Investigation into the circumstances surrounding the death of a young man at HMP & YOI Reading in December 2007

Report by the Prisons and Probation Ombudsman for England and Wales

August 2009

This is the report of an investigation into the circumstances of the death of a young man who was found hanging in his cell on A wing at HMP & YOI Reading on 19 December 2007. He had been in Reading for just two weeks.

I extend my sincere condolences to the man's family and friends for their loss.

The investigation was carried out by my colleague. The local Primary Care Trust carried out a review of the man's clinical care and treatment while at Reading.

I would like to thank the Governor of Reading, and her staff for their help.

The man was remanded into Reading in December 2007 having been charged with a public order offence and with breaching an anti-social behaviour order (ASBO). He hoped to obtain bail before Christmas but, to his annoyance, his application was refused.

On 18 December, the man had three telephone conversations with his mother and four with his girlfriend. In addition, he wrote two letters to his mother and another to his girlfriend. Two of the letters indicate that he believed his relationship with his girlfriend was over. Staff at Reading would not have been aware of these conversations and letters at the time.

After his death a letter was found on his bed indicating that it was his intention to end his life. The letter contains no explanation of the man's reasoning. Neither staff nor friends of his observed anything about his demeanour to cause them to fear for his safety. The death of a young person is always especially sad. However, I have found nothing to suggest that he should have been identified as especially at risk relative to the other young people held at Reading.

I have made one recommendation about provision of bedding material and one about cell sharing risk assessments. Additional recommendations are made in the clinical review. Other recommendations are made in an internal review commissioned by the Specialist Services Manager for Children's Services.

Stephen Shaw CBE
Prisons and Probation Ombudsman **August 2009**

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SUMMARY

The man had spent time in a number of children's homes and Young Offender Institutions (YOIs). His disruptive behaviour at home and at school was first recognised by outside agencies when he was nine years old. His treatment from that time included referral to child and adolescent psychiatric services and his clinical diagnoses included anxiety and depression.

The man had been released from YOI Feltham in November 2007. Less than a month later he was rearrested for a public order offence and breach of an ASBO. He was remanded into HMP & YOI Reading, arriving there on 3 December.

His brief time in Reading was largely uneventful. However, he was involved in an incident on 15 December that resulted in him being charged under the Prison Rules with use of abusive and insulting words. Later that day, the man apologised to the officer involved and it seems that he did so entirely of his own volition. At an adjudication hearing two days later, he was found guilty of the offence.

The man had been hoping to obtain bail, but his application was refused on 17 December. In a letter to his mother, he wrote about his frustration at the decision, particularly because it meant that he would be in prison for the Christmas celebrations.

In the early afternoon of 18 December, the man had a total of seven telephone conversations within a period of little more than an hour. The first three calls were to his mother, during which he expressed great anger towards his girlfriend (or ex-girlfriend). It seems that he blamed her either wholly or in part for his arrest and imprisonment. All four remaining conversations were with his girlfriend. In the first two, he was extremely angry and threatening. In the third conversation he apologised for things he had done in the past and told his girlfriend several times that he loved her. The conversation ended with them agreeing to speak again the following week. The fourth conversation was brief, his telephone credit was running out and he asked his girlfriend to pass a message to his mother.

The man wrote three letters that afternoon. The evidence indicates that they were written after the telephone conversations. One letter was to his mother and it included criticism of his girlfriend. Another letter was to his girlfriend in which he repeated his apologies for his previous behaviour. He again told his girlfriend that he loved her while making a comment about his regret that their relationship had ended 'like this'. The third letter was found on top of his bed after his death in which he indicated his intention to take his own life (although he gave no explanation for his reasons). He was found hanged in his cell during the early morning roll check on 19 December 2007.

Nothing occurred during the man's time in Reading for staff to suspect that he might have been at risk. His death came as a complete surprise both to staff and to the two friends of his who agreed to speak with my investigator.

THE INVESTIGATION PROCESS

1. The investigation was opened on 27 December 2007 when my colleague visited Reading and met a number of prison staff, including the Governor, the duty governor on the day of the man's death, and a representative from the Prison Officers' Association. My investigator informed the staff of the nature and scope of the investigation. Notices were issued to staff and prisoners notifying them of the investigation.

2. Nine members of staff and two prisoners were interviewed. No additional prisoners came forward to give evidence directly in response to the published notices.

3. The local Primary Care Trust agreed to carry out a review of the man's clinical care and treatment while at Reading.

4. One of my family liaison officers (FLO) contacted the man's mother who was listed as his next-of-kin. The FLO informed the man's mother of the scope of the investigation and gave her the opportunity to ask any questions or to raise any concerns she wished to be considered as part of the investigation. She and my investigator subsequently met the man's mother, his grandfather and his aunt. His mother said that her son had a history of mental health and psychiatric problems and been treated for depression from a young age. She said that his mental health problems included Seasonal Affective Disorder (SAD). She understood that her son had been on suicide watch at both Feltham and Huntercombe but it seemed few of the records were transferred to Reading. She said that her son had complained to her that the prison was cold and that his cell window was broken, but staff refused to give him additional blankets. She thought this would have added to any feelings of depression he might have been suffering – as would the fact that he would be parted from his family over Christmas. She thought it incomprehensible that her son was not being closely monitored.

