ms Owers concluded that Reading was an "improving establishment". However, she identified a number of areas where there was still much to do. These included "delivery of much more equitable provision of time out of cell and improved and expanded purposeful activity to occupy this time". This concern was echoed by members of the Independent Monitoring Board who spoke to my investigators.

12. There were two apparently self-inflicted deaths at Reading in June and July 2005 which have been investigated by my office. These have yet to proceed to inquest.

KEY EVENTS

Previous period in custody

13. The man was remanded into custody for the first time on 26 August 2004 when he was received at HMYOI Feltham. His Cell Sharing Risk Assessment (CSRA) form indicated that it was his first time in custody and stated 'history of fighting (states he has a problem with being on his own), single cell'. He completed an Initial Custodial Reception Assessment and said that he did not have a history of self-harm. He was not assessed to be at risk.

14. On 30 August, a security report was raised as a result of an allegation that the man had made an advance towards another boy in the showers. Subsequently he was moved to another wing. Following the incident an instruction appeared in his history record that he was to be showered alone. There were a number of further security reports that he had been confrontational with other prisoners.

15. Given the nature of the man's alleged offence (involving an underage female), he immediately became subject to Public Protection Procedures. As a result, monitoring procedures were put into place regarding contact with anyone under the age of 18 years old. On 1 September 2004 the man signed a notification regarding contact with those under 18. He was informed that these were in place due to his impending prosecutions.

16. The man was also told that all incoming and outgoing mail would be vetted and that he would not be allowed any correspondence with under 18 year olds, or visits, unless parental consent was obtained. His telephone calls would be recorded and vetted. He was informed that if he wanted contact with anyone under 18 he needed to apply.

17. An Assessment, Care in Custody and Teamwork (ACCT) document (monitoring those at risk from self-harm/suicide) was opened on September 14 as he told staff that he had previously tried to hang himself outside of prison, and felt he could self-harm at any time. Following indications that he was going to harm himself the man was admitted to healthcare on 17 September. He did not attempt to harm himself and on 22 September was discharged back onto the wing. The man remained on an ACCT until 21 October when he was released on conditional bail.

18. The man received a two year conditional discharge for his offence on 4 November 2004. Incorrectly, he was placed on the sex offender register for two years (the register is not applicable to those who receive a conditional discharge). The man also became subject to monitoring through Multi Agency Public Protection Arrangements (MAPPA) as a result of being placed on the register. On 19 December 2004 he was arrested for an offence of having an imitation firearm. He was bailed until 11 January 2005.

The man's arrest

19. On 10 January 2005 the man was remanded into custody at HMP Highdown for a further sexual offence involving an underage female. His CSRA stated, "… was on 2052SH at Feltham. Has attempted to hang himself since the incident and injury to left wrist." The man's wing history sheet indicated that during his time at Highdown the nature of his offence was discovered, and he subsequently moved to the segregation unit for his own safety. Following concerns about his ability to cope on the segregation unit he was seen by the mental health in-reach team who concluded, "this gentleman does not have a mental health illness in the true sense but does have personality issues." However, he was admitted to the healthcare unit and referred to the consultant psychiatrist. Prior to being assessed the man moved to Feltham.

20. The man received a four month Detention and Training Order for the offence of having an imitation firearm and was transferred to Feltham on 20 January 2005 as a sentenced prisoner. His CSRA stated that he should be in a single cell only. A F2058 (Security file) was raised the following day which stated that he was not to be placed in a multi-occupancy cell and that he must be kept away from some named prisoners. An ACCT was opened because of his history of self-harm. My investigators were unable to establish when this ACCT document was closed. On 23 January, an entry stated that "he will only shower on his own due to outstanding charges." The man again signed documentation in relation to public protection procedures on 24 January.

21. On 8 February the man was transferred from Feltham and taken to Scotland for an outstanding case. He remained in HMYOI Castington (in Northumberland) until 4 April before returning to Feltham. An ACCT was opened on 3 May after he received a newspaper cutting concerning his sister's suicide three years earlier. The ACCT was closed on 11 May, during which time there had been no incidents of self-harm.

22. The man attended hospital to have a plate and screws removed from an old injury to his right arm on 3 June. On 9 June, he gained enhanced level of the Incentives and Earned Privileges (IEP) scheme at Feltham. A few days later, following a number of behaviour warnings, he was downgraded to 'standard' level. His trial took place in June and, having been found guilty, a pre-sentence report and a psychiatric report were requested for sentencing.

23. On 4 July the man was placed in the segregation unit as there were concerns about his behaviour towards other prisoners and for his own safety. Feltham held an emergency MAPPA meeting to discuss how to accommodate him and he was included in some of these discussions. He was moved back to ordinary location the following day. However, four days later the man was again segregated at his own request and he also requested a transfer to another establishment. HMYOI Reading agreed to take him on the understanding that he could be located and managed on normal location.

The man's transfer to Reading

24. The man was transferred to Reading on 18 July 2005. His CSRA stated that he was "received from Feltham, security issues, to be single cell." A First Reception Health Screen was completed and the man said that he had previously tried to hang himself but he did not have any thoughts of harming himself at that time. His family bereavements were recorded. He was deemed fit for ordinary location and no further action was planned by medical staff. Reading inherited two F2052A documents (a prisoner's history record) and also opened a new one, the front page of which stated, "to be showered on his own, phone calls monitor, ring security, single cell." It indicated that the man was located to cell C2-20.

25. On 19 July, Reading's Reception and Induction Records were completed and the man said he was of no fixed abode. He was asked for details of his next of kin and he gave the name address and telephone number of a friend. As part of the induction process he was seen by the chaplain who recorded, "spoke at length about family bereavement issues – says he will be able to cope."