5. His mother commented that the healthcare questionnaire completed by prisoners on arrival is an ineffective way to collect medical information, particularly about the person's mental health. She thought that a telephone call to the family could have clarified a lot of matters about her son.

6. The way in which the news was broken about the man's death caused the family great distress. The two police officers who visited the house did not say why they were there and, in order to provoke a response from them, his mother put it to them that they were there to tell her that her son had taken his life. The family visited the prison the following day but they were given no information about the time of death, nor about the precise circumstances. Further contact with the prison had been primarily instigated by the family and they were not allocated a dedicated family liaison officer or single point of contact. The man's mother also said that his trainers had gone missing.

7. His mother said that she thought her son had been let down by ‘the system’ from a young age. She felt that his psychiatric history had been overlooked for years and there had been significant failings across a number of key agencies in sharing this information. She also said that as her son was still under licence (subject to a Supervision Order) when he went to Reading, he would still have come under the care of the Youth Offending Service and should still have been considered a youth offender. This should have given him better rights and, perhaps, better support.

8. An internal management review was carried out to consider the delivery of care to the man through Local Authority Children’s Services and the Youth Justice Service (YJS). Some of the findings of that review are referred to in this report.

9. In their response to the draft report the solicitors acting for the man’s family made a number of comments. Some of these have resulted in amendments to this version of the report; most notably, paragraphs 82 and 83.

HMP & YOI READING

10. HMP & YOI Reading is a small prison of Victorian design. It was built in 1844 on the site of a former jail. In 1973 Reading was designated as a local prison and in 1992 was re-roled as a Remand Centre and Young Offenders Institution, holding male prisoners between the ages of 18 and 21 years. Its operational capacity is around 300. The accommodation comprises a mixture of single and double cells.

11. Reading has an average of 10 to 12 Listeners available. Listeners play an active part in the prison reception process meeting and greeting new arrivals. There is always a Listener[1] based on the induction landing. A direct telephone line to the Samaritans is available 24 hours a day.

12. In May 2007, Reading received an unannounced inspection from Her Majesty's Chief Inspector of Prisons. In the introduction to her report the Chief Inspector wrote:

> "The busy reception facility was much brighter and better decorated than when we last visited, but the accommodation remained limited and staff struggled to manage safely all the young men who had to be dealt with. First night procedures were basic, while induction was brief and needed to be improved.
>
> "In the aftermath of three tragic deaths in 2005, much greater attention had been paid to suicide and self-harm prevention, and a small team of energetic and innovative staff had made significant progress in improving procedures.
>
> "The quality of accommodation at Reading varied … Staff-prisoner relationships also varied, with excellent interactions on two units, but much less interaction elsewhere in the prison. Consistency was not assisted by the lack of a functioning personal officer scheme and little use of the incentives and earned privileges scheme to challenge and motivate young prisoners.
>
> "Food was much improved and there were now two hot meals a day, as we had previously recommended. Most other services had also improved … Healthcare provided a reasonable service in poor surroundings …
>
> "Like many Victorian city centre local prisons, Reading had insufficient education, training and work places. This left too many young prisoners unemployed and locked in their cells for most of the day.

[1] Listeners are prisoners trained by the Samaritans to provide the same confidential service as Samaritans offer in the community.

> "Staff at Reading have the difficult task of managing a challenging and volatile population of young prisoners … some with serious mental and behavioural problems. The prison itself is old and has limited space, and too few resources, to provide the purposeful activity that they need. There were pockets of excellence, but this inspection also exposed some serious concerns about safety, which appeared to have deteriorated since our last inspection."

13. Later on in her report Her Majesty's Chief Inspector of Prisons talked more about the availability of purposeful activity. She reported on improvements to the physical education department with a significant increase in time available for access to physical education. The Chief Inspector repeated her concerns about the limited places for work and education. She reported on improved landing association since the previous inspection while adding that the vast majority of prisoners had no access to evening association, and that weekend association was often cancelled.

14. In their report for the year April 2007 to March 2008, the prison's Independent Monitoring Board (IMB) remarked on the fact that the year was one marked by the man's death, the first at Reading since 2005. In its executive summary the IMB said:

> "The year has seen changes at Reading to the management structure and staffing; to the regime; and to the expansion of resettlement opportunities. The Governor, and her staff, have managed the pressures to overcrowded Reading Prison extremely well.
>
> "The Board has reported and praised many good initiative and practices, and also commented where there might be improvements."

15. The man's was the fourth death at Reading since I took on the responsibility for the investigation of all deaths in prison custody in April 2004. There appear to be no significant similarities between his circumstances and those of the other three cases.

KEY EVENTS

16. The man had had contact with children's services from a comparatively young age and spent time both in children's homes and in young offender institutions. This included time in Feltham YOI in early 2006 when he was subject to special monitoring under the Assessment, Care in Custody and Teamwork (ACCT)[2] process after he had threatened to kill himself. He did not harm himself while being monitored and he later said that he only made the threat in the hope that he would be moved to the same wing where his younger brother was being held.

17. On 19 June 2006, the man was received into Huntercombe YOI on an 18 month detention and training order. He was discharged from Huntercombe on 19 March 2007, having served nine months of the sentence. For the remaining nine months of the sentence he was subject to a supervision order. (A supervision order requires that the young person be supervised by a youth offending team. The young person is required to take part in activities such as reparation to the victim of the crime and tackling offending behaviour.)

18. On 26 June 2007, the man reached the age of 18. Just before this, the leaving care services split into what were termed a '16+ service' and an '18+ service.' The latter team were now responsible for his ongoing support.

19. On 8 August, the man attended court for breaching his licence in three respects:

    - leaving home without a secure alternative address and not informing his supervisor where he was living,
    - failure to co-operate with his supervisor and making threats to him,
    - failure to attend specified supervision sessions.

20. The man was taken into Feltham where he remained for three months. He was released from Feltham in November and on that day he was seen by his new 18+ key worker. The key worker informed him that he was still under licence and the conditions were explained to him. After his release from Feltham, he initially stayed at his girlfriend's home before later moving into his mother's home.

21. He was arrested on 3 December for a public order offence and for breach of an ASBO. He was remanded into custody at HMP & YOI Reading. Upon arrival, the man was seen by a nurse for a standard first reception health screen assessment. The nurse told my investigator that the first reception health screen is used to explore any matters surrounding the person's general, mental and social health. He said that these interviews

[2] ACCT is the process used for monitoring and supporting prisoners who have been identified at possible risk of self-harm or suicide.

usually last between 10 to 20 minutes depending on the issues raised, and also on how talkative the person happens to be. The first reception nurse added that he tries to establish a friendly relationship with prisoners which he finds allows him to better assess their mental health.

22. In the man's case, he reported having previously been in Feltham and, as the first reception nurse had previously worked there, they spoke about that establishment. The first reception nurse said that the man was fit, healthy and co-operative so it was a straightforward consultation. However, the time they spent chatting about Feltham meant that the consultation probably lasted around 15 minutes. The information he gave included that he had not seen a doctor in the last few months, nor was he receiving any prescribed medication. He reported having no concerns about his physical health and the first reception nurse's observation of his physical appearance was that he appeared fit. The screening also explores mental health. The man denied any mental health history, denied ever trying to harm himself in the past, and said that he had no present thoughts of doing so. After completing the reception process he was allocated a cell on C wing. This was a double cell which he shared with another prisoner.

23. Reading contacted Feltham to ask for the man's records to be forwarded by them. The records were subsequently examined by my investigator and he found that they included records for his earlier time at Feltham, but not for his final time at that establishment (from 8 August 2007 to 7 November 2007). My investigator made enquiries of both establishments but neither was able to locate the missing records.

24. Prisoners at Reading receive a detailed follow-up assessment of their mental state on their second day in the establishment. It was the first reception nurse once more who saw the man for this assessment, which uses a 'depression scale' to help establish the individual's state of mind including any thoughts of self-harm. The clinician undertaking the assessment asks the patient a series of questions which are rated using a scoring system. The over all assessment of the patient's mental health is based upon their cumulative score and not upon the answer to any single question. The only negative answer that he gave was to say that his appetite was not as good as it used to be. The first reception nurse told my investigator that the man was again very co-operative and gave no indication that he could be at risk. He was also seen by one of Reading's doctors that day who noted that he was displaying no signs of mental health problems.

25. The man was moved into a new cell at some time on 4 December. The new cell was again a double cell which he again shared with another prisoner.

26. The prison reception process includes a cell sharing risk assessment to determine if a prisoner poses a risk to other prisoners with whom they might share a cell. The assessment includes the identification of racist,

homophobic or violent prisoners to ensure protection of potential victims. In the man's case he was initially classed as low risk for cell sharing. However, on 5 December, a note was made on his cell sharing risk assessment form that he had been charged with a racially motivated offence. As a result his level of risk for cell sharing was raised to medium and a note was made that he should be located into a single cell. It is unclear why the information about the racial aspect of his offence was not identified during his initial reception. Nor was he moved immediately from his shared cell when his risk assessment was raised.

27. The prison induction process also includes provision of information about religious services and support. The man gave his religion as Roman Catholic. One of Reading's chaplains has the same surname as the man. Because of their common surname the Reverend went to see the man on 5 December to find out if they were related (they were not). The Reverend told my investigator that the man was pleasant but did not fully engage with him. He did not express any issues or concerns. The Reverend told my investigator that Roman Catholic mass is held on Saturdays with an average congregation of around 20. No record is made of the names of those who attend mass so it is not known whether the man attended on either 8 or 15 December. He did not speak directly to Reading's Roman Catholic chaplain.

28. On 7 December, the man moved from C wing, the induction wing, to A wing, which is a residential wing. He was located into a cell on the third landing and this time he was the sole occupant of the cell. (From this time onwards, he did not share a cell again.)

29. The man seems to have settled into the regime on A wing. He attended the gym and associated with other prisoners. He would have had around five hours out of his cell each day and he had a television in his cell. Nevertheless, he wrote to his mother on 14 December saying that he was very bored as there was nothing to do. He also wrote that he was hoping to obtain bail the following Monday (17 December), but if he failed he would want a transfer to Feltham. The man also wrote that the worst aspect of all was the prospect of being in prison for the Christmas and New Year celebrations.

30. By 15 December, the man was occupying a cell on the second landing on A wing. At lunchtime he came down to the first landing, went to one of the locked cells, and began talking to one of his friends through the cell door hatch. The first officer told my investigator that he asked the man to return to his own landing as staff were in the midst of serving lunch. The first officer said that he became rude and abusive but eventually began to walk away when the first officer repeated his instruction that he should leave the landing.