26. The man's history sheet indicated that he was moved to cell C2-21 on 2 August. The next day an officer wrote in the wing observation book, "Asked to see Buddy today, after seeing Buddy I spoke to the man who explained pattern of suicide through out family members and has attempted in Reading and may attempt in the future." The officer opened a F2052SH booklet (self-harm/suicide monitoring procedures, superseded in some prisons by the ACCT document). A nurse was called to the wing by the officer to complete a healthcare assessment. She took a family history from the man and recorded him saying he "shouldn't be alive because other members of his family were dead." The nurse recommended that he be located on normal location, in a single cell and on a level 1 watch. (There are four levels of monitoring for those on a 2052SH booklet. However, for those in single cells, only level 1 and 2 are applicable. They are required to be on an intermittent watch at all times.) It was the policy at Reading for any prisoner on a F2052SH to be seen daily by a member of healthcare staff, preferably a mental health nurse.

27. The following morning, 4 August, the man was assessed by a General practitioner at 10.20am. The GP described him "clearly impulsive and labile. Will need close watching." He recommended a level 1 watch and said that the man was requesting a shared cell but was in single accommodation due to the nature of the charge he was facing. Additionally, he recommended that: "the man should have time with buddy, refer for bereavement counselling, and refer for psych opinion (due court report), and needs full risk assessment by in-reach, amenable to available help." The GP noted that the man was a poor sleeper and prescribed 50mg Amtriptyline nocte (at night) to help him sleep.

28. At 2.45pm the man's F2052SH Watch Sheet recorded "requested to see chaplain". There is no record of whether or not this was acted on by staff. At 3.10 pm, a self-harm injury form (F213SH) was completed after he was found

with superficial lacerations to his left wrist caused by cutting with broken glass. The wounds were cleaned and dressed. Following this incident he was moved to the care-suite, cell C1-22, for the night.

29. The next day a nurse saw the man and recommended that he be returned to ordinary location. She observed that he was much more settled. The man returned to cell C2 –21. Later she again recorded in the IMR (Inmate Medical Record) that the man, “feels that a lot of his problems is boredom – feels he is locked up for very long periods at Reading.” The nurse encouraged him to get involved in all aspects of the prison regime.

30. A psychiatric consultant undertook a psychiatric assessment, including a full family and social history, that morning. With reference to his forthcoming sentence the consultant noted that, “the man is uncertain of the sentence” and that “he denies suicidal thoughts at present although feels suicidal when in jail.” The consultant wrote the following entry in the F2052SH: “no evidence mental illness. Long history of self harm but <u>not</u> suicidal intent. In my opinion the 2052SH should be closed.”

31. During the afternoon the man was taken for a video link interview with a probation officer. The interview was for the purpose of preparing a Pre-Sentence Report. The man was not known to the probation officer, but she had had sight of a number of documents relating to him. In interview with my investigator, she described him as being “really unrealistic about what was going to happen [at court].” During the meeting he showed the probation officer cuts to his arms and told her that he was being monitored.

32. On 6 August, a review of the man’s F2052SH was conducted by an agency nurse and by an Acting Principal Officer. They noted that the man was cheerful and that he had no thoughts of self-harm. In response to being asked about the cuts he made the day before he stated that he “was bored and he had no one to talk to …” They spoke with him about ways of applying for activities in the prison. The review concluded that, “although a recent interview with the psychiatrist suggested this 2052 SH can be closed the review team agreed to reduce the level and to be observed/ monitored for a further week. Review 13/8/05.” A corresponding entry in his F2052SH stated, “2052SH review. Reduced to level 3, see review notes.” A further entry in his IMR said, “feeing [illegible] and bored in his cell. Cut his wrists – done it may times before. Does not want to go to education – boring. Would prefer to get a job – like a cleaner. Encouraged to [illegible] offending [illegible] courses but says does not like reading. Reviewed from level 1 to level 3. Review in a week’s time.” Level 3 observations are for those in a shared cell and stipulate that the prisoner must be watched intermittently when alone in the cell. Although the watch sheet had “level 3 – single cell” written at the top of the page the man continued to be monitored intermittently in line with level 1 observations.

33. Later that day he was seen by the same nurse. She described him as very positive over his future and recorded, “he’s been told ‘good things’ by the probation team – he may get out soon??” In interview the nurse explained

that the man told her that he had been led to believe that he was getting out soon. She was very shocked by this as she knew that he was facing serious charges. Furthermore, he said that an outstanding charge in Scotland had been dropped (this was not the case). The nurse did not want to deflate his upbeat mood so did not say anything to the contrary. She explained that he had mentioned that he was very bored in a cell on his own and, because of this, healthcare staff always tried to take him off the wing for their interviews.

34. There is no entry in the man's IMR for 7 August. His F2052SH stated that he was very settled in mood and there were no concerns about him. A duty governor's check of the F2052SH said "all correct". The next day, the duty governor commented, during a routine check of the documentation, that the man must be dealt with as a "level 1 as he is in a single cell." The man spent 25 minutes with another nurse who recorded that he appeared happy in mood.

35. On 9 August, his F2052SH indicated that he was in high spirits. He told staff that being on a F2052SH was helpful as it showed that officers cared, and were concerned about his welfare and well being.

36. During the day the man was seen by a psychiatrist for the purpose of preparing a psychiatric report for sentencing. In the IMR the psychiatrist recorded that the man had told him that he had attempted to kill himself nine times and noted that this was inconsistent with IMR documentation. The psychiatrist concluded that the man did not appear depressed during interview, and had no current thoughts of suicide, but had said that he would think again if he received a prison sentence. The psychiatrist and a nurse spoke about the man after the interview. In interview the nurse confirmed that the psychiatrist had explained that, whilst he did not think the man was a risk at this stage, this could change once he was sentenced.

37. The psychiatrist told my investigator that the man presented as cheerful, polite and jovial and had said that he had plans for the future. He did not view him as an imminent risk at that time. However the man had said that he might harm himself if he got a sentence and the psychiatrist confirmed that he had shared this information with healthcare.

38. An entry in the man's F2052SH that day indicated he told an officer that he did not know why he was in a single cell and that he would much prefer a cell mate. There are no entries in the IMR on 10 August. His F2052SH recorded that he had a legal visit via video link for most of the day. Otherwise, he was described as being in a happy mood.