31. The second officer told my investigator that she was in the A wing landing office when she heard a bit of a commotion. She noticed the first officer having words with a prisoner who was talking to another prisoner through

the cell door hatch. The second officer did not recognise the prisoner so she knew he was from a different landing. She went to assist. She told the man to leave the landing. He responded with abuse. He began to walk away from the cell but he continued making abusive comments so the second officer told him that she would place him on report for his behaviour. He was charged under Prison Rule 51, paragraph 20: "uses threatening, abusive or insulting words or behaviour".

32. That afternoon the second officer spoke to an officer from the second landing to see if they had capacity to take one of the prisoners from the first landing who had asked for a move. The second landing officer said that they in turn had a prisoner who wanted to move to the first landing so they agreed a swap. It was the man she had placed on report who turned out to be the prisoner who wanted to move down to the first landing. The second officer told my investigator that she unlocked the cell when the man came down to the first landing and the first thing he did was apologise for his earlier behaviour. She told my investigator that it was a genuine apology on his part and, in their few further contacts he was always polite and compliant with the prison regime.

33. The first officer told my investigator that he only had minimal contact with the man after his move down to the first landing. He also described him as being very polite after his move.

34. The man's friend told my investigator that they knew each other from before arriving in Reading. The friend said that on 15 December the man came to his cell on the first landing to ask for a cigarette and they began chatting. He heard staff telling the man to go back to his own landing. Later that day the man moved into the cell next to his. The friend said that the man was always laughing and joking. He mentioned that he had a girlfriend although he did not talk about her nor did they speak about important issues.

35. Allegations that prisoners have transgressed Prison Rules or have behaved inappropriately are dealt with at adjudication hearings. If the charges are proved, certain punishments can be applied. The allegation that the man had been rude and abusive to the second officer was considered at an adjudication hearing on 17 December. The man was given a copy of the second officer's report in which she set out her account of the event and of the language that the man had used. He declined to attend the hearing but pleaded guilty to the charge. The charge was proved and he was punished with five days loss of access to the prison shop and reduced time out of cell for three days. These penalties would not commence until the following week.

36. The man's hope that he would obtain bail on 17 December was dashed when bail was refused. His friend told my investigator that the man was initially angry about this outcome but he calmed down as the day wore on.

37. My investigator spoke to another prisoner who knew the man. He said that he had not known the man previously but met him when he came to Reading. He said that they chatted a few times, and played a few games of pool and table tennis. This prisoner said that the man never spoke about anything important, but he was always chirpy and never gave any signs that he was miserable. The last time this prisoner saw him was on 17 December when he thought that the man seemed his usual self.

38. On Tuesday 18 December, the man wrote a letter to his mother indicating his frustration that he would be in prison over Christmas. In the next sentence he indicated that it did not matter as the next Christmas would be 'the big one'. He complained in the letter that Reading was the worst prison he had been in. He complained about the quality of the food and that the prison was very cold. He also mentioned that he had placed money on his telephone account and he would telephone her as soon as the account was activated.

39. The man had been booked in to visit the doctor at 1.30pm that day. The reason for the consultation was not recorded. The man did not attend the appointment and nothing is known about why he failed to do so. (He had missed two previous appointments to visit a doctor. There is again nothing recorded about his reason for missing those appointments.)

40. After his telephone credit was activated, the man made a series of seven calls between around 2.00pm and around 3.20pm. The first three calls were to his mother during which he expressed great anger towards his girlfriend saying that he would assault her when he came out of prison. The next four calls were to his girlfriend (although the evidence is that their relationship might have ended, at least temporarily, before he arrived in Reading). In the first two calls the man told his girlfriend that both she and her family were going to be assaulted. About ten minutes later he telephoned her again telling her that he was sorry and that he loved her. At times he can be heard crying. This conversation ends with their agreement that he would telephone her again the following week. The final call is a very brief one. The man telephoned his girlfriend asking her to pass a message to his mother to say that he would not be able to telephone her until the following week as he had used up all of his telephone credit.

41. The man wrote to his girlfriend some time that afternoon in which he referred to having just come off the telephone to her. He apologised for the way he had behaved towards her in the past and wrote that he was 'sorry it had to end like this'. On the reverse of the letter he wrote a heading that included the word exit, followed by the date 2007. The letter appears too long for the man to have written it between his first and second conversations with his girlfriend or between their second and third conversations. I assume it was written after the third conversation or after the fourth, very brief and last, conversation.

42. The man also wrote another letter to his mother that afternoon which seems to have been written after the series of telephone calls as he mentions having used up all his telephone credit through speaking with his girlfriend. The man again mentions his regret at missing Christmas as he wished to have been at home for the celebrations.

43. One of Reading's physical education (PE) instructors told my investigator that he had met the man two or three years previously when he was 15 or 16 years old and a prisoner in Feltham YOI. The PE Instructor said that when he met the man again on arriving in Reading, he found that he had matured both physically and emotionally. At Feltham, he had been involved in a lot of incidents with staff and other offenders but whenever he came to the gym at Reading he was well behaved and always laughing and joking. The man told the PE Instructor that out of prison he had a job and a girlfriend.

44. The last time that the PE Instructor saw the man was just after 5.00pm on 18 December when prisoners were collecting their evening meal. He seemed in good spirits and was joking with other prisoners. The PE Instructor knew that the man had been refused bail so he asked him about that. He did not seem upset and said that he hoped to get bail after Christmas. After he had collected his meal he would have been locked in his cell for the remainder of the evening.

45. The man's friend told my investigator that the man had been quiet during the evening of 18 December. Ordinarily, he would have banged on the wall between their cells to have a chat but he did not do so that evening. The friend said that he was shocked that it seemed the man had taken his life as he never showed any signs that he would do such a thing.

46. Evening staff carried out a roll count at just after 8.00pm and a further count was carried out just after that by the on-coming night staff. The night officer counted the prisoners on the first landing and he signed the records to show that he had completed his count by 8.20pm. He told my investigator that he had no recollection of seeing anything untoward when he checked the man's cell. Through the night the landings would have been checked twice per hour at irregular intervals. Cell checks would also be made through the night on individual prisoners subject to monitoring through the ACCT process. This, of course, did not apply to this man.

47. In the early morning of 19 December, the night staff began to count the prisoners ahead of the arrival of the day staff. It was again the night officer who counted the prisoners on the first landing. As it is dark at that time of the morning in the winter months, the night officer switched on the in-cell lights so he could see the prisoners. When he reached the man's cell at around 5.40am he found the observation panel covered on the inside with toilet paper.

48. The night officer shook the door and the toilet paper slipped down. He looked into the cell and saw the man hanging from a ligature tied to the

window frame. The night officer said that it took him a few seconds to take stock of the situation and he then called for assistance from his two colleagues who were checking the other two landings. The night officer also sent a radio call to the communications room. This resulted in the Night Orderly Officer being called as well as a 999 call for an emergency ambulance.

49. Two officers responded to the night officer's shout for help. The night officer's set of keys were in a sealed pouch and he was trying to break the seal when the assistant night orderly officer arrived with open keys and unlocked the door. The officers went into the cell and cut the ligature with an anti-ligature knife. One of the officers checked for a pulse and found none. This officer told my investigator that the man's body was cold and blue in colour and it was obvious to him that he was dead. The assistant night orderly officer gave similar evidence about the appearance of the man's body and the clear signs that he was already dead. The assistant night orderly officer told his colleagues that attempting cardio pulmonary resuscitation would be futile so they should leave the cell.

50. Ambulance paramedics arrived within ten minutes of being called. They examined the man and confirmed his death.

After the man's death

51. To help decide the arrangements for breaking the news to the man's family, Reading's police liaison officer telephoned the police force local to the family home. The police informed Reading that there were potential concerns with the estate where the home is located and also concern about how the man's brother might react. The police advised that if staff from the prison were to visit, they should be supported by police officers. In the light of that advice, Reading's Governor decided that it would be better for the police to break the news alone and give contact details of appropriate staff at the prison. The police visited the family home at just after 11.00am and informed the man's mother of the death of her son.

52. The man's mother visited the prison the following day with her sister and was able to go to her son's cell. It was also arranged that the PE Instructor would speak to her about how her son had been getting on in the prison.

53. Reading instructed a funeral director to deal with the arrangements and asked that they send their bill directly to the prison. Representatives from the prison attended the man's funeral.

54. A hot debrief was held on the morning of the man's death before the night staff went off duty. However, my investigator received mixed responses from staff about the support offered to them. Staff said that members of the care team were available on the morning of the death but none was available that night when the same staff were on duty again. One officer

thought that an extra member of staff should have been on duty in case one of the officers found it too difficult and wanted to go home.

55. The second officer was on leave for several days after the man's death. Upon her return she made a point of speaking to the man's friend to check that he was okay.

The letter found in the man's cell

56. After his death a letter was found on the man's bed indicating that it was his intention to take his life, although he did not give an explanation for his decision. A date on the letter suggests that the man's life might have ended on 18 December rather than on 19 December when his body was found. All of the other letters that the man wrote on 18 December were recovered from the landing post-box where he would have deposited them before he was locked in his cell for the night. Neither of the letters that he wrote to his mother contain anything to suggest that the man might have been contemplating taking his life. However, in his letter to his girlfriend the man included the ambiguous remark about him being 'sorry it had to end like this'. The second page of the letter was also headed 'exit' which was followed by the year 2007.

ISSUES

The decision to allocate the man to a single cell

57. When the man arrived at Reading on 3 December it was not noticed that there was a racial aspect to the offences with which he had been charged. At that stage he was deemed suitable to share a cell. It is not clear why the information about his offences was not recognised. In other cases I have investigated there have been tragic outcomes when the cell sharing risk assessment has failed to identify such issues. Two days later, the information about the man's offences was acted on and it was then deemed that he should be allocated to a single cell (despite this, he continued to share a cell until 7 December). However, Prison Service Order 2750 which deals with reduction of violence in prisons advises that a prisoner who is understood to hold racist views can be allocated to a shared cell provided that the cell mate is from a non-targeted group. There is no reason therefore why the man could not have shared with a prisoner of the same ethnic origin.

58. Having said that, there was no obvious reason for there to have been any concern with placing the man in a single cell. He was not deemed to be at risk of self-harm, nor had he expressed a particular desire to share.

    I recommend that the Governor reminds staff of the importance of the cell sharing risk assessment both in terms of factors that mean a prisoner should not share a cell as well as situations where they can.