39. On 11 August the man told medical staff that he had not been given his medication the day before. This is confirmed by the prescription chart although there is no record of any follow-up. The F2052SH indicated that he was in good spirits. The next day, the IMR recorded that there was no change in his condition. However, the F2052SH stated that he was very angry after seeing the nurse but no other details are given. Otherwise he was described as quiet.

40. A nurse who had seen the man a few times previously described him as being well and with no concerns on 13 August. At 4.30 pm his F2052SH was reviewed and closed by a Principal Office, residential unit manager, and a Health Care Officer. Neither staff member had been present at the man's previous review nor written any entries in his F2052SH document. The review indicated that the man felt positive about his situation and that he had no thoughts of self–harm. It was recorded that he was having regular contact with his father and friends and that he felt that he might be released from custody in early September. The wing observation book recorded that the review was closed and that the man was "more relaxed". This is the last entry regarding the man the wing observation book. There is no record of the F2052SH being closed in the man's IMR.

41. In interview the nurse who had seen him a few times previous said she was on duty that day and was shocked when she discovered that she had not been called to the review. It was a Saturday and only two healthcare staff was on duty. The nurse was not aware of why she was not present at the review. She said that, although it was not unusual to close a 2052SH at weekends, it was not routine practice.

42. Entries in the IMR for 14, 15 and 16 August all identified the man as stable. There were no concerns about him self-harming. It may have been the case that healthcare staff continued to see him because it was not recorded that his F2052SH had been closed. On 19 August the nurse wrote that, "the man had seen the bereavement counsellor twice and is able to talk to her freely." In addition, she recorded, "F2052SH closure review also states not suicidal or has any thoughts of at all, has made friends within the prison and is feeling much more 'settled' now, going to exercise and association also." This is the last record in the man's IMR. According to the prescription chart, he did not have his medication that day. Again, there is no record of a follow-up.

43. On 20 August the nurse wrote in the healthcare centre's communication book, "apparently this young man's F2052SH closed by a PO and someone from healthcare – on 13th. I was not on that day yes I was sorry – name [removed] was it you? as me and you on that day, can you make an entry into the IMR F2052SH closed. But can we be aware that of Psychiatrist who visited him in the prison 9/08/05 – wrote 9/08/05 – if he gets a sentence to prison he would think again about killing himself – please can you find out when he is getting sentenced or next at court – as this young lad single cell and long history dsh. Due to be sentenced 5th September??"

44. The man saw a worker from the counselling, assessment, referral, advice and throughcare (CARAT) team for an initial assessment on 26 August. He discussed his drug and alcohol use, and it was the intention to start a structured one to one programme the following month. A written statement from the CARAT worker said that the man gave no indication that he intended to take his own life, and had spoken about making plans for the future.

4 September

45. Another nurse who saw the man previously, saw him at the treatment hatch when he collected his sleeping medication. In interview, she described feeling she had a rapport with him. Although she did not see him in a structured, formal setting, she often chatted with him when he came to collect his medication. Although she signed the prescription chart indicating that he was given his medication at tea time (around 4pm), in interview she said she believed that she had made a mistake and had actually given it to him at night-time. His prescription had been renewed the day before but had been written up for collection at teatime rather than at night, as had been the case previously. The nurse was aware that the man was going to court for sentencing the next day and she spoke to him about it. She described telling him that she would be there the next day if he needed to talk. The nurse told my investigators that she was aware of the psychiatrist's concerns for the man following sentence. Both nurses who had seen the man previously confirmed that they had spoken with each other about his impending court case and its implications in light of what he had said to the psychiatrist.

5 September

46. One of the nurses, who had seen the man previously was working in reception in the morning, could not recall whether she saw him prior to him leaving for court. The man's case was unusual because he was returning to Kingston Crown Court for sentencing. (Kingston is not a court usually served by Reading. The man had been transferred from Feltham which does accommodate prisoners from Kingston Crown Court.) The private company, Reliance, who collected and returned him to Reading, were not Reading's usual escort service.

47. According to his Prisoner Escort Form (PER), he was handed to the escort staff at 06.47am. The PER form, which is completed by prison staff, highlighted the risk categories 'sex offence' and 'suicide/self-harm'. Further details were given as "(2052 closed, MAPPA) rape, at/perv/just, must return to Reading, <u>not</u> to go to Feltham or H'Down." At 08.50am, the escort driver, wrote "15 min watch". My investigator spoke to the escort driver who explained that it was standard procedure to place everyone on a minimum of a 15 minutes watch. The man arrived at court at 9.50am.

48. When the man went into court at 3.00pm, he was sentenced to five years imprisonment. For the purpose of sentencing, the court had sight of the Pre-Sentence Report (PSR) and the psychiatric report. The probation officers PSR concluded that -

> "The man is aware that the Court will be considering a lengthy custodial sentence today and this is an outcome he is anxious about. He unrealistically stated that a 'curfew would do for him' or a fine. The man will present as a risk of suicidal thoughts and actions and should be monitored by the prison staff."

49. The psychiatrist, Specialist Registrar in Forensic Psychiatry, concluded his lengthy Psychiatric Report -

> "The man has given contradictory accounts of his history of self harming and suicide attempts. However, there is evidence of self harming taking the form of cuts to his forearms, he has a number of depressive personality traits and has recently suffered the loss of his sister. He has also made threats of suicide if he were to be given a custodial sentence. Therefore if he is given a custodial sentence he will require close monitoring and a considerable amount of input to manage the increased likelihood of self harm. It is likely that following sentence he may require a period as an inpatient in the healthcare centre and will require appointments with the prison in-reach team. He will need support in dealing with bereavement issues following the loss of his sister in traumatic circumstances."

50. These reports do not appear to have been returned to the prison with the man. The probation officer explained that it was unusual for her not to read the psychiatric report in advance of the court date. My investigator has had sight of an email which highlighted her concerns about this. She had requested that the court probation officer try to seek an adjournment, but it had been thought that this would not be granted by the judge. Instead she and the psychiatrist had spoken on the telephone about the man. However, she did not recall them speaking in detail about the psychiatrists concerns in relation to the man's threat to self-harm.