The adjudication decision

59. At an adjudication hearing on 17 December, the man was found to have contravened paragraph 20 of Prison Service Rule 51. Specifically, two days previously he had used abusive and insulting words towards the second officer. The man pleaded guilty to the charge and was punished through five days loss of access to canteen and three days loss of association. I do not consider this to have been an unreasonable punishment.

60. Nor is there any evidence to indicate that the man considered himself to have been treated harshly. He made no mention of the adjudication decision during his telephone conversations on 18 December. Significantly, in one of his two letters to his mother written that day, he complained about the food and that the prison was very cold. He made no complaint, however, about the adjudication or about the staff.

The man's complaints about HMP & YOI Reading

61. The man's mother told my staff that her son complained to her that he was very cold and that his cell window was broken but his request for extra blankets had been refused. In one of the letters he wrote to his mother on 18 December he complained that he was so cold he was sleeping in his clothes. He also complained about the food.

62. My investigator made enquiries of Reading about the provision of bedding material. He was told that prisoners are given two sheets and one blanket. If a prisoner complains that he is cold a check will first be made that the cell window closes properly. Any defects with the window will be corrected but if there are no problems with the window the prisoner will be told to submit an application (a written request). The claim for an additional blanket will then be considered.

63. My investigator spoke with Reading's complaints clerk who informed him that the man submitted no applications while in the prison. My investigator was also told that there was no record that any of the windows in any of the cells occupied by the man were broken.

64. I understand that at some prisons it is standard for prisoners to be issued with two blankets during the winter months. It might well be that the majority of prisoners at Reading find one blanket sufficient even in winter. However, even if that is so, it is self-evident that some prisoners will feel the cold more than others. I do not see why it should be necessary for prisoners to have to submit a formal application in order to obtain an additional blanket.

    I recommend that the Governor should allow prisoners to obtain an additional blanket on a simple oral request.

Letters and phone calls on 18 December

65. The man made seven telephone calls between 1.58pm and 3.18pm on the day before his death. My investigator listened to all of these calls. The first three calls were to his mother and, during one of them he spoke briefly to his grandfather. He was very angry during these conversations, appearing to blame his girlfriend for his being in prison.

66. The remaining four telephone calls were to his girlfriend. The man was again very angry and agitated in the first two calls. However, during the penultimate call they discussed some of the problems that had occurred in their relationship. The man apologised for his past behaviour and told his girlfriend that he still loved her. She did not return his expressions of love. Even so, the conversation ended with them agreeing to speak again the following week once he had re-credited his telephone account. Their final conversation was very brief. The man asked his girlfriend to pass a message to his mother. He said that he had tried to telephone her direct but it seemed that she was not at home when he rang.

67. The man wrote two letters to his mother that day. The first was written before any of the telephone calls as he said that he was still waiting for credit to be put on his telephone account. He wrote of his regret about being refused bail meaning that he would miss Christmas at home. However, the very next sentence appears to anticipate Christmas 2008. The second letter was clearly written after the telephone calls as the man referred to using up his telephone credit. In the letter he indicated that his relationship with his girlfriend was at an end.

68. The man also wrote to his girlfriend after either the third telephone conversation or after the fourth. The evidence shows that he and his girlfriend had a fairly volatile relationship. It seems that they had separated and been reconciled on a number of occasions in the past. He wrote in the letter that he was 'sorry it had to end like this'. It could be understood that he was referring to the end of the relationship, rather than the end of his life. However, the letter also contains the word 'exit' followed by the year 2007.

69. The man wrote one further letter some time in the next few hours. This was the one found on top of his bed the following morning in which he indicated his intention to take his life.

Continuity of care

70. Following the man's death, the Specialist Services Manager for Children's Services, commissioned a confidential internal review to consider his involvement from 2005 with the Local Authority Children's Services, with the local service provider of 16+ Services and with the Youth Justice Services (YJS). My investigator obtained a copy of this report to help him consider the man's mother's belief that her son had been let down over a number of years by a number of agencies involved in his care. The relevant services granted me permission to summarise the main findings of the review.

71. The review found that the level of multi-agency communication and joint working was very variable and it was questionable whether it was particularly effective. It was found that in the two and a half years after June 2005 no individual professional took on the role of key worker and there was no discussion by any agency that one was needed. The result was that individual professionals worked within their own remit and with limited knowledge of and concerns for the remit of others. Nor was there any thought that other colleagues might have information that would provide a more complete picture of the situation.

72. It was also found that the quality of assessment and planning by the 16+ Service in 2006 and 2007 was not adequate. However, the quality of assessment and intervention by the YJS was considered to have been sound, with the only exception being the number of different officers involved with the man in the final two year period.

73. Neither the 16+ Service nor the new 18+ Service visited the man while he was in Reading, but the review concluded that it would be harsh to be critical of that fact. The 18+ Service depends on the young person wanting support and the man had previously indicated that he could look after himself. It was also unclear who the key contacts would be as the YJS involvement was due to end in December 2007 at the end of the licence period.

74. The review also found no indication in the man's records that he would treat this last period in custody any differently to his previous ones. Nor was there any such indication from interviews with staff.

75. The review included three recommendations for changes to processes and procedures. (At the time of the issue of this report the recommendations were yet to be adopted by the relevant services.)

Main findings from clinical review

76. The main findings of the clinical review include the need to improve management of the doctors' clinic. This relates to the fact that the man missed three appointments to see the doctor but nothing was recorded about why he missed the appointments nor about the original reasons for the consultations. The review team add that they do not believe that this issue contributed to the man's death.

77. The clinical review team found deficiencies and inconsistencies in record keeping. This included the omissions set out above as well as other deficiencies such as a failure to enter in the man's records that he had been dispensed a skin moisturiser and a failure to record the timing for a consultation about a headache. Another finding linked to record keeping was Reading's failure to obtain the clinical records from the man's time at Feltham.

78. Based on their consideration of all the evidence the clinical review team conclude that on the occasions the man presented to the healthcare team he appeared to be coping well and no concerns were raised about his mental health. They also note, however, that his community medical records show that he was prone as a child and as a young man to impulsive behaviour.

Should HMP & YOI Reading have realised that the man might have been at risk?

79. No one who encountered the man during his brief time in Reading noticed anything about his demeanour to suggest that he might have been at risk. Apart from the one incident when he used abusive language towards the second officer he otherwise seems to have complied with the prison regime. The second officer's evidence included that the man went out of his way to apologise to her for his behaviour on 15 December and thereafter he was always polite and well behaved. The first officer, who was also involved in the incident that led to the adjudication hearing, agreed that the man was polite thereafter. As has already been discussed, there is no evidence to indicate that he was upset at the punishment imposed at the hearing.

80. The physical education instructor first met the man at Feltham when he was around 15 or 16 years of age. It would seem that he was quite volatile at that time but the PE Instructor told my investigator that he had matured in the two or three years since they last met. He said that the man was always laughing and joking but was also well behaved. He mentioned that he had a job and a girlfriend. The last time the PE Instructor saw the man was on the afternoon of 18 December 2007. He asked him how he was feeling about being refused bail the previous day. The PE Instructor did not think that he seemed upset; he said he would reapply after Christmas.

81. My investigator spoke to two prisoners who were on friendly terms with the man. One of whom knew him from outside prison. Neither noticed any signs that he might be at risk.

82. In response to the draft report the solicitors acting for the man's family raised a number of matters that they consider might have alerted staff to the possibility that he was at risk. They consider that there is an evident contradiction between the staff's impression as to how he was coping and the fact that he had a history of ADHD, OCD, anxiety and depression. Although it is true that the man had been diagnosed with these conditions in the past, there is no evidence that any of these conditions were active at the time of his arrival into Reading. At that time he denied having any physical or mental health problems and he was not in receipt of any prescribed medication. ADHD is usually diagnosed in childhood and is a condition that many children simply grow out of. The PE Instructor's evidence, as already mentioned, was that the man had matured since he had last seen him. In addition, there are entries in his clinical records from 2006 indicating that he considered some of his past clinical diagnoses to be behind him.

83. Another matter raised by the family's solicitor was whether the man should have been more closely monitored given that this was his first time in an adult prison. There is no such provision in place. It should be borne in mind, however, that for many of the young men in Reading at any time

this will be their first time in an adult prison. It should also be borne in mind that although Reading is an adult prison, none of the men there are older than 21. Thus, for this man, he was still among what could be termed, a peer group.

The way the man's mother was informed of her son's death

84. Prison Service Order (PSO) 2710 provides guidance and instruction on notification to families following a death in custody. The only mandatory requirement is for the notification to be made as soon as possible and in a suitable manner, giving an accurate factual account of what has happened. In general, face to face notification by staff from the prison is considered to be the preferred option. However, Governors are also advised that they should be mindful of the safety of their staff so advice should be sought from the local police force on the level of likely hostility in the neighbourhood and at the family home. The guidance goes on to say that, if judged necessary, the police should be asked to escort the team or to remain nearby.

85. The guidance acknowledges that asking the police to inform the family may sometimes be necessary, and that the police should be asked to break the news if there is a risk to staff going into the neighbourhood or family home. The guidance warns, however, that if the police are asked to break the news, it should not be assumed that the officer deployed to visit the family will have been trained to break bad news.

86. When my family liaison officer and investigator visited the man's mother at her home she expressed great anger about the way the news was broken to her. She was angry that the risk assessment indicated the apparent necessity of a police presence as it might not be safe for prison staff to visit alone. She also said that the two police officers who visited her home handled matters extremely poorly.

87. I can understand why the man's mother felt affronted that the risk assessment advised that it might not be safe for prison staff to visit the family home. I can certainly place on record that my staff were made very welcome when they visited the family home where they met his mother, her sister and their father (the man's grandfather). I also understand from my staff that they felt no concern about the neighbourhood in general. Having said that, Reading were adhering to protocol in contacting the police for their advice on security issues. When the advice came back that a police presence was advisable it would have been unreasonable to have expected staff to visit the home unaccompanied. In my view the most appropriate option would have been for Reading's Governor to arrange for her staff to make the visit with the support of the local police.

88. Once the police were tasked to make the visit the prison was no longer in control of the situation. The man's mother's evidence indicates that the police officers who visited were either untrained or unskilled in dealing with the extremely sensitive task of delivering the news of the death of a

family member. That can only serve to intensify any family's distress. I am certain that Reading's Governor will be sorry to learn of the family's experience. This is a matter on which she will wish to reflect to see what lessons can be learned for any future tragedy.