51. The probation officer explained that she understood that the court duty officer would read the report and pass any information regarding risk to the necessary staff. The senior probation officer in court stated in interview that on the basis of what he had read in the probation officers report he telephoned down to the court cells to relay the concerns about the man to staff. Serco staff have confirmed this was the case.

52. Following the man's death, his barrister wrote to Reading to highlight that she had drawn the attention of court staff to the man's vulnerability to self-harm. My investigator spoke with the barrister and she subsequently produced a statement. She explained that she was familiar with the man having represented him at his trial, but had not been aware of his self-harming and suicide attempts prior to learning of them in the court reports. She described how she had visited him in the cells both before and after sentence. After sentence she approached the cell staff and explained that she was very worried about him as reports had mentioned his potential to self-harm. She asked for the man to be put on suicide watch "for a couple of weeks" as he had just received a substantial sentence.

53. Serco staff provided statements to my investigator via their solicitors. A prisoner custody officer stated that the man's advocate mentioned concerns to him and said "can you tell your supervisor to keep an eye on him?" The custody officer said that he passed this information onto his supervisor who is a Senior Custody Officer. The Senior Custody Officer did not recall being told

this. However, she said that she had taken a phone call from the courts Senior Probation Officer, regarding the man's self-harm history. She remembered looking at the PER and seeing that the F2052SH had been closed which she took "to mean that the prison had therefore assessed him to be no longer at risk." She added, "I decided not to increase his watch from our normal ten minutes to five minutes. I can't remember if I mentioned that conversation to any member of my staff."

54. A prisoner custody officer at the court said that she was aware of the concerns that had been expressed about the man and that she told the escort staff to keep a close eye on him. However, he appeared fine and did not give her any cause for concern.

55. The man's barrister said that after sentence the man was most concerned with the Sexual Offences Prevention Order (SOPO) and the terms within it. He explained that he was being prevented from phoning anyone female, or his male friend who was 15/16 years old. (The terms of the man's SOPO were all related to females under the age of 16 years old. However, restrictions placed on him in custody were as a result of public protection restrictions in line with prison policy.) The barrister spoke to court staff and was told to write to the governor of Reading, which she duly did.

56. My investigator spoke with the two Reliance escort staff who escorted the man to and from court. The driver recalled the man saying that he thought he was going to get three years but he seemed fine. He thought that the man had joked about killing himself on the way to court. However, his co-worker, who sat with the man in the back of the van, could not recall him saying anything about suicide. He thought that he had said that he was expecting a sentence of a couple of months. They did not recall being told anything about the man by staff at court.

57. An officer was working on the desk in reception when the man returned from court. He had some knowledge of him from the wing and said that he appeared to be fine. The man told him he had received five years and had not been expecting the sentence. He did not say whether he thought it was going to be more or less.

58. As part of the procedure for those returning from court, each prisoner was required to see a member of healthcare. One of the nurses who had seen the man a few times was in reception fulfilling this role. In interview, she explained that when she saw someone returning from Crown Court, she would not have any documentation with her regarding the prisoner as the IMR was kept in healthcare. However, in his case, he was known to her.

59. The nurse was asked in interview to explain the purpose of a member of healthcare seeing a returning prisoner from court. She explained that she "would see them to actually establish whether I felt they were at risk because of the sentence they got." However, there is no formal assessment to complete and the only requirement was for prisoners to sign a disclaimer if they declined to see the doctor. The man signed such a disclaimer.

60. One of the nurses who saw the man a few times recalled speaking to him through the gate of the holding cell in reception, where she said he was sitting alone. She said she spoke to him for a few minutes and asked him how he was and "whether he wanted to talk more?" She recalled that he had not wanted to and that there was nothing in his demeanour to suggest he would take his own life. She did not directly ask prisoners about feeling suicidal as she believed this might in some way influence them. She did not write anything in his IMR about her assessment of the man.

61. The man was one of four sentenced prisoners who returned from court that evening. From the records, it seems the nurse saw 11 prisoners in total, which she described as not being a particularly busy evening duty in reception.

6 September

62. In interview the other nurse who saw the man a few times recalled that she had seen him in passing, on the landing during the morning of 6 September. She asked him about court and he said that he could have got eight years so it had been a good result. She felt that he was fine and was not concerned about him.

63. Records from the man's cell bell indicated that he pressed it at 8.44am, 9.50am, 10.09am and 3.39pm. The prison was in 'patrol state' that day as many of the officers were on Control and Restraint training. As a consequence, only a minimal number of staff were available on the wing so prisoners would have been locked in their cells for the majority of the day. Of those patrolling the landings, none was able to recall answering the man's cell bell.

64. Between 1.45pm and 3.00pm the man was seen by a prison officer for the purpose of completing an Initial Classification and Allocation document (a form completed on all sentenced young offenders for the purpose of classifying and allocating them to a training establishment). This was the first time the officer had met him. In interview, the officer said that the man "seemed to be ok, nothing untowards, he wasn't agitated, he didn't seem depressed, seem like your average normal prisoner." The man did tell him that he had been expecting a three year sentence, but the officer had no concerns about his well being.

65. The man's prescription chart was not signed for 6 September so it is assumed that he did not collect his medication that day. My investigators have been unable to establish why this was the case.

66. The cell bell records for the evening identify the man ringing his bell at 7.49pm, 8.30pm and 8.55pm. My investigators have spoken with staff on duty and no-one can recall responding to his bell. In a nearby cell, the prisoner was on an open F2052SH and was being checked regularly. Between 7.30pm and 8.32pm an officer carried out this prisoner's checks. He was

familiar with the man and in interview said that, if a cell bell had gone off in his vicinity, he would always answer it. However, he was unable to recall whether or not he answered the man's cell bell. He explained that cell bells ring all the time and he would not recall individual ones unless something of significance occurred. He stated, "it might have been me but I just can't remember, like I said it would have jogged my memory if it was significant."

67. Similarly two other officers signed the F2052SH watch of the other prisoner at 8.52 pm and 9.10 pm respectively. Both officers were on their first night duty for the week, having had the last four days off. Neither was aware that the man had been to court and sentenced the day before. One of the officers could not recall whether he answered the man's cell bell. The other officer said that he always checks all the F2052SHs when he first comes on duty, but did not have reason to speak to the man.

68. An officer who was responsible for the night roll check on C2 and records indicate that he completed the check at 8.15pm. In interview, he recalled that the man was sat at his table when he observed him through the cell door hatch. The officer said that they had a 'laugh and a joke', but could not remember exactly what had been said during the course of the conversation.

69. A number of prisoners were spoken to as part of the investigation. Two prisoners said that they had spoken to the man on exercise after he had been sentenced. One of the prisoners said that he told him that he had got five years and seemed fine about that. The other prisoner who said he knew the man well saw him in the dinner queue and also felt that he was fine. He said that the man thought he was going to get eight years. Another prisoner said that the man was surprised to get five years and told him that he thought he would have got a shorter sentence had he been in Scotland.

70. Members of the IMB informed my investigators that the chaplain had told them that, during a group session, one prisoner had spoken about hearing the man shouting out that he was going to hang himself, and was ringing the bell, between 9.00pm and 11.00pm. The same prisoner had since moved prison and was spoken to on the telephone by one of my investigators. He said that he had heard an officer tell the man "to shut the fuck up" and "ride it out". Given that none of the officers are able to recall going to the man's cell, my investigators have been unable to verify this. Another prisoner located in the vicinity said he had heard and seen the man's cell door being opened at about 10.30 by a number of officers who then entered the cell. My colleagues tested this out and found that it was not possible to view the cell door from the cell this prisoner was located in. Another prisoner said that he had heard someone shouting comments out to the man saying that they were going "to get him" and that he was there for raping someone. Again, this has not been verified by staff or fellow prisoners. It has not possible to gain a clear picture of what happened in response to the man pressing his cell bell that night.

Finding the man

71. At approximately 6.10am on 7 September, during the morning roll check one of the officers who signed the F2052SH watch of the other prisoner looked through the cell hatch into the man's cell and saw him hanging from the ventilation unit. He immediately shouted out and the other officer who signed the F2052SH watch who was counting another landing ran and joined him at the cell door. On the way the officer radioed for Oscar 1, the most senior officer on duty at the time. The duty governor was on the wing as part of his morning duties, and upon hearing the call for Oscar 1 immediately attended the cell and unlocked the door with his key.

72. One of the officers supported the man's legs whilst the second officer climbed up onto the sink and attempted to remove the shoe lace ligature from around his neck. Eventually, and with some difficulty, he was able to pass the man's head through the loop. Neither officer carried a fish knife which is used to cut ligatures. Both officers described the man's body as being stiff and cold and it was clear that rigor mortis had already set in. They placed him onto the bed. Paramedics arrived at the prison at 6.19am and the man was declared dead at 6.23am.

73. The man left the following note in his cell -

    "Dear Whom Ever finds me please tell my **nominated next of kin** and my father that I cannot handle 5 years for something I have <u>NOT</u> done. TELL all my friends and family that I loved them very much and I will be waiting for them over there
    Yours sincerely the man"

74. The prison did not contact the man's nominated next of kin. Instead, the Governor managed to locate the man's birth father, by checking through the man's telephone records. The father attended the prison the next day. The details of the man's adopted parents were found through Scottish Social Services as there was no record of them in the man's file.

75. The death in custody contingency plans were complied with by staff. The care team spoke to all those involved. Two members of staff on duty when he was found, went off on long-term sick and felt very well supported by the prison and the care and support team.

ISSUES

The increase in risk following sentence

76. The man was a troubled young man with a history of self-harm who had suffered two sibling suicide bereavements. He had been found guilty of a number of serious offences and was facing a lengthy custodial sentence. In spite of telling some staff and fellow prisoners that he was expecting up to eight years, his remarks to the probation officer suggested that the man harboured some hope that he might be released from court with a non-custodial sentence

77. The visiting psychiatrist, interviewed the man for the purpose of a psychiatric report and he said he might consider suicide if he received a custodial sentence. This information was relayed by the psychiatrist to healthcare staff both verbally and in the IMR. Following her discussion with the psychiatrist one of the nurses wrote an entry in the communications book so all healthcare staff were aware of the man's remarks. I am concerned that no other method was used for communicating such a vital piece of information to a wider audience. When he went to court, I would have expected that the Prisoner Escort Record (PER) would have reflected the risk he faced upon sentence.

    The Governor should develop a system to ensure that those at risk after sentence can be identified by court staff, cell staff, discipline and healthcare staff. This system should be kept under review.

78. In court, both the psychiatrist and the probation officer, reports made reference to the man's risk of self-harm. Having learnt about his vulnerability to self-harm from these reports, the man's barrister informed the staff managing the cells at Kingston Crown Court of her concerns. In addition, the senior probation officer in court contacted the senior custody officer regarding the man's self-harm risks. However, staff made their own assessment of him and did not record any of this information. On the basis of what court staff was told by both his barrister and the senior probation officer, the 'At Risk of Self-Harm' form should have been completed by the custody officers. The purpose of this form is to communicate any concerns about the risk of self-harm that arise when a prisoner is at court. This form should have travelled back to Reading with the man and alerted reception staff to events at court.

    Serco should undertake a local investigation to establish why the 'A Risk of Self-Harm' form was not opened after the man was sentenced.

79. Upon his return to the prison one of the nurses conducted a very brief post-sentence interview in reception. She was aware of the psychiatrists concerns but did not directly ask him if he felt suicidal. From his demeanour she concluded that he was not at risk. I am concerned there may have been an over-reliance on how the man presented, and that insufficient account was taken of his previous history. The nurse had not received any suicide or self-awareness training during her time at Reading.