Liaison between HMP & YOI Reading and the man's family

89. The man's mother complained that most of the contact with the prison had to be instigated by the family and she also complained that there seemed to be no single point of contact at the prison.

90. One of Reading's governors, who no longer works at the prison, was the intended family contact person for the man's family. I do not know whether or to what extent this arrangement broke down. Nor do I know the reasons why it might have broken down. However, prison governors are extremely busy people and, in a small prison such as Reading, will have many different tasks to carry out every day. It is probably not practical therefore to allocate family liaison work to a governor grade. I understand from Reading that one of its officers has recently received family liaison officer training and that she will carry out this important role in the case of any future deaths. I am pleased to learn of this development.

The man's training shoes

91. At some stage after the man's death his training shoes went missing. It is unclear when they went missing although I presume that his body remained fully clothed until reaching the mortuary where all clothing would have been removed for post mortem. His body would have subsequently been released to funeral directors, but they deny receiving the shoes. I sympathise with his mother for the distress caused through the loss of some of her son's belongings. Unfortunately, I cannot say how the shoes came to be lost.

CONCLUSION

92. Nothing occurred during the man's brief time in Reading for staff to suspect that he might have been at risk. He had had something of a troubled past, but that could probably be said of most, if not all, of the young men at Reading. Two matters that troubled him around 18 December were the prospect of being in prison over Christmas and the seeming end of his relationship with his girlfriend. However, most of the other prisoners still in Reading by 19 December would be there for Christmas and I am certain that he would not have been the only one experiencing the end of a relationship.

93. It was written of the man that he was prone to impulsive behaviour – that, of course, might equally be said of a great number of young people who are to be found in custody. Although he left behind a letter indicating that he was planning to take his life, he gave no explanation why he was intending to do so.

RECOMMENDATIONS

I make the following recommendations and I note the Prison Service's responses to date in italics following each recommendation. I invite the Service to respond to the first recommendation:

1. I recommend that the Governor reminds staff of the importance of the cell sharing risk assessment process.

2. I recommend that the Governor should allow prisoners to obtain an additional blanket on a simple oral request.

   Prison Service response: Recommendation accepted. There never has been any local policy stating that request for a blanket has to be through a formal written application. However, a Governors Order has been issued advising staff that a formal written application is not required to request an additional blanket. If a prisoner makes any such request verbal or otherwise a blanket will be issued to the prisoner concerned. Action completed.

I also endorse the following recommendations which appear in the clinical review:

3. A clear clinic protocol should be developed supported by the prison governor so that prisoners are enabled to see the doctor when requested.

   Prison Service response: Recommendation accepted. Protocol now in place and a dedicated officer is funded by the PCT to escort prisoners who need to see the GP on a daily basis. An audit trail is in place to record the outcome. Action completed.

4. A clear protocol for the management of prisoner requests to see the doctor should be developed which includes how prisoners get rescheduled for appointments if appropriate.

   Prison Service response: As above.

5. Record keeping must be improved in line with Nursing and Midwifery Council guidelines and should form part of regular supervision of staff. Sharing best practice with Feltham is recommended.

   Prison Service response: Recommendation accepted. Record keeping was audited on 26 January 2009. PCT staff will be attending PCT record keeping training through Feb 2009 and training will be on going for new staff. Record keeping is discussed as part of personal development plans. A number of protocols have been obtained from Feltham and are now in place. Target for completion: March 2009 and ongoing.

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

Prison Service response: Recommendation accepted. As above. This will continue to be reinforced by weekly audits by the Primary Care Lead. Target for completion: March 2009 and ongoing.

7. Medication given to prisoners within the treatment room must include a time on the prescription chart.

   Prison Service response: Recommendation accepted. For those on regular prescribed medication the timings are recorded as am, pm or night based on current set treatment room times. Whilst those that report sick have date, complaints, dosage, complaint and signature. There is no box to record time on the national prescription chart used. However, primary care lead will direct nurses in the treatment room to record time in the date box. Target for completion: February 2009.

8. A records audit should be completed to establish a baseline and then repeated in six months to measure improvement

   Prison Service response: Recommendation partially accepted. Annual record keeping audits are carried out. The last one on took place on 26 January 2009, actions are implemented and discussed in team meetings. Target for completion: February 2009 and ongoing.

9. We recommend that at a local level previous prison and community healthcare records be sought. At national level we would request the Ombudsman to alert authorities to the need to integrate community and prison records to ensure that prisoners have the same lifelong records as those in the community.

   Prison Service response: Recommendation partially accepted. Prison records are sought. In the man's case they had been requested but not arrived. In relation to health care records, locally, these are requested if a prisoner self reports concerns or concerns are identified by health care staff as part of the health care assessment. These include Mental Health records. In this case no such concerns were raised. Action completed.

10. There should be urgent consideration of the early implementation of an integrated and comprehensive IT system to replace hand written records, similar to those systems within GP surgeries. This would enable all healthcare information to be made available between HMP YOI institutions.

    Prison Service response: Recommendation accepted. Locally agreed and HMP Reading identified as a pilot for the introduction of System One as part of the existing phased introduction across establishments. National Implementation was due in April 2009 but has been delayed until Sept 2009. Once in place this will enable Reading to obtain information from other establishments, but only those that take part in the national programme. Target for completion: September 2009.