All staff who are engaged in reception screening should have training in risk assessment, interview skills and suicide awareness, taking into account the new ACCT procedures, due to be implemented.

80. Prison officers on the man's wing were not aware that he had received a five year sentence. I am of the view that a long sentence imposed on a 19 year old should be regarded as a significant change in circumstances and staff should be notified of this change. Wing staff were not aware of his increased risk after sentence. I am concerned that there is no existing method for healthcare staff to communicate important information to discipline staff. The clinical reviewers discussed this in detail and I endorse their comments and recommendations.

    Structured systems and processes must be put in place, for communication both within the healthcare team and the wider prison.

F2052SH procedures

81. The man's F2052SH was closed on 13 August by two staff members who had not been involved in any previous reviews. The concerns about his risk following sentence are not acknowledged in the F2052SH, and it must be assumed that they were unaware of the psychiatrist's comments in the IMR. The clinical review team recommend that once an individual is removed from a F2052SH/ACCT there should be a system in place for review and follow up. I strongly endorse this. Reading introduced the ACCT system on 25 September 2006.

    A comprehensive post closure support plan should be put in place for all prisoners at Reading. This should take place at the final review meeting and prior to the closure of the F2052SH/ACCT booklet. The Suicide Prevention Co-ordinator (SPC), along with wing staff, should monitor and follow up each plan.

82. Although the man was in a single cell in Reading, it was recommended that his level of observations be changed from level 1 to level 3 following a review. However, for those prisoners in single cells, F2052SH guidance states that they must be observed at either level 1 or 2 at all times. The error was quickly rectified and it would appear that his level of observations was not actually reduced. However, it is worrying that staff responsible for reviews should not be completely familiar with the self-harm monitoring system.

    The Governor should review arrangements for holding, and caring for, prisoners at risk of suicide or self-harm in single cells.

Medication

83. On 19 August the man did not collect his medication. Records indicate that this was not followed up by medical staff and there are no policy instructions for medical staff in such circumstances.

84. On 3 September, a repeat prescription for Amitriptyline, an anti-depressant, was started. Whereas his medication had previously been given at night-time, the new chart was written up as an evening collection. The arrangements for collecting medication differ depending on the time given. An evening prescription would have been collected from the medication treatment hatch by the prisoner during his time out to collect the evening meal. Those on night medication are unlocked individually by staff and escorted to the treatment hatch before returning to their cell.

85. The man did not have his medication on 6 September. It is unknown whether he intentionally did not collect it at teatime, or whether he had not become accustomed to collecting it at that time, if indeed this is what happened the preceding days.

    When a prisoner does not attend for their medication this should be followed up by Health Care staff. The reason for declining medication and/or alternative arrangements should be recorded in the clinical record.

    Healthcare staff must record in the Clinical Record the reason for altering the requirements of a prescription.

Cut-down scissors or fish-knife

86. Neither of the two officers who found him carried any means by which to cut through a ligature. In the absence of having any quick way of removing it the officer struggled to release the ligature from around his neck. Tragically the man was already dead and there was nothing that could have been done to save him. However, this is not always the case, and any hindrance could have lost valuable seconds.

87. It would be better and safer for all staff working with prisoners to be issued with a pair of cut-down scissors, or a fish-knife, which are specifically designed for the purpose of cutting ligatures. I welcome the fact that the Prison Service is shortly to issue a mandatory instruction requiring staff to carry such equipment and therefore make no further recommendation.

History booklets

88. HMP Reading inherited two history booklets on the man from Feltham and also opened a new one. However, the Feltham ones remained in circulation and so three booklets were completed at different times and no consequential account was found in one document. There are only a scant number of entries during his time at Reading**.**

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

The management of the man

89. Due to concerns about the man's behaviour in custody, he had to be placed in a single cell, had limited contact with other prisoners and frequently complained about being bored. In previous establishments he had to be segregated so Reading did well to locate him on normal location during his time there. However, during his time at Feltham it is evident that there were regular discussions about how best to manage him and work with him through his problems, including how to cope with the lack of activity. From his records, this work appears to have been undertaken by his personal officers and probation staff. However, whilst at Reading there is no evidence that any 'extra' work was undertaken, and there is only one entry in his public protection action log which related to the day he came to Reading. At the time of his death Reading did not have a personal officer scheme and I believe that he may have missed out as a result. I understand that the Governor has now reintroduced a personal officer scheme. I strongly commend this and judge that any recommendation of my own would now be otiose.

Contacting the next of kin

90. In Reading's Reception and Induction Record the man named somebody other than his biological father as his next of kin. During the course of this investigation, my investigator met the man's nominated next of kin who said that he had not been contacted by the prison following the man's death. The Governor told my investigator that telephone contact between the nominated next of kin and the man had been barred in line with a police investigation. She added that the relationship between the two was not clear and so she had contacted the man's father. However, prison records indicated that the man last telephoned the nominated next of kin on 30 August 2005.

91. Whilst the Governor was trying to do the right thing, the wishes of the man were ignored. Given a prisoner's utter dependence upon the authorities for most aspects of their lives, this is one area where individuals are able to express their own wishes and these should be respected unless there are overwhelming reasons to the contrary.

The NOMS Safer Custody Group should review current guidance to assess whether there are any circumstances when nominated next of kin should not be approached following a death in custody.

Clinical Review

92. Reading Primary Care Trust undertook a clinical review of the healthcare provided to the man during his time at HMYOI Reading. The review has highlighted a number of shortcomings and makes a number of far reaching

recommendations which will need to be considered jointly by Reading PCT, Reading's Healthcare Manager and the Governor.

93. The clinical review team believe that the decision not to open a F2052SH on the man's return from court, the lack of training in suicide awareness and lack of effective communication systems were significant factors in him taking his own life.

94. The recommendations made by the clinical review team echo the issues identified in my report and I endorse all their recommendations. I am aware that Reading PCT have developed an action plan in the light of these recommendations.

RECOMMENDATIONS

1. **The Governor should develop a system to ensure that those at risk after sentence can be identified by court staff, cell staff, discipline and healthcare staff. This system should be kept under review.**

   Accepted A system for communication to Reading Prison by Court/ Cell staff is in operation. There is a proforma with instructions to contact a Healthcare pager for immediate response at all times. This is in addition to the Prisoner Escort Record (PER) and suicide/self-harm warning form.
   In Reception, the Inmate Medical Record (IMR) is available to all those returning from court and first night keep safe arrangements are used until full assessment next day by Healthcare and Induction staff.
   In addition local system has been developed to identify those sentenced at Court and on transfer.

2. **Serco should undertake a local investigation to establish why the 'A Risk of Self-Harm' form was not opened after the man was sentenced.**

   Accepted. An internal investigation was conducted by the Deputy Investigations Officer Serco in November 2005. He made no formal recommendations but noted from the Kingston Crown Court officer's statements that the man had arrived from HMYOI Reading and that a 2050SH warning had been closed by the prison. He displayed no signs or warnings at court of any intention to self-harm. That verbal information was given to an officer by a member of the man's legal team that he had previously tried to self-harm and that a request is made to the supervisor to keep an eye on him. The SCO at the court took note of all the information and had spoken to the man, he gave her no concerns over his behaviour and the SCO did not consider it appropriate to open a Suicide/Self-harm warning form. The SCO did in the knowledge of this information inform staff to keep an eye on the man.

3. **All staff who are engaged in reception screening should have training in risk assessment, interview skills and suicide awareness, taking into account the new ACCT procedures, due to be implemented.**

   Accepted. ACCT was implemented in September 2006. Training was given prior to implementation for all staff involved in the process. Enhanced training was given in line with HMPS policy for Healthcare staff and key individuals within Reading.
   In addition, the Gruben Health screen is being used to assist in identification of prisoners who may require extra support whilst in custody

4. **Structured systems and processes must be put in place, for communication both within the healthcare team and the wider prison**

   Accepted. Reading PCT Communication protocol and HMPS Communication strategy detail the formal principles for communication. Within Reading, Healthcare staff attends the morning briefings, Safer Custody reviews and a

manager attends the daily meeting. There is a weekly High dependency meeting attended by all disciplines to ensure effective communication and management of difficult cases

5. **A comprehensive post closure support plan should be put in place for all prisoners at Reading. This should take place at the final review meeting and prior to the closure of the F2052SH/ACCT booklet. The Suicide Prevention Co-ordinator (SPC), along with wing staff, should monitor and follow up each plan.**

   Accepted. There is a dedicated Safer Custody team who liaise closely with Healthcare and discipline staff. When an ACCT document is closed, a post closure interview is arranged in line with National Policy.
   The Safer Custody Manager is responsible for monitoring documentation

6. **The Governor should review arrangements for holding, and caring for, prisoners at risk of suicide and self-harm in single cells.**

   Accepted. The ACCT document facilitates multi-discipline involvement and ownership of care for those young prisoners at risk of suicide and self-harm. Those also risk assessed as single cell are reviewed when there is a change in circumstances. If there is a benefit in multi-share occupancy indicated by the ACCT process, a review of cell sharing is actioned.

7. **When a prisoner does not attend for their medication this should be followed up by Health Care staff. The reason for declining medication and/or alternative arrangements should be recorded in the clinical record**.

   Accepted. Healthcare staff introduced a system, to explore, with individuals, their reasons for declining medication. This is recorded in the Inmate Medical Record (IMR) and non medical-in-confidence information is disclosed to discipline staff where necessary to keep the individual safe.

8. **Health care staff must record in the Clinical Record the reason for altering the requirements of a prescription.**

   Accepted. This relates to any specific time or change to time of medication requirement of the prescription that might alter the effectiveness, at night, for example. Detailed records are now in existence to remedy this possibility.

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

   Accepted. The personal officer scheme has been re-established at Reading to ensure better quality information is recorded in History sheets for individual prisoners

10. The NOMS Safer Custody Group should review current guidance to assess whether there are any circumstances when nominated next of kin should not be approached following a death in custody.

Accepted. This will be considered in the wider review of PSO 2710 Follow up to deaths in custody

RECOMMENDATIONS FROM THE CLINICAL REVIEW

11. **Clear policy and guidance should be developed which clearly states the roles and responsibilities of those individuals within the health care team, particularly with regard to:**
    - **The lead nurse on duty**
    - **The health care representative of the review team for F2052SH**
    - **Daily communication and updates on individuals causing concern.**

    Accepted. There is an Action Plan in conjunction with Reading PCT to address recommendations from Clinical Reviews already in place.
    The Role of the Lead nurse has been published.
    RMN attends Safer Custody meetings and the Role of a Healthcare representative on the ACCT review team has been formalised.
    There is a morning handover book for outstanding issues and attendance of Healthcare at the daily Prison staff briefing. A weekly High Dependency meeting operates for difficult case management.

12. **Consideration should also be given to developing a key nurse role for those prisoners who are considered to be at risk.**

    Accepted. Within the local Safer Custody team there is an individual identified as lead in each case. This will be developed within the Healthcare staff roles and responsibilities for those considered at risk.

13. **All staff should undertake annual mandatory training in suicide awareness and risk assessment and a record of this should be monitored by the head of health care.**

    Partially accepted. All Healthcare staff has undergone training prior to implementation of ACCT in September 2006 and are competent in completion of Gruben Health screening where appropriate. National Policy no longer has mandatory training. All training is monitored by Head of Healthcare.

14. **All staff who are engaged in reception screening should have training in risk assessment, interview skills and suicide awareness and be competent to do so**.

    Partially accepted. All Healthcare staff has undertaken training in line with ACCT implementation to better assess risk and improve the inquiry process to better identify those potentially at risk, which includes the Gruben Health screening tool

15. **IMRs should be accessible to staff on reception for prisoners returning from sentencing.**

    Accepted. Written Operating Instructions are in place to ensure IMR's are accessible to staff on reception for prisoners returning from court. Entries are monitored by Head of Healthcare.

16. **All staff who are engaged in reception screening should have training in risk assessment, interview skills and suicide awareness**.

    This is the same as number 14.

17. **There is a review of current systems within the health care team to ensure that there are robust processes in place for the:**
    - **Instigation**
    - **Removal**
    - **Follow up of individuals on F2052SH**.

    Accepted. F2052SH has now been replaced by the ACCT document. Robust processes exist with the local Safer Custody team in ensuring reviews are conducted by individuals who have detailed knowledge of the individual. Rationale for removal from ACCT is detailed and cases followed up with a care plan.

18. **Structured systems and processes should be put in place for communication both within the healthcare team and between the team and the wider prison staff.**

    This is the same as number 4

19. **The current communication process should be reviewed, identifying areas of risk and developing a more consistent pathway approach between individuals and teams providing health care.**

    Accepted. A review of relevant meetings has taken place to ensure improved communication and appropriate attendance at relevant meetings by all involved in the welfare of a young prisoner.

20. **The IMR should be regarded as the main record and all information must be recorded on the IMR, e.g. open and closure of F2052SHs.**

    Accepted. Comprehensive information is now recorded on the IMR which included rationale regarding opening and closure of ACCT documents which replaced the F2052SH

21. **All relevant communications and interventions should be written in the relevant record/s and signed and the name should also be printed under the signature.**

    Accepted. All relevant communications and interventions are recorded in detail and names are printed under the signature to ensure no doubt exists as to the author.

22. **Record keeping must be improved in line with NMC guidelines and should form part of regular supervision of staff.**

Accepted. All staff has a copy of the NMC guidelines for record keeping and this forms part of the regular supervision of staff.

23. **Training related to record keeping and records management should be provided for all staff**

No response given.

24. **A system should be established which:**

- **will alert staff to potential risks, and**
- **will record changes in circumstances**.

Accepted. There are a number of systems that have developed to ensure changes in circumstances are communicated and recorded.
These include:
Safer Custody meeting
Multi-discipline team meetings
Daily briefings
Morning handover
High Dependency meeting
Personal Officer scheme
More consistent use of the IMR

25. **The initial reception screening should be reviewed in line with ACCT**.

Accepted. ACCT was implemented in September 2006. All documentation relates to the revised system.

26. **A system to ensure follow up and compliance with healthcare should be developed**.

Accepted. Referral forms, which are audited, have been introduced and all non-attendance for appointments and medication is followed up

27. **A records audit must be undertaken at baseline and reviewed in 6 months.**

Accepted. This will be completed.

28. **There should be a system in place to ensure that nominated staff who are involved in closure of F2052SH are fully informed of factors relating to that prisoner in order to make an informed decision.**

Accepted. F2052SH has now been replaced by the ACCT document. Robust processes exist with the local Safer Custody team in ensuring reviews are conducted by individuals who have detailed knowledge of the individual. Rationale for removal from ACCT is detailed and cases followed up with a care plan.

29. **Closure of F2052SH should be communicated effectively to all team members both in written and oral form and a follow up programme developed in line with an agreed 'step down' approach.**

Accepted. The implementation of ACCT ensures this system operates effectively.

30. **To implement a system to ensure that medical follow-ups at the required intervals are achieved with reasons for non-attendance made in the IMR.**

Accepted. Referral forms, which are audited, have been introduced and all non-attendance for appointments and medication is followed up.

31. **Medication charts should be reviewed on a regular basis by a senior member of nursing staff and non-compliance monitored.**

Accepted. This exists within the published Role of the Lead nurse, supported by the prison pharmacist.

32. **All team members should have a clear understanding of their roles and responsibilities.**

Accepted. These are drafted with further consultation planned on an away day involving Team Leaders. This will be published following this.

33. **Regular clinical supervision should be available to all staff and arrangements for this and ongoing management support should be in place**.

Accepted. Supervision and Management support are under development for all Healthcare staff

34. **There should be regular interdisciplinary team meetings where individual care plans are discussed**.

Accepted. There are a number of meetings involving all disciplines that have developed to ensure individual care plans are discussed
These include:
Safer Custody meeting
Multi-discipline team meetings
Daily briefings
Morning handover
High Dependency meeting

35. **Wherever possible, there is an integrated approach across health and prison staff in the development and implementation of policies**.

Accepted. Reading PCT have reviewed their integrated policy documents to reflect both Healthcare and Prison guidance and policy.

All documents have been and are signed off at The Prison Partnership Board meeting, held quarterly. In addition the Quality Forum ensures that improvements are monitored.

36. Efforts should be made to employ staff within the team rather than be reliant upon agency staff.

Accepted. Posts are advertised as they arise and Agency staff are kept to a minimum.

37. There should be regular team meetings to discuss clinical care and significant events.

Accepted. There is a daily meeting to discuss clinical care and a weekly meeting in which significant events are discussed.

38. Key events and information that affect a prisoners' behaviour or attitude should be communicated as a matter of urgency. This should be in written as well as oral form and should be recorded in the IMR.

Accepted. There are a number of meetings involving all disciplines that have developed to ensure individual care plans are discussed along with any changes in behaviour that needs to be communicated
These include:
Safer Custody meeting
Multi-discipline team meetings
Daily briefings
Morning handover
High Dependency meeting
Consistency with IMR recording
Personal Officer scheme
Mental Health referral system

39. There should be urgent consideration of the early implementation of an integrated and comprehensive IT system to replace hand written records to the standard described above.

Not accepted. Until this is a National initiative with other prisons and the NHS involved, any information would only be relevant within Reading Young Offender Institution and not transferable to another establishment.

40. Urgent consideration is giving to the range of skills and resources available to support the particular needs of this group of young men.

Accepted. A review of Mental Health services has been undertaken for Reading YOI. This will look at utilising existing skills and potentially introducing new resources for gaps in service provision for the young men at Reading. This will be discussed at The Partnership Board meeting in November 2006.
New resources are subject to the financial constraints of the NHS.